

# ARKANSAS HEALTHCARE TRANSPARENCY INITIATIVE – ARKANSAS APCD DATA SUBMISSION GUIDE

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# TABLE OF CONTENTS

<b>GLOSSARY OF TERMS</b> .....	<b>III</b>
<b>OVERVIEW</b> .....	<b>1</b>
DATA REQUIREMENTS .....	1
<b>FREQUENTLY ASKED QUESTIONS</b> .....	<b>3</b>
<b>DATA CATEGORIES FOR SUBMISSION</b> .....	<b>5</b>
ENROLLMENT DATA .....	5
MEDICAL CLAIMS DATA .....	6
PHARMACY CLAIMS DATA .....	7
DENTAL CLAIMS DATA .....	8
PROVIDER DATA.....	9
CONTROL COUNTS.....	10
TEST DATA.....	11
<b>DATA SUBMISSION REQUIREMENTS</b> .....	<b>12</b>
FILE SUBMISSION REQUIREMENTS.....	12
SUBMITTED DATA ENCRYPTION REQUIREMENTS .....	16
DATA VALIDATION .....	18
<b>DATA FORMATTING REQUIREMENTS</b> .....	<b>20</b>
FILE FORMAT.....	20
<b>EXHIBIT A – DATA ELEMENTS</b> .....	<b>22</b>
FILE GUIDELINE AND LAYOUT LEGEND .....	22
HEADER AND TRAILER RECORDS .....	24
MEMBER ENROLLMENT DATA.....	27
MEDICAL CLAIMS DATA .....	36
PHARMACY CLAIMS DATA .....	58
DENTAL CLAIMS DATA.....	68
PROVIDER DATA.....	76
DATA SUBMISSION EXAMPLE .....	82
<b>EXHIBIT B – ENCRYPTION PROTOCOLS</b> .....	<b>83</b>
DATA SUBMISSION ENCRYPTION PROTOCOLS.....	83
ENCRYPTION SOFTWARE RECOMMENDATIONS .....	83
COMMAND LINE EXAMPLES.....	84
<b>EXHIBIT C – SAMPLE DATA EXCEPTION REQUEST FORM</b> .....	<b>85</b>
<b>EXHIBIT D – ADJUSTMENTS/VERSIONING REQUIREMENTS</b> .....	<b>86</b>
<b>APPENDICES</b> .....	<b>87</b>
APPENDIX A: INSURANCE TYPE PRODUCT CODE .....	87
APPENDIX B: RELATIONSHIP CODE.....	88
APPENDIX C: DISCHARGE STATUS .....	89
APPENDIX D: TYPE OF BILL.....	90
APPENDIX E: FACILITY TYPE .....	99
APPENDIX F: PROCEDURE MODIFIER CODES .....	100
APPENDIX G: LANGUAGE .....	101
APPENDIX H: RACE .....	102
APPENDIX I: ETHNICITY.....	122
APPENDIX J: PROVIDER TYPE CODES .....	124
APPENDIX K: EXTERNAL CODE SOURCES .....	125
APPENDIX L: PLAN AND GROUP DEFINITIONS.....	126
<b>REVISION HISTORY</b> .....	<b>128</b>

## GLOSSARY OF TERMS

Term	Definition
<b>ACHI</b>	Arkansas Center for Health Improvement
<b>AID</b>	Arkansas Insurance Department
<b>APCD</b>	Arkansas all-payer claims database
<b>APCD Data Staging Server</b>	Protected data environment where submitted data is stored and managed
<b>Checksum</b>	A checksum is a count of the number of bits in a transmission unit that is included with the data file for APCD Data Intake verification
<b>CMS</b>	The Centers for Medicare and Medicaid Services
<b>Detached signature file</b>	A digital signature certifies and timestamps a the files submitted to the APCD Data Intake process
<b>DLZ</b>	APCD Data Landing Zone. The DLZ is the secure infrastructure that receives encrypted data pulled from the APCD Secure File Transfer Protocol (SFTP) site
<b>DRG</b>	Diagnosis Related Group. DRG is a statistical system of classifying any inpatient stay information into groups for the purpose of payment
<b>DSG</b>	APCD Data Submission Guide
<b>HIPAA</b>	Health Insurance Portability and Accountability Act of 1996
<b>HIRRD</b>	Health Insurance Rate Review Division of the AID
<b>JIRA</b>	ACHI-APCD team issue tracking tool
<b>MIME-type</b>	Multipurpose Internet Mail Extensions type
<b>NPI</b>	A national unique identification number for covered health care providers
<b>Onboarding</b>	The process to enable data file submission for submitting entities. Process includes web portal assignment and activation, encryption key exchange and protocols, and data submission guidelines
<b>Provider</b>	A “provider” is defined as a person or entity, including physicians, nurse practitioners, and physician assistants rendering medical care
<b>Rule 100<sup>1</sup></b>	AID guidelines for submission of medical, dental, and pharmaceutical claims, unique identifiers and geographic and demographic information for covered individuals, and provider files to the Arkansas Healthcare Transparency Initiative for the purpose of creating and maintaining a multi-payer claims database as a source of healthcare information to support consumers, researchers, and policymakers in healthcare decisions within the state.
<b>SFTP</b>	Secure File Transfer Protocol
<b>Submitting Entity</b>	Entity required to submit data per in Act 1233 of 2015
<b>UAMS</b>	University of Arkansas for Medical Sciences
<b>URL</b>	Uniform Resource Locator. A URL specifies a resource location, or web address, for a website

<sup>1</sup> “Proposed Rule 100: Arkansas Healthcare Transparency Initiative Standards.” Arkansas Insurance Department Proposed Rule 100 is issued pursuant to Act 1233 of 2015 of the Arkansas 90th General Assembly, also known as the “Arkansas Healthcare Transparency Initiative Act of 2015.” <http://insurance.arkansas.gov/Legal/PropRules/PropRule100.pdf>.

## OVERVIEW

Access to timely, accurate, and relevant data is essential to improving quality, mitigating costs, and promoting transparency and efficiency in the healthcare delivery system. Pursuant to the Arkansas Healthcare Transparency Initiative of 2015,<sup>2</sup> the Arkansas Center for Health Improvement (ACHI), or the “Administrator,” is hosting a comprehensive all-payer claims database (APCD) on behalf of the Arkansas Insurance Department (AID) that houses member enrollment data, medical claims, pharmacy claims, dental claims, and provider data. As noted in Arkansas Insurance Department Rule 100 (the “Rule”), the Arkansas Healthcare Transparency Initiative - Arkansas APCD Data Submission Guide (DSG) establishes file requirements from which submitting entities develop data files for voluntary or mandatory data submission.

*The DSG is a dynamic document that will be reviewed and updated on an ongoing basis. Proposed changes to the DSG will be implemented according to the specifications in the Rule.*

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### Data Requirements

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Submitting entities must provide specified data categories in the timeframes required unless granted an exemption pursuant to the Rule.

#### Required Data Categories

- Member Enrollment data (ME)
- Medical claims (MC)
- Pharmacy claims (PC)
- Dental claims (DC)
- Provider data (PV)

A data exception process relating to the submission of specific element variables defined in the DSG is provided herein. This exception process is distinct from the exemption process defined in the Rule.

Submitting entities must provide look-up tables and validation counts supporting the data file categories listed above.

Data file layouts, data element descriptions, and other relevant data submission information for the data categories are provided in [Exhibit A – Data Elements](#). Each data element description includes the data element definition, associated values, value definitions, format, data type, coverage expectation, and required/optional indicators. Data submission requirements include the following:

- Submitting entities must provide data in the layouts defined in [Exhibit A – Data Elements](#).
- Data element values must be provided based on DSG definitions.
- Data exception requests must be submitted to the ACHI-APCD team for data elements or values that cannot be supplied as defined by the DSG.
- Data exceptions must be submitted to the ACHI-APCD team and approved in writing.
- Submitting entities must provide look-up tables for data elements values where specified.

The dataset formats in [Exhibit A – Data Elements](#) created by the APCD Administrator were developed in compliance with the Act and were identified after careful review of APCD layouts used in other states, APCD

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<sup>2</sup> Act 1233 of 2015

Council guidance, and the APCD Council’s Core Set of Data Elements.<sup>3</sup> The Administrator selected formats and variables that (1) conform to the minimum standard APCD core layout provided by the APCD Council; (2) include the data elements required for health system analytics and consumer data reporting; and (3) facilitate healthcare data transparency in Arkansas.

Each data element is represented by a Data Element Identifier (Data Element ID) comprised of the two-character data category abbreviation—ME, MC, PC, DC, or PV—and a three or four character value such as 001, 025A, 161A. Data elements are referred to by their Data Element ID throughout the DSG (e.g., ME001, MC001, and ME161A). This naming convention aligns with standards defined by the United States Health Information Knowledgebase.<sup>4</sup>

### ***Control Count Requirements***

Submitting entities must provide control counts for validation reporting to provide benchmarks against which to measure data accuracy. These counts are outlined in the [Control Counts](#) section of the DSG.

### ***Onboarding Documentation Requirements***

Submitting entities must provide the following documentation during the onboarding process:

**Submitting Entity Data Dictionary/Codebook.** Internal system data elements mapped to the DSG-defined data elements.

**Extract Specifications.** Detailed description of how the data extracts were created.

**Claims Processing Information.** Overview of how the submitting entity processes claims. This information will enable the APCD Development team to understand the origin of the data to inform integration with other submitting entities’ data.

### ***APCD Technical Support***

If you have questions, please visit the [Frequently Asked Questions](#) section within this guide. If you still have questions or concerns, please direct them to the APCD Technical Support team. See contact information below.

Technical support is available to all submitting entities and data users, and issues are logged and tracked upon notifying the APCD Technical Support team. The APCD Technical Support team will provide regular feedback during the resolution process.

#### **Hours of Operation:**

Monday through Friday, 9:00 am - 4:00 pm Central Standard Time (excluding state and federal holidays)  
Please report issues by emailing a detailed message that includes your contact information to initiate the resolution process. The APCD Technical Support team will respond to your reported issue as soon as possible.

#### **APCD Technical Support Contact Information:**

Phone: (501) 526-4306

Email: [arapcd@uams.edu](mailto:arapcd@uams.edu)

Website: <http://www.arkansasapcd.net>

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<sup>3</sup> “APCD Medical Data Reporting: Proposed Core Set of Data Elements for Data Submission.” *APCD Council, UNH, and NAHDO*, October 2011. Accessed on June 1, 2014 at [http://www.apcdouncil.org/sites/apcdouncil.org/files/media/apcd\\_council\\_core\\_data\\_elements\\_5-10-12.pdf](http://www.apcdouncil.org/sites/apcdouncil.org/files/media/apcd_council_core_data_elements_5-10-12.pdf).

<sup>4</sup> “United States Health Information Knowledgebase.” Accessed at <http://ushik.org/mdr/portals/>.

## FREQUENTLY ASKED QUESTIONS

	Question	Answer
<b>1</b>	How often are files submitted to the Arkansas APCD?	Data submission occurs according to the schedule in Rule 100, Appendix B.
<b>2</b>	Is the hashed or masked unique identifier required if the Carrier Specific Unique Member ID is included in the data?	Yes. The hashed or masked unique identifier represents the member across products, plans, and enrollment dates. The Carrier Specific Unique Member ID can change based on member activity.
<b>3</b>	Fields on enrollment data appear to be similar to those collected on the MC, PC, and DC files. Can you clarify?	Many of the elements in the data files use similar semantics and a few are exact duplicates. These fields on the claims files must be submitted to allow the data to be joined across tables.
<b>4</b>	What might cause a member to have more than one enrollment record per month?	A member will have more than one enrollment record when they are enrolled in more than one product, have secondary coverage, have a break in enrollment, or have multiple active primary care provider (PCP) assignments within a reporting period. Accurate enrollment data are needed to calculate member months by product and by provider.
<b>5</b>	If the submitting entity is not a risk holder, many elements do not apply. Should this be handled using an exception request?	Yes. When a submission is coming from a non-risk holder (e.g., TPA, claims processor, pharmacy benefits manager, device benefit manager, etc.), several elements may not be available to report. A data exception shall be submitted to identify each unavailable element.
<b>6</b>	Are denied claims required in the APCD?	No. Denied claims are not required for the APCD at this time.
<b>7</b>	Are claims that are paid under a “global payment” or “capitated payment” (thus, zero paid) reported in the Arkansas APCD?	Yes. Any medical claim that is considered “paid” by the submitting entity will appear in the appropriate claims file. “Paid amount” is reported as zero (0) and the corresponding allowed contractual and deductible amounts are calculated accordingly by the submitting entity.
<b>8</b>	Will claim versioning be included in the APCD processes?	Adjustments and versioning processes are not required for the initial historical submission of data files to the Arkansas APCD. The Arkansas Insurance Department (AID) and ACHI will work with submitting entities to develop APCD-specific versioning processes for deployment effective prior to July 31, 2016.
<b>9</b>	Are APCD data to be encrypted?	All Arkansas APCD data files are encrypted upon submission. The APCD team will provide encryption protocols to each submitting entity for file level encryption. See the <a href="#">Encryption Requirements</a> section within the DSG for more information.
<b>10</b>	How many fields have to fail the data quality checks for data file submission failure?	If one or more data elements that are not already approved exceptions fail the data quality check, the entire submitted file will fail.

	<b>Question</b>	<b>Answer</b>
<b>11</b>	Whom should I contact if I have questions about the APCD or DSG?	Questions concerning APCD data should be sent to the APCD Technical Support team. APCD Technical Support information is listed in the <a href="#">Overview</a> section of the DSG.
<b>12</b>	When will DSG revisions be published?	Changes to the Arkansas APCD Data Submission Guide will be published by October of each year with required submission changes due the following January.
<b>13</b>	Where is the data encrypted?	All submitted data files are encrypted in motion and at rest in the APCD processes. Direct identifiers are transformed into meaningless strings of numbers and letters within the encrypted files.
<b>14</b>	Should the member ID and/or subscriber ID be hashed by the submitting entity prior to submission?	The member ID should be hashed or masked prior to submission to the APCD and mapped to the Carrier Specific Unique Member ID. The subscriber ID must be hashed or masked prior to submission to the APCD and mapped to the Carrier Specific Unique Subscriber ID.  Hashing should be consistent across all data submissions so the hashed values representing the Member ID and Subscriber ID do not change.
<b>15</b>	Do medical claims, pharmacy claims, and dental claims files require an APCD unique identifier?	No. The Carrier Specific Unique Member ID will be used to link medical claims, pharmacy claims, and dental claims to enrollment or member data.
<b>16</b>	What is the definition of an Arkansas resident?	“Arkansas resident” means an individual for whom a submitting entity has identified an Arkansas address as the individual’s primary place of residence. For individuals covered by a student health plan, “Arkansas resident” means any student enrolled in a student plan for an Arkansas college or university regardless of his or her address of record.
<b>17</b>	What is a submitting entity?	“Submitting entity” is defined in Arkansas Insurance Department Rule 100 in Section 4(21).
<b>18</b>	What entities are not considered an APCD submitting entity?	“Submitting entity” does not include an entity that provides health insurance or a health benefit plan that is accident-only, specified disease, hospital indemnity and other fixed indemnity, long-term care, disability income, Medicare supplement, or other supplemental benefit coverage.
<b>19</b>	How should county be determined?	If county is not available in your data, assign based on street address and ZIP code.

## DATA CATEGORIES FOR SUBMISSION

This section provides data submission requirements for each data category provided by submitting entities. Data submissions must meet the requirements herein.

Note, references to submitting entities are defined in the *Act* as “an entity that provides health or dental insurance or a health or dental benefit plan in the state, including without limitation an insurance company, medical services plan, hospital plan, hospital medical service corporation, health maintenance organization, or fraternal benefits society...” Also, references to “members” and “subscribers” within each data category are defined in the *Act* as “covered individuals.”<sup>5</sup>

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### Enrollment Data

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#### Required Submission Information

Submitting entities must provide a dataset for each submission period defined in Rule 100 that contains information on all covered and termed members who are Arkansas residents associated with subscribers holding certificates of coverage from submitting entities.

“Arkansas resident” is defined per Rule 100 as an individual for whom a submitting entity has identified an Arkansas address as the individual’s primary place of residence. For individuals covered by a student health plan, “Arkansas resident” means any student enrolled in a student plan for an Arkansas college or university regardless of his or her address of record.

#### File Content

- Files must include variables specified in [Exhibit A – Data Elements: Enrollment Data](#).
- Files must include information for members with and without claims.
- Submitting entity’s Carrier Specific Unique Member ID and Carrier Specific Unique Subscriber ID must be hashed or masked prior to submission to the APCD. Hashing should be consistent across data submissions so the hashed value representing the Carrier Specific Unique Member ID and/or Carrier Specific Unique Subscriber ID does not change.
- **Historical/Initial data submission:** Enrollment data submitted with the initial historical data feed must contain information for all members enrolled as of January 1, 2013, and thereafter.
- **Ongoing, periodic submissions:** Each enrollment file submitted should contain enrollment data for the applicable time period.

#### Other Information

- Many of the elements in different files use similar semantics and a few are exact duplicates. Each file can be used individually or in combination with other files for analyses. Repeated data elements allow for streamlined data management for analyses.
- A required data element must contain the DSG specified values, formats, and thresholds unless an exception is put in place for a specific submitting entity when unable to provide that data element or value. Exceptions are granted using the APCD [data exception process](#) described within the DSG.

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<sup>5</sup> Act 1233 of 2015

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## Medical Claims Data

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### Required Submission Information

Submitting entities shall provide paid claims and adjustment claims for institutional and professional healthcare services rendered during update period. All claims must have an associated member record in the enrollment file.

### File Content

- Files must include variables specified in [Exhibit A – Data Elements: Medical Claims Data](#).
- Submitting entity must provide one row per claim line. If there are multiple services performed and billed on a claim, each of those services will be uniquely identified and reported on a separate line with the claim number linking the lines together.
- Submitting entity's Carrier Specific Unique Member IDs and Carrier Specific Unique Subscriber IDs must be hashed or masked prior to submission to the APCD. Hashing should be consistent across time so the hashed value representing the Carrier Specific Unique Member ID and/or Carrier Specific Unique Subscriber ID does not change.
- Submitting entity's Carrier Specific Unique Member IDs and Carrier Specific Unique Subscriber IDs must be consistent across member enrollment data, medical claim, and pharmacy claim files.
- Files must contain all claims based on paid date during the observation period for all covered services provided to eligible members.
- Files must include all non-pharmacy and non-dental claims submitted for services provided to covered members, including inpatient, outpatient, professional service, behavioral health, therapies, durable medical equipment (DME), and rehabilitation claims.
- Quarterly submission files shall contain adjustment claims for the APCD versioning process (see [Exhibit D: Adjustment/Versioning Requirements](#)).

### Other Information

- If the submitting entity only knows the billing entity, and the billing entity is not the service rendering provider, then the billing provider data is not appropriate in the service rendering provider fields. In this case an exception request is required.
- If the submitting entity does not know who performed the service or the specific site where the service was performed, the submitting entity will need to request an exception for one or both of these elements. It is not appropriate to include facility or billing information in field MC134, National Service Organization Provider ID.
- Redundancies will exist within some fields across multiple claim lines and will be managed by the APCD team in the database solution design. For example, Carrier Specific Unique Member IDs and paid dates will appear on each line of a claim. Aggregation will recognize these as the same claim and not as multiple claims.
- A required data element must contain the DSG specified values, formats, and thresholds unless an exception is put in place for a specific submitting entity when unable to provide that data element or value. Exceptions are granted using the APCD [data exception process](#) described within the DSG.

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## Pharmacy Claims Data

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### Required Submission Information

Submitting entities shall provide paid claims and adjustment claims for pharmaceutical products and services rendered during update period from submitting entities, including pharmaceutical benefit managers (PBM). All claims must have an associated member record in the enrollment file.

### File Content

- Files must include variables specified in [Exhibit A – Data Elements: Pharmacy Claims Data](#).
- Submitting entity must provide one row per claim number and claim line.
- Submitting entity's Carrier Specific Unique Member IDs and Carrier Specific Unique Subscriber IDs must be hashed or masked prior to submission to the APCD. Hashing should be consistent across data submissions so the hashed value representing the Carrier Specific Unique Member ID and/or Carrier Specific Unique Subscriber ID does not change.
- Submitting entity's Carrier Specific Unique Member IDs and Carrier Specific Unique Subscriber IDs must be consistent across member enrollment data, medical claims, and pharmacy claims files.
- Files shall contain all claims based on paid date during the observation period for all covered services provided to eligible members.
- Quarterly submission files shall contain adjustment claims for the APCD versioning process ([see Exhibit D – Adjustment/Versioning Requirements](#)).

### Other Information

- Redundancies will exist within some fields across multiple claim lines, and will be managed by the APCD team in the database solution design. For example, Carrier Specific Unique Member IDs and paid dates will appear on each line of a claim. Aggregation will recognize these as the same claim and not as multiple claims.
- In the event that the health plan submitting entity contracts with a pharmacy benefits manager or other service entity that manages claims for Arkansas residents, the health plan submitting entity shall be responsible for ensuring that complete and accurate files are submitted to the Arkansas APCD by the subcontractor. The health plan submitting entity shall ensure that the member identification information in the subcontractor's file(s) is consistent with the member identification information in the health plan's ME, MC, PC, and DC files. The health plan shall include utilization and cost information for all services provided to members under any financial arrangement, including sub-capitated, bundled, and global payment arrangements.
- A required data element must contain the DSG specified values, formats, and thresholds unless an exception is put in place for a specific submitting entity when unable to provide that data element or value. Exceptions are granted using the APCD [data exception process](#) described within the DSG.

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## Dental Claims Data

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### Required Submission Information

Submitting entities shall provide paid claims and adjustment claims for all members utilizing dental services. All claims must have an associated member record in the enrollment file.

### File Content

Files must include variables specified in [Exhibit A – Data Elements: Dental Claims Data](#).

- Submitting entity's Carrier Specific Unique Member ID and Carrier Specific Unique Subscriber ID must be hashed or masked prior to submission to the APCD. Hashing should be consistent across time so the hashed value representing the Carrier Specific Unique Member ID and/or Carrier Specific Unique Subscriber ID does not change.
- Submitting entity Carrier Specific Unique Member IDs and Carrier Specific Unique Subscriber IDs must be consistent across dental plan member and dental claims files.
- Submitting entities must provide one row per claim line. If there are multiple services performed and billed on a claim, each of those services will be uniquely identified and reported on a separate line with the claim number linking the lines together.
- Files should contain all claims (based on paid date) during the observation period for all covered services provided to eligible members.
- Quarterly submission files should contain adjustment claims for the APCD versioning process ([see Exhibit D – Adjustment/Versioning Requirements](#)).

### Other Information

- Redundancies will exist within some fields across multiple claim lines, and will be managed by the APCD team in the database solution design. For example, Carrier Specific Unique Member IDs and paid dates will appear on each line of a claim. Aggregation will recognize these as the same claim and not as multiple claims.
- A required data element must contain the DSG specified values, formats, and thresholds unless an exception is put in place for a specific submitting entity when unable to provide that data element or value. Exceptions are granted using the APCD [data exception process](#) described within the DSG.

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## Provider Data

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### Required Submission Information

Submitting entities shall provide information on all providers contracted at any time from January 1, 2013, forward. Look-up tables for specialty codes shall be included as part of the submitted information.

A “provider” is defined as any person or entity rendering medical care, including physicians, nurse practitioners, physician assistants, and others.

All providers must have a unique National Provider ID and/or ID assigned by submitting entity.

### File Content

- Records must include variables specified in [Exhibit A – Data Elements: Provider Data](#).
- **Historical/Initial data submission:** Provider data submitted with the initial historical data feed shall contain information for all providers from January 1, 2013, forward
- **Ongoing, periodic submissions:** Each provider file submitted must be a complete updated replacement beginning January 1, 2013, forward
- One record shall be submitted for each provider for each unique physical address.

*For example:* Helen Green, MD, 123 Main St., NPI: 123ABC

Helen Green, MD, 456 Oak St., NPI: 123ABC

### Other Information

- A required data element must contain the DSG specified values, formats, and thresholds unless an exception is put in place for a specific submitting entity when unable to provide that data element or value. Exceptions are granted using the APCD [data exception process](#) described within the DSG.

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## Control Counts

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Each submitting entity shall provide control counts with data feeds for validation reports. These control counts outlined below will also be used for baseline validation and benchmarking.

### Control Counts:

- Number of unique members for each month within the submitted data
- Number of medical claims per member in data submission
- Number of pharmacy claims per member in data submission
- Number of dental claims per member in data submission
- Number of unique active members per quarterly submission period who did not have a medical, pharmacy, or dental claim
- Number of unique active members per quarterly submission period who did have a medical, pharmacy, or dental claim
- Number of unique medical claims based on claim number for each month within submitted data
- Number of unique pharmacy claims based on claim number for each month within submitted data
- Number of unique dental claims based on claim number for each month within submitted data

### Definitions:

- Members are represented by submitting entity member ID.
- Submitting entity member ID is the value mapped to Carrier Specific Unique Member ID in the APCD DSG layout.
- Medical, pharmacy, or dental claim number is the value mapped to Payer Claim Control Number for each claim category.

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## Test Data

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Two types of test data will be required.

- **Onboarding:** During the onboarding process, each submitting entity will be required to test their SFTP access through the APCD web portal. Small test files containing up to 100 records shall be sent by the submitting entity with the appropriate file compression, naming conventions, and data encryption in order to verify the submitting entity has the appropriate access through the web portal.
- **Production Data Test File Submission:** Each submitting entity shall provide data prior to the submission of full datasets. Test data shall include a full month of activity for the following data categories:
  - Member Enrollment data
  - Medical claims
  - Pharmacy claims
  - Dental claims
  - Provider data

## DATA SUBMISSION REQUIREMENTS

The Data Submission Requirements section provides file transfer, encryption, data quality, exception, formatting, and naming convention information for the submitting entity to use when planning and executing data file extraction and transfer to the APCD.

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### File Submission Requirements

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#### Registration/Web Portal Set-up

All submitting entities must register on the APCD Website<sup>6</sup> to initiate web portal access for data file submission. After registration, the ACHI-APCD team will set up a submitting entity-specific web portal and University of Arkansas for Medical Sciences (UAMS) SFTP site for data submission. The ACHI-APCD team will work with the submitting entity to test data transfer and, after successful testing is complete, will request the Production Data Test File Submission described above..

#### Submission Methods

Submitting entities will submit files to the APCD using a web portal. This method allows the transfer and receipt of files and messages from the APCD website using SFTP protocol without the installation of additional software. This method requires Internet access, a username, and a password.

#### Submission Components

Each data submission must be zipped and posted to the submitting entity-specific SFTP site through the web portal. The zipped submission must include the following files that meet the encryption requirements outlined in the [Submitted Data Encryption Requirements](#) section of the DSG:

- Encrypted data file
- Encrypted signature file

#### Detached-signed Signature File Components

The “detached-signed” file is a means to (1) verify the identity of the submitter of the encrypted/signed file upon its receipt and (2) verify via the checksum that the encrypted-signed file has arrived in full and was uncorrupted. Component requirements and naming conventions are outlined in DSG section [Submitted Data Encryption Requirements](#).

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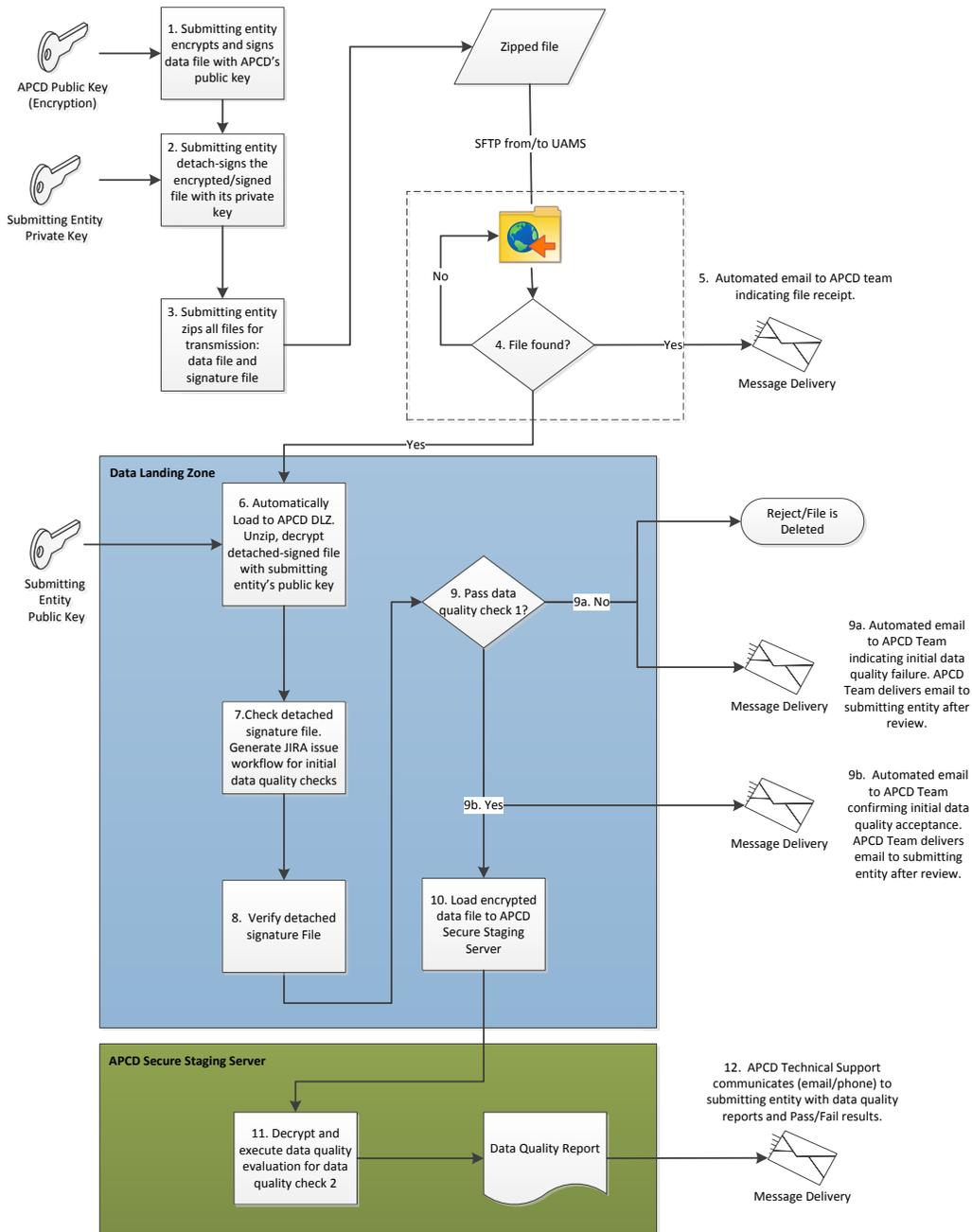
<sup>6</sup> Visit the Arkansas APCD online at <http://www.arkansasapcd.net>.

## Submission Process and Communication

Submitting entities will work with the ACHI-APCD team to understand data submission requirements and exchange public and private keys.

The data file submission process is illustrated below in Figure 1: APCD Data Submission Process. Process step descriptions follow the process map in Table 1: Data Submission Process Step Descriptions.

**Figure 1: APCD Data Submission Process**



**Table 1: Data Submission Process Step Descriptions**

Process Task	Description
1. Submitting entity encrypts and signs data file with APCD’s public key	Submitting entity will work with the ACHI-APCD team to understand data submission requirements and exchange public and private keys  The submitting entity will encrypt and sign required data using the APCD public key
2. Submitting entity detach-signs the encrypted/signed file with its private key	The submitting entity will also pull a detached signature file and encrypt it using its private key
3. Submitting entity zips all files for transmission: data file and signature file	Submitting entity “zips” both the encrypted/signed file (.gpg) and the detach-signed file (.sig) in one .zip archive file
4. File Found?	APCD processes scan SFTP site for dropped files
5. Email confirming receipt	Automated email is sent to ACHI-APCD team confirming data receipt
6. Automatically Load to APCD DLZ. Unzip, decrypt detached-signed file with submitting entity’s public key	Zipped data file automatically transferred to the APCD DLZ and unzipped into two files: <ul style="list-style-type: none"> <li>• Detached signature file</li> <li>• Encrypted data file</li> </ul> The detached signature file is decrypted using the submitting entity’s public key.
7. Check detached signature file. Generate JIRA issue workflow for initial data quality checks	Upon receipt on the DLZ, a JIRA workflow will be generated to unzip the file and trigger initial data quality checks
8. Verify detached signature file	Verify detached signature file <ul style="list-style-type: none"> <li>• MIME-type</li> <li>• Signature verification</li> <li>• Checksum matches</li> </ul>
9. Pass data quality check 1?  Messaging a. Automated email is generated from JIRA to the ACHI-APCD team indicating initial data quality validation failure. ACHI-APCD team delivers email to submitting entity	If the MIME-type is correct, signature verification is correct, and checksum matches, the file passes. If not, the file does not pass, and file is deleted from APCD data landing zone (DLZ)  If the file does not pass, an automated email is sent to the APCD team confirming initial quality validation

<p>after review</p> <p>b. Automated email is generated from JIRA to the ACHI-APCD team indicating initial data quality validation acceptance. ACHI-APCD team delivers email to submitting entity after review</p>	<p>failure. If the file fails, the APCD Technical Support team will contact the submitting entity directly to determine next steps</p> <p>If the file passes, an automated email is sent to ACHI-APCD team confirming initial quality check acceptance.</p>
<p>Steps 1 through 9 are automated.</p>	
<p>10. Load encrypted data file to APCD Secure Staging Server</p>	<p>Load encrypted data to APCD Data Staging Server.</p>
<p>11. Decrypt and execute final data validation for data quality check 2</p>	<p>Decrypt the data file. Execute final data quality validation</p>
<p>12. APCD Technical Support communicates (email/phone) to submitting entity with data quality reports and Pass/Fail results.</p>	<p>APCD Technical Support communicates (email/phone) to submitting entity with Pass/Fail results and data quality reports</p>

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## Submitted Data Encryption Requirements

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Submitted data must be encrypted at two levels to protect protected health information.

**Field level:** Unique identifiers representing member last name and date of birth combinations are required to create the member's APCD unique IDs (ME998). These data must be encrypted or masked securely prior to being delivered to the Arkansas APCD. APCD unique identifiers are only required for member enrollment data. Note: To further secure the APCD Unique ID, additional masking is applied to APCD Unique IDs during the APCD data intake process. **The ACHI-APCD team will provide specific encryption methodology to each submitting entity during the onboarding process.**

**File level:** All data files submitted must be encrypted at the file level before being sent to the APCD. Data files submitted to the APCD must be encrypted using public key cryptography (also known as asymmetric cryptography). [Self-identifying file naming conventions](#) are to be used for submitted data files to enable the automated delivery receipt notification and decryption process. The APCD Development team will work with each submitting entity to exchange the appropriate encryption keys and data intake protocols.

All data submissions must be secured for transfer using encryption requirement protocols defined in [Exhibit B - Encryption Protocols](#). These protocols are presented at the file encryption level.

### Public and Private Keys

The following keys will be required for the encryption and data transfer processes:

- APCD public key
- APCD private key (APCD internal use only)
- Submitting entity public key
- Submitting entity private key

### File Encryption

The ACHI-ACPD team will provide the APCD public key to submitting entities to encrypt the data file. Each submitting entity will provide the APCD its public key to decrypt the signature file.

Two files within a single .zip archive will be delivered with each data submission:

- Data file encrypted with APCD public key and signed with submitting entity private key
- Submitting entity detached-signed signature file (using the submitting entity's private key) of the encrypted/signed file just created in the above bullet

### Report Delivery

The ACHI-APCD team will provide final data quality reports to submitting entities after data validation is complete for each data submission. These reports will be encrypted before delivery to submitting entities. The ACHI-APCD team will provide the following files after data evaluation:

Two files within a single .zip archive will be delivered with each data quality report submission:

- Data quality report encrypted with submitting entity public key and signed with APCD private key

- APCD detached-signed signature file (using the APCD private key) of the encrypted/signed file just created in the above bullet

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## Data Validation

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As described in the [File Submission Requirements section](#), all data submitted to the APCD will go through two levels of data quality assessment:

- Detached signature file check
- DSG alignment assessment

Files passing both levels of data validation will be moved to the APCD production platform for transformation and database build.

Files not passing data validation will be deleted from all APCD systems. The APCD Technical Support team will contact the submitting entity to address the issues identified and request the submitting entity resubmit the data file(s).

### Detached Signature File Check

The “detached-signed” files received with the encrypted data files are assessed to verify that the sender of the encrypted/signed file is from the expected sender and, via the checksum, that the encrypted/signed file has arrived in full and is uncorrupted.

### DSG Alignment

Submitted files are assessed for conformance to the DSG field requirements. If the submitted data conforms to the DSG, data element level quality reporting is produced and delivered to submitting entities. Data files missing required data elements will be rejected unless exceptions have been put in place in advance.

Additionally, other data elements will be validated against established ranges and/or data element relationships. For example, all claim lines should have a valid paid date and paid amount.

DSG alignment evaluation produces data quality validation reports for each submitting entity. The final data quality validation reports will be encrypted and placed on the submitting entity-specific web portal for retrieval and review.

### Pass/Fail Criteria

**Data files failing the detached signature file check or at least one DSG specified value, format, or threshold requirement for DSG alignment will fail the data submission process unless a data exception is in place.**

**Files failing the data submission process will be deleted from the SFTP site and the DLZ. Submitting entities will be notified of submission failure. The APCD Technical team will work with the submitting entity to identify issues and coordinate data resubmission.**

### Data Exceptions

If required data elements or values are not available, submitting entities can apply for **data exceptions** addressing data variances that cannot be corrected due to systematic issues. Data exceptions shall be submitted to the APCD Technical Support team as described in the Data Exception Request Process section below.

### Data Exception Request Process

If a data exception is required, the submitting entity shall obtain the APCD Data Exception Request Form from the APCD website at [www.arkansasapcd.net](http://www.arkansasapcd.net). The submitting entity must return the completed data exception request form to the APCD Technical Support team prior to test file data submission by following the instructions provided in the exception form.

Data exception request will include:

Exception Report Category	Description
<b>DSG Data Element ID</b>	Unique identifier associated with each data element. This identifier is pre-populated from the value in the left most column of each DSG table layout
<b>DSG Data Element Name</b>	Name of the data element for exception. This name is pre-populated from the Data Element field in the DSG Layout
<b>Exception Reason</b>	Explanation of why data element and/or value cannot be provided
<b>Future Availability</b>	Indication of if and when the data element and/or value will become available
<b>Impact to APCD and Possible Workaround</b>	ACHI-APCD team use only. Not required by submitting entity with exception request. ACHI-APCD team will work with submitting entity to quantify impact and identify possible workarounds

### Exception Request Review

The APCD Technical Support team will work with submitting entities to understand the impact of exceptions and identify any needed processing changes. After the final exception request is mutually agreed upon in writing, the APCD Technical Support team will adjust the data intake process to accommodate the missing data. Files that do not conform to these new specifications and thresholds will be rejected. Corrected files must be submitted and will be reviewed again.

*Note: The Arkansas Center for Health Improvement (ACHI) is not responsible for correcting or applying “fixes” to the submitting entity's data.*

## DATA FORMATTING REQUIREMENTS

This section provides data file submission components, layouts, formats, variables, and value requirements.

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### File Format

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#### File Formatting Requirements

All files submitted to the APCD must adhere to the following formatting requirements:

- Submitted files must be in 7-Bit American National Standard Code for Information Interchange (7-Bit ASCII) single byte character format using the standard character set ANSI\_X3.4-1986. Valid files will not have a byte order mark. The character set is defined online at <http://www.columbia.edu/kermit/ascii.html>.
- Submitted files must be in the layout and Data Element ID order described in [Exhibit A – Data Elements](#)
- All files must contain a header record containing the data element ID for each variable specified in [Exhibit A – Data Elements](#)
- All files submitted to the Arkansas APCD must be formatted as standard .dat files
- All .dat files must comply with the following standards:
  - Files must always contain fully formed data records ending in a carriage return/linefeed.
  - No data element may contain carriage returns or line feed characters.
  - All data elements are variable data element length, delimited using a pipe (“|”). No pipes (“|”) should appear in the data itself. If data contains pipes, remove them or discuss using an alternate delimiter character
  - .dat data elements are only demarcated or enclosed in double quotes when a column delimiter (e.g., |) is present and is to be considered as data and not a delimiter
  - Unless otherwise stipulated, numbers (e.g., ID numbers, account numbers, etc.) do not contain spaces, hyphens, or other punctuation marks
  - .dat data elements are never padded with leading or trailing spaces or tabs
  - All fields shall be coded with the values specified herein. If data is unavailable and an approved [data exception](#) is in place, the data element value will be loaded as NULL.

#### Header and Trailer Records

Each submitted file must be accompanied by control totals and transmission control data as defined in header and trailer records. See layouts in [Exhibit A – Data Elements: Header and Trailer Records](#).

### File Naming Convention

All files submitted to the APCD should use the naming convention below designed to facilitate file management without requiring access to the contents. All file names will mimic the following example:

ARAPCD\_[EntityCode]\_[Test or Prod]\_[SubmissionDate]\_[CoveragePeriodDate]\_[FileNo]\_[FileCount]\_[EntityAbbreviation].dat

### File Name Component Definitions

- **EntityCode** –Codes representing submitting entities.
  - Private Carriers: NAIC codes
  - Other submitters: A unique 5-digit alphanumeric code assigned by the ACHI-APCD team
- **[Test or Prod]** – *Test* is for test data files; *Prod* is for production data files
- **SubmissionDate** – Date the file was produced. This date should be in the YYYYMMDD format
- **CoveragePeriodDate** – Represents coverage month transmission. This date should be in the YYYYMM format, e.g., CoveragePeriodDate = 201510 (October 2015). The date should represent the end month of data date range, e.g., for data pulled between 7/15/2015 and 9/14/2015, the CoveragePeriodDate = 201509
- **FileNo** – Represents the number of the file as it relates to the total number of files to be received.
- **FileCount** – Represents the total number of files to be received

#### **For Example:**

FileNo\_FileCount example 01\_09 represents file 01 of 09 expected files.

FileNo\_FileCount example 01\_01 represents file 01 of 01 expected file.

- **EntityAbbreviation** – Abbreviation representing file type
  - DNT = Dental Claims
  - CLM = Medical Claims
  - ELG = Member Enrollment Data
  - PHM = Pharmacy Claims
  - PRV = Provider Data
  - RPT = Control Count reports
  - LU = Look-up tables

## EXHIBIT A – DATA ELEMENTS

### File Guideline and Layout Legend

Layout Column	Column Definition
ID	Table row id representing required variable order
Data Element ID	Unique identifier representing data element by file type
Data Element	Data element name
Description	Data element definition and associated values with definition
Type	<p><b>Date</b> – Identifies value as date. Must be represented as YYYY-MM-DD</p> <p><b>Integer</b> – Identifies value as whole number</p> <p><b>Numeric</b> – Identifies values containing digits from 0 to 9 and a sign and/or a decimal point where required. If dollar amount, represent dollars and cents with decimals, e.g. 25.79</p> <p><b>Text</b> – Identifies values as having variable length alpha numeric characters</p>
Format*	<p><b>char</b> – A fixed length element of characters. Values must be the specified length column. This can be any type of data but is governed by the type listed for the element, such as Text versus Numeric. An example would be a zip code value of '3415' which will be submitted as '03415' as the Zip Code field has a specified field length of 5. For the 'char' format, the Length definition is a requirement, and not a maximum.</p> <p><b>varchar</b>– A variable length field of characters. Values cannot be longer than the specified length column. This can be any type of data but is governed by the type listed for the element, such as Text versus Numeric</p> <p><b>int</b> – A variable length field containing numeric values. Values cannot be longer than the specified length column. Records with numeric value formats cannot contain decimal points or leading zeroes</p> <p><b>unsigned int</b> - A variable length field containing a non-negative integer</p> <p><b>YYYY-MM-DD</b> - Required format for dates with year, month, and day</p> <p><b>decimal</b> – Numeric value with up to four digits right of the decimal</p> <p><i>*The plus/minus (±) symbol preceding the format indicates that a negative can be submitted in the element under the specified conditions</i></p>

Layout Column	Column Definition
Length	The definite or maximum width of a data element value. For example, for a dollar amount value of 15.25, the length indicator would be 10, 2, representing a 10-digit numeric value ("10") with up to 2 decimal places allowed (",2")
Threshold	Defines the minimum percent of data element values that are present and meet the validation requirements per the DSG
Required	Indicates if variable is required for initial APCD build. Not indicated in Header or Trailer record layout. All data elements are required for Header and Trailer record

## Header and Trailer Records

Every submitted data file should have its associated Header and Trailer records. Use values in Data Element ID column as column names in the header record of the Header and Trailer records. See [Data Submission example](#).

### *File Guidelines*

All fields shall be coded with the values specified in the Header and Trailer records data file.

- All fields must be included in the data submission
- Use values in Data Element ID column as column names
- If a value is not present for Date, Integer or Numeric fields, pass a NULL value (| |)
- If a blank is a valid value for a field, place the word “BLANK” in the field (|BLANK|)
- If a value is unavailable and is not the word “BLANK” for Text fields, pass a NULL value (| |)

### Header Record Layout

Data Element ID	Data Element	Description	Type	Format	Length	Threshold
HH	Record Prefix	Record Prefix  Place the value HD in the header detail record.	Text	char	2	100%
HD001	Submitter	Code representing payer submitting payments. Use NAIC codes for private carrier. Use five-character alpha numeric code for other submitting entities. Must match TR001	Text	varchar	5	100%
HD002	National Plan ID	Centers for Medicare and Medicaid Services (CMS) National Plan Identification Number (Plan ID). Do not report any value here until National Plan ID is fully implemented. This is a unique identifier as outlined by CMS for Plans or Sub plans. Must match TR002	Integer	unsigned int	10	0%
HD003	Type of File	MC = Medical Institutional & Professional Claims PC = Pharmacy Claims ME = Member Enrollment Data DC = Dental Claims PV = Medical/Dental Provider Data Must match TR003	Text	char	2	100%

Data Element ID	Data Element	Description	Type	Format	Length	Threshold												
HD004	Period Beginning Date	First date covered in submission period. Must match TR005	Date	YYYY-MM-DD	10	100%												
HD005	Period Ending Date	Last date covered in submission period. Must match TR006	Date	YYYY-MM-DD	10	100%												
HD006	Record Count	Total number of records in the submission, excluding the header records, trailer records and data file column name row. If the number of records within the submission do not equal the number reported in this field, the submission will fail	Integer	unsigned int	10	100%												
HD007	Submission File Count	<p>Number of datasets to expect for this file submission. Should match the [FileCount] value in the file name</p> <p>For example: If a submitted file required division into 3 manageable smaller data sets, each file would contain a header record representing the number of datasets to expect and the number of the single dataset as it relates to the entire file.</p> <table border="1"> <thead> <tr> <th>File 1</th> <th>File 2</th> <th>File 3</th> </tr> </thead> <tbody> <tr> <td>HD007 = 3</td> <td>HD007 = 3</td> <td>HD007 = 3</td> </tr> <tr> <td>HD008 = 1</td> <td>HD008 = 2</td> <td>HD008 = 3</td> </tr> </tbody> </table> <p>If a single file is submitted, the header record would include these values.</p> <table border="1"> <thead> <tr> <th>File</th> </tr> </thead> <tbody> <tr> <td>HD007 = 1</td> </tr> <tr> <td>HD008 = 1</td> </tr> </tbody> </table>	File 1	File 2	File 3	HD007 = 3	HD007 = 3	HD007 = 3	HD008 = 1	HD008 = 2	HD008 = 3	File	HD007 = 1	HD008 = 1	Integer	unsigned int	2	100%
File 1	File 2	File 3																
HD007 = 3	HD007 = 3	HD007 = 3																
HD008 = 1	HD008 = 2	HD008 = 3																
File																		
HD007 = 1																		
HD008 = 1																		
HD008	Submission File Number	<p>Number representing the dataset within file submission. Should match the [FileNo] value in the file name.</p> <p>See example in HD007</p>	Integer	unsigned int	2	100%												
HD009	DSG Version	<p>APCD Data Submission Guide version number.</p> <p>All records should contain the value "4.1.2015"</p>	Text	varchar	10	100%												

Trailer Record Layout

Data Element ID	Data Element	Description	Type	Format	Length	Threshold
TH	Record Prefix	Record Prefix  Place the value TD in the trailer detail record	Text	varchar	2	100%
TR001	Submitter	Code representing payer submitting payments. Use NAIC codes for private carrier. Use five-character alpha numeric code for other submitting entities. Must match HD001	Text	varchar	5	100%
TR002	National Plan ID	Centers for Medicare and Medicaid Services (CMS) National Plan Identification Number (Plan ID). Do not report any value here until National Plan ID is fully implemented. This is a unique identifier as outlined by CMS for Plans or Sub plans. Must match HD002	Integer	unsigned int	10	0%
TR003	Type of File	MC = Medical Institutional & Professional Claims PC = Pharmacy Claims ME = Member/Enrollment Data DC = Dental Claims PV = Medical/Dental Provider Data  Must match HD003	Text	char	2	100%
TR004	Period Beginning Date	First date covered in submission period. Must match HD004	Date	YYYY-MM-DD	10	100%
TR005	Period Ending Date	Last date covered in submission period. Must match HD005	Date	YYYY-MM-DD	10	100%
TR006	Date Processed	Date that the file was created by the submitter	Date	YYYY-MM-DD	10	100%
TR007	Posting Date	This field contains the date the file was posted by the submitting entity to the SFTP site	Date	YYYY-MM-DD	10	100%

## Member Enrollment Data

### File Guidelines

All fields shall be coded with the values specified in the Enrollment data file.

- All fields must be included in the data submission
- Use values in Data Element ID column as column names
- If a value is not present for Date, Integer or Numeric fields, pass a NULL value (| |)
- If a blank is a valid value for a field, place the word “BLANK” in the field (|BLANK|)
- If a value is unavailable and is not the word “BLANK” for Text fields, pass a NULL value (| |)
- If a [data exception has been applied](#), pass a NULL value (| |) in the field
- If a required field contains only values representing Unknown, Other, or Not Applicable, the submission will be failed and a data exception required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
1	DH	Record Prefix	Record Prefix  Place the value DD in the Enrollment Data detail record	Text	char	2	100%	Required
2	ME999	Unique Row ID	Each row must contain a unique ID or row number	Integer	unsigned int	10	100%	Required
3	ME001	Submitter	Code representing payer submitting payments. NAIC codes for private carrier. Five-digit alpha numeric code for other submitting entities	Text	char	5	100%	Required
4	ME002	National Plan ID	Centers for Medicare and Medicaid Services (CMS) National Plan Identification Number (Plan ID). Do not report any value here until National Plan ID is fully implemented. This is a unique identifier as outlined by CMS for Plans or Sub plans.	Integer	unsigned int	30	0%	Optional
5	ME003	Insurance Type/Product Code	Insurance type or product identification code that indicates the individual’s type of insurance coverage.  <a href="#">See Appendix A - Insurance Type/Product Code</a>	Text	varchar	6	99%	Required
6	ME006	Insured Group or Policy Number	The alpha numeric group or policy number is associated with the entity that has purchased the insurance. For self-funded individuals this relates to the purchaser. For the majority of	Text	varchar	30	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			enrollment and claims data the group relates to the employer					
7	ME007	Coverage Level Code	This field indicates the type of benefit coverage or type of contract  CHD = Children Only DEP = Dependents Only ECH = Employee and Children ELF = Employee and Life Partner EMP = Employee Only EPN = Employee with dependents ESP = Employee and Spouse FAM = Family IND = Individual SPC = Spouse and Children SPO = Spouse Only	Text	char	3	99%	Required
8	ME009	Plan Specific Contract Number	Contract number for the subscriber	Text	varchar	20	99%	Required
9	ME010	Member Suffix or Sequence Number (Person Code)	Unique number of the member within the contract. Must be an identifier that is unique to the member. This column is the unique identifying column for membership and related medical and pharmacy claims, e.g. the value for person 1 is 001, person 2 = 002, etc.	Integer	char	3	100%	Required
10	ME012	Individual Relationship Code	Member's relationship to the subscriber or the insured  See Appendix B - Relationship Code	Integer	char	2	100%	Required
11	ME013	Member Gender	Gender of the member  M = Male F = Female U = Unknown	Text	char	1	100%	Required
12	ME014	Member Date of Birth	Member's date of birth	Date	YYYY-MM-DD	10	100%	Required
13	ME016	Member State or Province	State or province of member's residence  See <a href="#">Appendix K - External Sources</a>	Text	char	2	100%	Required
14	ME017	Member ZIP Code	Five-digit USPS ZIP Code of the member's residence  See <a href="#">Appendix K - External Sources</a>	Integer	char	5	99%	Required
15	ME018	Medical Services Indicator	Medical Coverage provided for this member on this policy	Integer	unsigned int	1	100% if enrolled in a	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable				medical plan	
16	ME019	Pharmacy Services Indicator	Pharmacy coverage provided for this member on this policy  1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Integer	unsigned int	1	100% if enrolled in a pharmacy plan	Required
17	ME020	Dental Services Indicator	Dental Coverage provided for this member on this policy  1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Integer	unsigned int	1	100% if enrolled in a dental plan	Required
18	ME021	Member Race 1	Member's self-disclosed primary race  See <a href="#">Appendix H – Race</a>	Text	char	6	0%	Optional
19	ME022	Member Race 2	Member's self-disclosed Secondary race  See <a href="#">Appendix H – Race</a>	Text	char	6	0%	Optional
20	ME025	Member Ethnicity 1	Member's Primary Ethnicity  See <a href="#">Appendix I - Ethnicity</a>	Text	varchar	6	0%	Optional
21	ME026	Member Ethnicity 2	Member's Secondary ethnicity  See <a href="#">Appendix I - Ethnicity</a>	Text	varchar	6	0%	Optional
22	ME028	Primary Insurance Indicator	Indicates status of insurance  N = No, secondary or tertiary insurance Y = Yes, primary insurance U = Unknown	Text	char	1	0%	Optional
23	ME030	Market Category	The code that defines the market, by size and or association, to which the policy is directly sold and issued  IND = Individuals (non-group)	Text	varchar	4	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			<p>HMO = Health Maintenance Organization            LRG = Large Employer/Group            SML = Small Group/Employer            SMM = Small-Group Market            SLF = Self-Funded            FGP = Federal Government Plan            GPL = Government Plan</p> <p>See <a href="#">Appendix L - Plan and Group Definitions</a></p>					
24	ME032	Group Name	Name of the group under which the member is covered	Text	varchar	128	99%	Required
25	ME033	Member language preference	<p>Member's self-disclosed verbal language preference</p> <p>See Appendix G - Language</p>	Text	char	3	0%	Optional
26	ME034	Health Care Home EIN/Federal Tax ID Number	Federal tax payer identification number for medical home. An Employer Identification Number (EIN) is used to identify a business entity. This field will be used to create a master provider index for Arkansas providers encompassing medical service providers, prescribing physicians and medical homes. Alpha numeric characters only—omit spaces and hyphens	Text	varchar	15	0%	Optional
27	ME035	Health Care Home National Provider ID	<p>National Provider Identification (NPI) number for the entity or individual serving as the medical home. This field will be used to create a master provider index for Arkansas providers encompassing medical service providers, prescribing physicians, and medical homes</p> <p>See <a href="#">Appendix K - External Sources</a></p>	Integer	char	10	0%	Optional
28	ME036	Health Care Home Name	Full name of the provider - facility, organization, or individual. If the medical home is an individual, report in the format of last name, first name and middle initial with no punctuation	Text	varchar	60	0%	Optional
29	ME040	Product ID Number	Submitter-assigned product identifier for type of coverage/product purchased.	Text	varchar	30	99%	Required
30	ME045	Exchange Offering	<p>Identifies if policy was purchased through the Arkansas Health Insurance Exchange (HIE)</p> <p>Y = Commercial small or non-group purchased through the Exchange            N = Commercial small or non-group purchased outside the Exchange</p>	Text	char	1	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			U = Not applicable (plan/product is not offered in the commercial small or non-group market)					
31	ME046	Member PCP ID	The NPI of the member's PCP. The value in this element must have a corresponding Provider ID in the Provider File	Integer	char	10	60%	Required
32	ME047	Member PCP Effective Date	PCP Effective Date with Member	Date	YYYY-MM-DD	10	0%	Optional
33	ME048	Member PCP Termination Date	Date member terminated PCP association	Date	YYYY-MM-DD	10	0%	Optional
34	ME049	Member Deductible	Annual maximum out of pocket Member Deductible across all benefit types. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	90%	Required
35	ME050	Member Deductible Used	Member deductible amount used. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	0%	Optional
36	ME056	Last Activity Date	Date of last activity/change on Enrollment file for this line of eligibility. This includes any/all life change updates, open enrollment changes, or benefit design changes by the submitting entity	Date	YYYY-MM-DD	10	50%	Required
37	ME057	Date of Death	Member's date of death	Date	YYYY-MM-DD	10	0%	Optional
38	ME059	Disability Indicator	Member's disability status  1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Integer	unsigned int	1	0%	Optional
39	ME060	Employment Status	Employment status of member  A = Active I = Involuntary Leave P = Pending R = Retiree S = Student Z = Unemployed U = Unknown	Text	char	1	100%	Required
40	ME062	Marital Status	Marital status code  S = Single	Text	char	1	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			D = Divorced M = Married P = Domestic Partnership N = Never Married W = Widowed X = Legally Separated U = Unknown C = Child					
41	ME063	Benefit Status	Code that defines status of benefits for the subscriber  A = Active C = COBRA R = Retiree U = Unknown	Text	char	1	100%	Required
42	ME065	Retirement Date	Date Member retired	Date	YYYY-MM-DD	10	100% if ME063 = R	Required
43	ME072	Covered Individuals	Number of individuals covered under the policy/contract of the subscriber  Minimum value 1	Integer	unsigned int	2	100%	Required
44	ME077	Member SIC Code	Member Standard Industrial Classification (SIC) code  See <a href="#">Appendix K - External Sources</a>	Text	char	4	0%	Optional
45	ME078	Employer ZIP Code	Five digit USPS ZIP Code of the Employer's address  See <a href="#">Appendix K - External Sources</a>	Integer	char	5	50%	Required
46	ME082	Employer Name	Member's employer name	Text	varchar	60	99%	Required
47	ME083	Employer EIN/Federal Tax Identification Number	Member's Employer Identification Number (EIN)/Federal Tax Identification Number.  An Employer Identification Number is also known as a Federal Tax Identification Number, and is used to identify a business entity. Alpha numeric characters only—omit spaces and hyphens	Text	varchar	15	50%	Required
48	ME107	Carrier Specific Unique Member ID	Member's Unique ID.  Value must be hashed or masked prior to submission to the APCD. Hashing should be consistent across time so the hashed value representing the Member ID does not change	Text	varchar	50	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
49	ME109	Subscriber State or Province	State or province of the Subscriber's residence  See Appendix K - External Sources	Text	char	2	99%	Required
50	ME110	Subscriber ZIP Code of Residence	Five digit USPS ZIP Code of Subscriber's residence  See <a href="#">Appendix K - External Sources</a>	Integer	char	5	99%	Required
51	ME112	Pharmacy Deductible	Annual maximum out of pocket amount of member's deductible applied to pharmacy coverage. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	0%	Optional
52	ME113	Medical Deductible	Annual maximum out of pocket amount of member's deductible applied to Medical coverage. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	0%	Optional
53	ME117	Carrier Specific Unique Subscriber ID	Subscriber's Unique ID  Value must be hashed or masked prior to submission to the APCD. Hashing should be consistent across time so the hashed value representing the Subscriber ID does not change	Text	varchar	50	100%	Required
54	ME120	Actuarial Value	Actuarial value of grandfathered plan. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value  Required as of January 1, 2014 for small group and non-group (individual) plans sold inside or outside the Exchange.  Use values provided in the most recent version of the HHS Actuarial Value Calculator available at : <a href="http://cciio.cms.gov/resources/regulations/index.html">http://cciio.cms.gov/resources/regulations/index.html</a>	Numeric	±decimal	10,2	100% if ME122 = Y	Required
55	ME121	Metallic Value	Metal Level (percentage of Actuarial Value) as subject to or aligned with federal regulations.  1 = Platinum 2 = Gold 3 = Silver 4 = Bronze 0 = Not Applicable	Integer	unsigned int	1	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
56	ME122	Grandfather Status	See definition of “grandfathered plans” in HHS rules CFR 147.140  Y = Yes (if ME030 = IND, SML) N = No  Required as of January 1, 2014 for small group and non-group (individual) plans sold inside or outside the Exchange	Text	char	1	100%	Required
57	ME123	Monthly Premium	The amount the subscriber is responsible for on a monthly basis to maintain this line of eligibility. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	decimal	10,2	100%	Required
58	ME124	Attributed Primary Care Provider (PCP) Provider ID	PCP attributed to the patient for prior year. Leave blank if unavailable	Text	varchar	30	0%	Optional
59	ME132	Total Monthly Premium	Employer + subscriber's total contribution to monthly premium. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	decimal	10,2	0%	Optional
60	ME150A	Subscriber Date of Birth	Subscriber's date of birth	Date	YYYY-MM-DD	10	90%	Required
61	ME151A	Subscriber Gender	Subscriber gender  M = Male F = Female U = Unknown	Text	char	1	100%	Required
62	ME153A	Subscriber County	County Name of Subscriber's residence	Text	varchar	25	50%	Required
63	ME154A	Subscriber Race 1	Primary race of Subscriber  See <a href="#">Appendix H - Race</a>	Text	char	6	0%	Optional
64	ME155A	Subscriber Race 2	Secondary race of Subscriber  See <a href="#">Appendix H - Race</a>	Text	char	6	0%	Optional
65	ME156A	Subscriber Ethnicity 1	Primary ethnicity of Subscriber  See <a href="#">Appendix I - Ethnicity</a>	Text	varchar	6	0%	Optional
66	ME157A	Subscriber Language	Subscriber's self-disclosed verbal language preference	Text	char	3	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			See Appendix G - Language					
67	ME161A	Consumer Directed Health Plan (CDHP) with HSA or HRA Indicator	Member participates in a Consumer Directed Health Plan (CDHP) with Health Savings Account (HSA) or Health Resources Account (HRA) indicator  1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Integer	unsigned int	1	95%	Required
68	ME162A	Date of First Enrollment	The date of that the member was initially enrolled	Date	YYYY-MM-DD	10	99%	Required
69	ME163A	Date of Disenrollment	End date of enrollment for the member in this delivery system (in this data submission time period)	Date	YYYY-MM-DD	10	75%	Required
70	ME164A	Health Plan	Health Plan Name	Text	varchar	100	100%	Required
71	ME166A	Subscriber Ethnicity 2	Secondary ethnicity of Subscriber  See <a href="#">Appendix I - Ethnicity</a>	Text	varchar	6	0%	Optional
72	ME170A	Member NAICS Code	Member industry description  See <a href="#">Appendix K – External Code Sources</a>	Text	varchar	6	0%	Optional
73	ME173A	Member County	County of Member's residence Code or name	Text	varchar	25	75%	Required
74	ME998	APCD Unique ID	Encrypted identifier representing members' last name and date of birth. APCD Unique IDs will be consistent across records, representing every instance of a unique combination of the fields specified. See <a href="#">Submitted Data Encryption Requirements</a>	Text	varchar	100	100%	Required

## Medical Claims Data

### File Guidelines

All fields shall be coded with the values specified in the Medical Claims Data file.

- All fields must be included in the data submission
- Use values in Data Element ID column as column names
- If a value is not present for Date, Integer or Numeric fields, pass a NULL value (| |)
- If a blank is a valid value for a field, place the word “BLANK” in the field (|BLANK|)
- If a value is unavailable and is not the word “BLANK” for Text fields, pass a NULL value (| |)
- If a [data exception has been applied](#), pass a NULL value (| |) in the field
- If a required field contains only values representing Unknown, Other, or Not Applicable, the submission will be failed and a data exception required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
1	DH	Record Prefix	Record Prefix  Place the value DD in the Medical claims data detail record.	Text	char	2	100%	Required
2	MC999	Unique Row ID	Each row must contain a unique ID or row number	Integer	unsigned int	10	100%	Required
3	MC001	Submitter	Code representing payer submitting payments. Use NAIC codes for private carrier. Use five-character alpha numeric code for other submitting entities.	Text	char	5	100%	Required
4	MC002	National Plan ID	Centers for Medicare and Medicaid Services (CMS) National Plan Identification Number (Plan ID). Do not report any value here until National Plan ID is fully implemented. This is a unique identifier as outlined by CMS for Plans or Sub plans.	Integer	unsigned int	10	0%	Optional
5	MC003	Insurance Type/Product Code	Insurance type or product identification code that indicates the individual’s type of insurance coverage.  See <a href="#">Appendix A - Insurance Type/Product Code</a>	Text	varchar	6	99%	Required
6	MC004	Payer Claim Control Number	Claim number used by the submitting entity to internally track the claim. In general the claim number is associated with all service lines of the bill. It must apply to the entire claim and be unique within the submitting entity’s system	Text	varchar	35	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
7	MC005	Line Number	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim. This field is used in algorithms to determine the final payment for the service. If the submitting entity's processing system assigns an internal line counter for the adjudication process, that number may be submitted in place of the line number submitted by the provider	Integer	unsigned int	4	99%	Required
8	MC005A	Version Number	Final version number of the claim service line.  See <a href="#">Exhibit D: Adjustments/Versioning Requirements</a> Note: Versioning will be implemented in later phases. The threshold will change from optional to required at implementation	Integer	unsigned int	4	0%	Optional
9	MC005B	Version Number Date	Date of latest version of claim service line in Year and Month (YYMM) format  See Exhibit D: Adjustments/Versioning Requirements. Note: Versioning will be implemented in later phases. The threshold will change from optional to required at implementation	Integer	char	4	0%	Optional
10	MC006	Insured Group or Policy Number	The alpha numeric group or policy number associated with the entity that has purchased the insurance. For self-funded individuals this relates to the subscriber. For the majority of eligibility and claims data the group relates to the employer	Text	varchar	30	100%	Required
11	MC008	Plan Specific Contract Number	Submitting entity's assigned contract number for the subscriber. Set as blank if unavailable. Set as blank if contract number = subscriber's social security number	Integer	unsigned int	20	100%	Required
12	MC009	Member Suffix or Sequence Number (Person Code)	Unique number of the member within the contract. Must be an identifier that is unique to the member. This column is the unique identifying column for membership and related medical and pharmacy claims, e.g. the value for person 1 is 001, person 2 = 002, etc.	Integer	char	3	99%	Required
13	MC011	Individual Relationship Code	Member's relationship to the subscriber or the insured  See Appendix B - Relationship Code	Integer	char	2	100%	Required
14	MC012	Member Gender	Gender of the member M = Male F = Female U = Unknown	Text	char	1	100%	Required
15	MC013	Member Date of Birth	Member's date of birth	Date	YYYY-MM-DD	10	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
16	MC015	Member State or Province	State or province of member's residence  See Appendix K - External Code Sources	Text	char	2	100%	Required
17	MC016	Member ZIP Code	Five digit USPS ZIP Code of member's residence  See Appendix K - External Code Sources	Integer	char	5	100%	Required
18	MC017	Paid Date	Date the record was approved for payment	Date	YYYY-MM-DD	10	100%	Required
19	MC018	Admission Date	Date of the inpatient admission	Date	YYYY-MM-DD	10	100% if MC037 = 21	Required
20	MC019	Admission Hour	Hour the inpatient was admitted to the hospital. Required for all inpatient claims. Time is expressed in military time - HHMM. If only the hour is known, code the minutes as 00. 4 PM would be reported as 1600	Integer	char	4	100% if MC037 = 21	Required
21	MC020	Admission Type	Represents admission type for inpatient stay.  1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 5 = Trauma 9 = Information not available	Integer	unsigned int	1	100% if MC037 = 21	Required
22	MC022	Discharge Hour	Hour the inpatient was Discharged from the hospital. Time expressed in military time - HHMM. If only the hour is known, code the minutes as 00. 4 PM would be reported as 1600	Integer	char	4	100% if MC037 = 21	Required
23	MC023	Discharge Status	Status for the patient discharged from the hospital  See Appendix C - Discharge Status	Integer	char	2	100% if MC037 = 21	Required
24	MC024	Service Provider Number	Submitting entity's assigned or legacy rendering/attending provider number. Submitting facility for institutional claims; physician or healthcare professional for professional claims	Text	varchar	30	0%	Optional
25	MC025	Service Provider EIN/Federal Tax ID Number	Federal tax payer's identification number for rendering/attending provider. An Employer Identification Number (EIN) is also known as a Federal Tax Identification Number, and is used to identify a business entity. Alpha numeric characters only—omit spaces and hyphens	Text	varchar	15	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
26	MC026	National Service Provider ID	National Provider Identification (NPI) number for the entity or rendering/attending provider directly providing the service. If not known, leave blank. Do not populate with associated servicing organization NPI (MC134)	Integer	char	10	100%	Required
27	MC027	Service Provider Entity Type Qualifier	HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as "Person" 1 = Person 2 = Non-Person entity	Integer	unsigned int	1	90%	Required
28	MC028	Service Provider First Name	Service provider first name. Set to blank if provider is a facility or an organization	Text	varchar	25	100%	Required
29	MC029	Service Provider Middle Name	Service provider middle name. Set to blank if provider is a facility or an organization	Text	varchar	25	50%	Required
30	MC030	Service Provider Last Name or Organization Name	Service provider last name. If not individual, place organization name in this field	Text	varchar	100	100%	Required
31	MC031	Service Provider Suffix	Service provider suffix is used to capture any generational identifiers associated with an individual clinician's name (e.g., Jr., Sr., III). <b>Do not code the clinician's credentials (e.g., MD, LCSW) in this field.</b> Set to blank if the provider is a facility or an organization	Text	varchar	10	5%	Required
32	MC032	Service Provider Specialty	Code defining provider specialty. Provide look-up tables for every field containing non-standard codes.	Text	varchar	10	90%	Required
33	MC033	Service Provider City	City of service provider's address	Text	varchar	30	90%	Required
34	MC034	Service Provider State	State or province of service provider's address  See Appendix K - External Code Sources	Text	char	2	90%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
35	MC035	Service Provider ZIP Code	Five digit USPS ZIP Code of the servicing provider's address, preferably the practice location  See Appendix K - External Code Sources	Integer	char	5	90%	Required
36	MC036	Type of Bill - Institutional	Bill type for institutional claims. Set to blank for professional claims  See Appendix D - Type of Bill	Integer	char	3	100% if MC037 = 21	Required
37	MC037	Facility Type	For professional claims, this field records the type of facility where the service was performed. The field should be set to blank for institutional claims  See Appendix E - Facility Type	Integer	unsigned int	2	100%	Required
38	MC038	Claim Status	This field contains the benefit coordination status of claim  01 = Processed as primary 02 = Processed as secondary 03 = Processed as tertiary 19 = Processed as primary, forwarded to additional payer(s) 20 = Processed as secondary, forwarded to additional payer(s) 21 = Processed as tertiary, forwarded to additional payer(s) 22 = Reversal of previous payment 25 = Predetermination pricing only – no payment	Integer	char	2	100%	Required
39	MC038A	Coordination of Benefits (COB) flag	Indicates if claim was Coordination of Benefits (COB) claim 1 = Yes 2 = No	Integer	unsigned int	1	100%	Required
40	MC039	Admitting Diagnosis	This field contains the ICD-9-CM or ICD-10-CM diagnosis code indicating the reason for the inpatient admission. Decimal point is not coded  See Appendix K - External Code Sources.	Text	varchar	7	100% if MC037 = 21	Required
41	MC040	E-Code	This field describes an injury, poisoning or adverse effect using an ICD-9-CM or ICD-10-CM E-code diagnosis. Decimal point is not coded. Additional E-Codes may be reported in other diagnosis fields MC041 - MC053  See Appendix K - External Code Sources	Text	varchar	7	0%	Optional
42	MC041	Principal Diagnosis	This field contains the ICD-9-CM or ICD-10-CM diagnosis code for the principal diagnosis. Decimal point is not coded  See Appendix K - External Code Sources	Text	varchar	7	100%	Required
43	MC042	Other Diagnosis - 1	This field contains the ICD-9-CM or ICD-10-CM diagnosis code for the first secondary diagnosis. Decimal point is not coded	Text	varchar	7	50%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			See Appendix K - External Code Sources					
44	MC043	Other Diagnosis - 2	This field contains the ICD-9-CM OR ICD-10-CM diagnosis code for the second secondary diagnosis. Decimal point is not coded See Appendix K - External Code Sources	Text	varchar	7	20%	Required
45	MC044	Other Diagnosis - 3	This field contains the ICD-9-CM or ICD-10-CM diagnosis code for the third secondary diagnosis. Decimal point is not coded See Appendix K - External Code Sources	Text	varchar	7	5%	Required
46	MC045	Other Diagnosis - 4	This field contains the ICD-9-CM or ICD-10-CM diagnosis code for the fourth secondary diagnosis. Decimal point is not coded See Appendix K - External Code Sources	Text	varchar	7	<1%	Required
47	MC046	Other Diagnosis - 5	This field contains the ICD-9-CM or ICD-10-CM diagnosis code for the fifth secondary diagnosis. Decimal point is not coded See Appendix K - External Code Sources	Text	varchar	7	<1%	Required
48	MC047	Other Diagnosis - 6	This field contains the ICD-9-CM or ICD-10-CM diagnosis code for the sixth secondary diagnosis. Decimal point is not coded See Appendix K - External Code Sources	Text	varchar	7	<1%	Required
49	MC048	Other Diagnosis - 7	This field contains the ICD-9-CM or ICD-10-CM diagnosis code for the seventh secondary diagnosis. Decimal point is not coded See Appendix K - External Code Sources	Text	varchar	7	<1%	Required
50	MC049	Other Diagnosis - 8	This field contains the ICD-9-CM or ICD-10-CM diagnosis code for the eighth secondary diagnosis. Decimal point is not coded See Appendix K - External Code Sources	Text	varchar	7	<1%	Required
51	MC050	Other Diagnosis - 9	This field contains the ICD-9-CM or ICD-10-CM diagnosis code for the ninth secondary diagnosis. Decimal point is not coded See Appendix K - External Code Sources	Text	varchar	7	<1%	Required
52	MC051	Other Diagnosis - 10	This field contains the ICD-9-CM or ICD-10-CM diagnosis code for the tenth secondary diagnosis. Decimal point is not coded See Appendix K - External Code Sources	Text	varchar	7	<1%	Required
53	MC052	Other Diagnosis - 11	This field contains the ICD-9-CM or ICD-10-CM diagnosis code for the eleventh secondary diagnosis. Decimal point is not coded See Appendix K - External Code Sources	Text	varchar	7	<1%	Required
54	MC053	Other Diagnosis - 12	This field contains the ICD-9-CM or ICD-10-CM diagnosis code for the twelfth secondary diagnosis. Decimal point is not coded See Appendix K - External Code Sources	Text	varchar	7	<1%	Required
55	MC054	Revenue Code	Revenue code for institutional claims. It is one of three fields used to report type of service. National Uniform Billing Committee Codes are accepted. Code using leading zeroes, left	Text	varchar	4	100% if MC037 = 21	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			justified and four digits					
56	MC055	Procedure Code	HCPCS or CPT code for the procedure performed. It is one of three fields used to report the service. Health Care Common Procedural Coding System (HCPCS), including CPT codes of the American Medical Association, are accepted. See Appendix K - External Code Sources	Text	varchar	5	80%	Required
57	MC056	Procedure Modifier - 1	Modifier is used to indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code. Modifiers may be used to indicate a service or procedure that has both a professional and a technical component, only part of a service was performed, a bilateral procedure was performed, or a service or procedure was provided more than once See Appendix F - Procedure Modifier Codes	Text	char	2	10%	Required
58	MC057	Procedure Modifier - 2	Modifier is used to indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code. Modifiers may be used to indicate a service or procedure that has both a professional and a technical component, only part of a service was performed, a bilateral procedure was performed, or a service or procedure was provided more than once See Appendix F - Procedure Modifier Codes	Text	char	2	2%	Required
59	MC057B	Procedure Modifier - 3	Modifier is used to indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code. Modifiers may be used to indicate a service or procedure that has both a professional and a technical component, only part of a service was performed, a bilateral procedure was performed, or a service or procedure was provided more than once See Appendix F - Procedure Modifier Codes	Text	char	2	<1%	Required
60	MC057C	Procedure Modifier - 4	Modifier is used to indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code. Modifiers may be used to indicate a service or procedure that has both a professional and a technical component, only part of a service was performed, a bilateral procedure was performed, or a service or procedure was provided more than once See Appendix F - Procedure Modifier Codes	Text	char	2	<1%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
61	MC058	Principal ICD-9-CM or ICD-10-CM Procedure Code	Principal inpatient ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary. This is one of three fields used to report type of service  <a href="#">See Appendix K - External Code Sources</a>	Text	varchar	7	55% if MC037 = 21	Required
62	MC058A	Other ICD-9-CM or ICD-10-CM Procedure Code - 1	First secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary  <a href="#">See Appendix K - External Code Sources</a>	Text	varchar	7	30% if MC037 = 21	Required
63	MC058B	Other ICD-9-CM or ICD-10-CM Procedure Code - 2	Second secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary  <a href="#">See Appendix K - External Code Sources</a>	Text	varchar	7	15% if MC037 = 21	Required
64	MC058C	Other ICD-9-CM or ICD-10-CM Procedure Code - 3	Third secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary  <a href="#">See Appendix K - External Code Sources</a>	Text	varchar	7	10% if MC037 = 21	Required
65	MC058D	Other ICD-9-CM or ICD-10-CM Procedure Code - 4	Fourth secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary  <a href="#">See Appendix K - External Code Sources</a>	Text	varchar	7	5% if MC037 = 21	Required
66	MC058E	Other ICD-9-CM or ICD-10-CM Procedure Code - 5	Fifth secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary  <a href="#">See Appendix K - External Code Sources</a>	Text	varchar	7	<1% if MC037 = 21	Required
67	MC058EA	Other ICD-9-CM or ICD-10-CM Procedure Code - 6	Sixth secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary	Text	varchar	7	<1% if MC037 = 21	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			See Appendix K - External Code Sources					
68	MC058F	Other ICD-9-CM or ICD-10-CM Procedure Code - 7	Seventh secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary  See Appendix K - External Code Sources	Text	varchar	7	<1% if MC037 = 21	Required
69	MC058G	Other ICD-9-CM or ICD-10-CM Procedure Code - 8	Eighth secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary  See Appendix K - External Code Sources	Text	varchar	7	<1% if MC037 = 21	Required
70	MC058H	Other ICD-9-CM or ICD-10-CM Procedure Code - 9	Ninth secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary  See Appendix K - External Code Sources	Text	varchar	7	<1% if MC037 = 21	Required
71	MC058J	Other ICD-9-CM or ICD-10-CM Procedure Code - 10	Tenth secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary  See Appendix K - External Code Sources	Text	varchar	7	<1% if MC037 = 21	Required
72	MC058K	Other ICD-9-CM or ICD-10-CM Procedure Code - 11	Eleventh secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary  See Appendix K - External Code Sources	Text	varchar	7	<1% if MC037 = 21	Required
73	MC058L	Other ICD-9-CM or ICD-10-CM Procedure Code - 12	Twelfth secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary  See Appendix K - External Code Sources	Text	varchar	7	<1% if MC037 = 21	Required
74	MC059	Date of Service - From	First date of service for this service line.	Date	YYYY-MM-DD	10	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
75	MC060	Date of Service - Thru	Last date of service for this service line. <b>Future dates are acceptable</b>	Date	YYYY-MM-DD	10	100%	Required
76	MC061	Quantity	Count of Services rendered.	Integer	unsigned int	3	100%	Required
77	MC062	Charge Amount	Total Charges for the services rendered.. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	99%	Required
78	MC063	Paid Amount	Amount paid for claim. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	99%	Required
79	MC063A	Header/ Line Payment Indicator	Flag indicating whether the payment is reported on the header or line level  H = Header level - If H, populate each line after the first line with "H" and a paid amount of \$0 L = Line level - If L, populate each line as necessary	Text	char	1	100%	Required
80	MC063C	Withhold Amount	Amount withheld from payment to a provider by a submitting entity, which may be paid at a later date. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	99%	Required
81	MC064	Capitation Amount	Fee for service equivalent that would have been paid by the health care claims processor for a specific service if the service had not been capitated. "Capitated services" means services rendered by a provider through a contract where payments are based upon a fixed dollar amount for each member on a periodic basis. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	100% if MC206 = Y	Required
82	MC065	Copay Amount	Pre-set, fixed dollar amount of copay payable by a member/patient and paid to the service provider. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
83	MC066	Coinsurance Amount	Member's Coinsurance amount. Patient's share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	99%	Required
84	MC067	Deductible Amount	Amount that is required to be paid by a member before health plan benefits will begin to reimburse for services. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	99%	Required
85	MC068	Patient Account/Control Number	Identifying number assigned by hospital	Text	varchar	20	100% if MC037 = 21	Required
86	MC069	Discharge Date	Date patient discharged. Required for all inpatient claims	Date	YYYY-MM-DD	10	100% if MC037 = 21	Required
87	MC070	Service Provider Country Code	Country code of the Service Provider. Use 3-digit ISO Country Codes See Appendix K - External Sources	Text	char	3	100%	Required
88	MC071	DRG	Diagnostic Related Group Code: DRG paid by payer. If not available send billed DRG. Not applicable to Medicaid.	Text	char	3	20% if MC037 = 21	Required
89	MC072	DRG Version	Diagnostic Related Group Version Number: Version of DRG (inpatient) grouper used	Text	char	2	100% if MC071 <> NULL	Required
90	MC073	APC	Ambulatory Payment Classification Number: Carriers and health care claims processors shall code using CMS methodology. Precedence shall be given to APCs transmitted from the health care provider	Text	char	4	0%	Optional
91	MC074	APC Version	Ambulatory Payment Classification Version: Version of APC (outpatient) grouper used	Text	char	2	0%	Optional
92	MC075	Drug Code	National Drug Code (NDC): Used only when a medication is paid for as part of a medical claim or when a DME device has an NDC code. J codes should be submitted under procedure code	Text	varchar	11	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			(MC055), and have a procedure code type of 'HCPCS'. Drug Code as defined by the FDA in 11 character format (5-4-2) without hyphenation					
93	MC076	Billing Provider Number	Payer assigned billing provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change. Required if National Billing Provider ID is not filled	Text	varchar	30	10%	Required
94	MC077	National Billing Provider ID	National Provider Identification (NPI) number for the billing provider. The NPI is mandated for use under HIPAA Required if Billing Provider Number is not filled	Integer	char	10	100%	Required
95	MC078	Billing Provider Last Name or Organization Name	Billing provider last name. If not an individual, place organization name in this field.	Text	varchar	100	100%	Required
96	MC079	Diagnosis Code Pointer -1	Number indicating order of importance for Primary Diagnosis code. For example, if Primary Diagnosis code is the most important diagnosis on the claim line, the value in Diagnosis Code Pointer 1 becomes 1	Integer	unsigned int	1	90%	Required
97	MC080	Diagnosis Code Pointer -2	Number indicating order of importance for Other Diagnosis Code 1. For example, if Other Diagnosis code 3 becomes the most important diagnosis on the claim line, the value in Diagnosis Code Pointer 3 becomes 1	Integer	unsigned int	1	10%	Required
98	MC081	Diagnosis Code Pointer -3	Number indicating order of importance for Other Diagnosis Code 1. For example, if Other Diagnosis code 2 becomes the most important diagnosis on the claim line, the value in Diagnosis Code Pointer 2 becomes 1	Integer	unsigned int	1	<1%	Required
99	MC082	Diagnosis Code Pointer -4	Number indicating order of importance for Other Diagnosis Code 3. For example, if Other Diagnosis code 3 becomes the most important diagnosis on the claim line, the value in Diagnosis Code Pointer 3 becomes 1	Integer	unsigned int	1	<1%	Required
100	MC088	Billing Provider EIN /Federal Tax ID Number	Billing Provider's Federal Tax Identification Number . An Employer Identification Number (EIN) is also known as a Federal Tax Identification Number, and is used to identify a business entity. Alpha numeric characters only—omit spaces and hyphens	Text	varchar	15	50%	Required
101	MC090	LOINC Code	Logical Observation Identifiers, Names and Codes (LOINC)	Text	varchar	7	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
102	MC092	Covered Days	Covered Inpatient Days	Integer	unsigned int	4	100% if MC037 = 21	Required
103	MC093	Non Covered Days	Non-covered Inpatient Days	Integer	unsigned int	4	0%	Optional
104	MC094	Type of Claim	Type of Claim Indicator  001 = Professional 002 = Facility 003 = Encounter	Integer	char	3	100%	Required
105	MC095	Coordination of Benefits/TPL Liability Amount	Amount paid by the primary carrier. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	10%	Required
106	MC098	Allowed amount	Maximum amount contractually allowed for a particular procedure or service. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value.	Numeric	±decimal	10,2	100%	Required
107	MC099	Non-Covered Amount	Amount of claim line charge not covered. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	100%	Required
108	MC108	Service Provider Street Address	Service Provider practice location street address line 1	Text	varchar	100	100%	Required
109	MC110	Claim Processed Date	Claim Processed Date	Date	YYYY-MM-DD	10	99%	Required
110	MC112	Referring Provider ID	Referring Provider NPI number	Integer	char	10	0%	Optional
111	MC113	Payment Arrangement Type	Value for contracted payment methodology at the claim level  01 = Capitation 02 = Fee for Service 03 = Percent of Charges 04 = DRG 05 = Pay for Performance 06 = Global Payment 07 = Other 08 = Bundled Payment	Integer	char	2	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			09 = Payment Amount Per Episode					
112	MC119	PCP Indicator	PCP Rendered Service indicator  1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Integer	unsigned int	1	0%	Optional
113	MC120	DRG Level	APR Diagnostic Related Group Code Severity Level  1 = Minor 2 = Moderate 3 = Major 4 = Extreme	Integer	unsigned int	1	0%	Optional
114	MC121	Patient Total Out of Pocket Amount	The sum of copay, coinsurance, and deductible representing the total amount the member is responsible to pay to the provider as part of their costs for services on this claim. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	99%	Required
115	MC122	Global Payment Flag	Global Payment Indicator  1 = Yes 0 = not applicable	Integer	unsigned int	1	100% if MC094 = 003	Required
116	MC124	Denial Reason	Denial Reason Code  Placeholder for future requirements	Text	char	5	0%	Optional
117	MC126	Accident Indicator	Accident Related indicator  1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Integer	unsigned int	1	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
118	MC131	Out-of-Network Indicator	Network Rate Applied indicator  1 = Yes 2 = No	Integer	unsigned int	1	100%	Required
119	MC134	National Service Organization Provider ID	National Provider Identification (NPI) number for the organization with which the rendering/attending provider directly providing the service is associated.	Integer	char	10	100%	Required
120	MC136	Discharge Diagnosis	ICD-9 or ICD-10 Discharge Diagnosis Code  See Appendix K – External Code Source	Text	varchar	7	0%	Optional
121	MC137	Carrier Specific Unique Member ID	Member's Unique ID  Value must be hashed or masked prior to submission to the APCD. Hashing should be consistent across time so the hashed value representing the Member ID does not change	Text	varchar	50	100%	Required
122	MC138	Claim Line Type	Status of the claim header or claim line  O = Original D = Delete/Drop R = Replacement  See Exhibit D: Adjustments/Versioning Requirements	Text	char	1	0%	Optional
123	MC139	Former Claim Number	Previous Claim Number. Report the Claim Control Number (MC004) that was originally sent in a prior filing that this line corresponds to. When reported, this data cannot equal its own MC004.	Text	varchar	35	25% if MC005A > 1	Required
124	MC141	Carrier Specific Unique Subscriber ID	Subscriber's Unique ID  Value must be hashed or masked prior to submission to the APCD. Hashing should be consistent across time so the hashed value representing the Subscriber ID does not change.	Text	varchar	50	100%	Required
125	MC154	Present on Admission Code (POA) Primary	Code indicating the primary diagnosis was present at the time of admission  3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient	Text	char	1	50% if MC037=21 and MC041 <> NULL	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission					
126	MC155	Present on Admission Code (POA) - 01	Code indicating the presence of Other Diagnosis - 1 at the time of admission  3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% if MC037=21 and MC042 <> NULL	Required
127	MC156	Present on Admission Code (POA) - 02	Code indicating the presence of Other Diagnosis - 2 at the time of admission  3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% if MC037=21 and MC043 <> NULL	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
128	MC157	Present on Admission Code (POA) - 03	Code indicating the presence of Other Diagnosis - 3 at the time of admission  3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	>1% if MC037=21 and MC044 <> NULL	Required
129	MC158	Present on Admission Code (POA) - 04	Code indicating the presence of Other Diagnosis - 4 at the time of admission  3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	>1% if MC037=21 and MC045 <> NULL	Required
130	MC159	Present on Admission Code (POA) - 05	Code indicating the presence of Other Diagnosis - 5 at the time of admission  3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	>1% if MC037=21 and MC046 <> NULL	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
131	MC160	Present on Admission Code (POA) - 06	Code indicating the presence of Other Diagnosis - 6 at the time of admission  3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	>1% if MC037=21 and MC047 <> NULL	Required
132	MC161	Present on Admission Code (POA) - 07	Code indicating the presence of Other Diagnosis - 7 at the time of admission  3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	>1% if MC037=21 and MC048 <> NULL	Required
133	MC162	Present on Admission Code (POA) - 08	Code indicating the presence of Other Diagnosis - 8 at the time of admission  3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	>1% if MC037=21 and MC049 <> NULL	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
134	MC163	Present on Admission Code (POA) - 09	Code indicating the presence of Other Diagnosis - 9 at the time of admission  3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	>1% if MC037=21 and MC050 <> NULL	Required
135	MC164	Present on Admission Code (POA) - 10	Code indicating the presence of Other Diagnosis - 10 at the time of admission  3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	>1% if MC037=21 and MC051 <> NULL	Required
136	MC165	Present on Admission Code (POA) - 11	Code indicating the presence of Other Diagnosis - 11 at the time of admission  3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	>1% if MC037=21 and MC052 <> NULL	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
137	MC166	Present on Admission Code (POA) - 12	Code indicating the presence of Other Diagnosis - 12 at the time of admission  3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	>1% if MC037=21 and MC054 <> NULL	Required
138	MC203	Billing Provider First Name	Billing provider first name. Set to blank if provider is a facility or an organization	Text	varchar	25	100%	Required
139	MC204	Billing Provider Middle Name	Billing provider middle name. Set to blank if provider is a facility or an organization	Text	varchar	25	25%	Required
140	MC205	ICD-9-CM or ICD-10-CM Procedure Date	Date the principle inpatient procedure was performed.	Date	YYYY-MM-DD	10	100% if MC058 is not NULL	Required
141	MC205A	ICD-9-CM or ICD-10-CM Procedure Date 1	Date the first secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	100% if MC058A is not NULL	Required
142	MC205B	ICD-9-CM or ICD-10-CM Procedure Date 2	Date the second secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	100% if MC058B is not NULL	Required
143	MC205C	ICD-9-CM or ICD-10-CM Procedure Date 3	Date the third secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	100% if MC058C is not NULL	Required
144	MC205D	ICD-9-CM or ICD-10-CM Procedure Date 4	Date the fourth secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	100% if MC058D is not NULL	Required
145	MC205E	ICD-9-CM or ICD-10-CM Procedure Date 5	Date the fifth secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	100% if MC058E is not NULL	Required
146	MC205F	ICD-9-CM or ICD-10-CM Procedure Date 6	Date the sixth secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	100% if MC058EA is not NULL	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
147	MC205G	ICD-9-CM or ICD-10-CM Procedure Date 7	Date the seventh secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	100% if MC058F is not NULL	Required
148	MC205H	ICD-9-CM or ICD-10-CM Procedure Date 8	Date the eighth secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	100% if MC058G is not NULL	Required
149	MC205I	ICD-9-CM or ICD-10-CM Procedure Date 9	Date the ninth secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	100% if MC058H is not NULL	Required
150	MC205J	ICD-9-CM or ICD-10-CM Procedure Date 10	Date the tenth secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	100% if MC058J is not NULL	Required
151	MC205K	ICD-9-CM or ICD-10-CM Procedure Date 11	Date the eleventh secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	100% if MC058K is not NULL	Required
152	MC205L	ICD-9-CM or ICD-10-CM Procedure Date 12	Date the twelfth secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	100% if MC058L is not NULL	Required
153	MC206	Capitated Service Indicator	<p>Payment arrangement where a physician or group of physicians is paid a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care</p> <p>Y = services are paid under a capitated arrangement  N = services are not paid under a capitated arrangement  U = unknown</p>	Text	char	1	100%	Required
154	MC207	Billing Provider Street Address	Billing Provider practice location street address line 1	Text	varchar	100	100%	Required
155	MC208	Billing Provider City	City of Billing provider's address	Text	varchar	30	90%	Required
156	MC209	Billing Provider State	<p>State or province of Billing provider's address</p> <p>See Appendix K - External Code Sources</p>	Text	char	2	90%	Required
157	MC210	Billing Provider ZIP Code	<p>Five digit USPS ZIP Code of the billing provider's address, preferably the practice location</p> <p>See Appendix K - External Code Sources</p>	Integer	char	5	90%	Required
158	MC211	Billing Provider Country Code	<p>Country of the Billing Provider. Use 3-digit ISO Country Codes</p> <p>See Appendix K - External Sources</p>	Integer	unsigned int	3	100%	Required
159	MC212	Billing Provider Specialty	Code defining provider specialty. Provide look-up tables for every field containing non-standard codes	Text	varchar	10	100% if MC201 is not NULL	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
160	MC213	Billing Provider Suffix Billing	Billing provider suffix is used to capture any generational identifiers associated with an individual clinician's name (e.g., Jr., Sr., III). <b>Do not code the clinician's credentials (e.g., MD, LCSW) in this field.</b> Set to blank if the provider is a facility or an organization	Text	varchar	10	5%	Required
161	MC214	Capitation Flag	Periodicity of Capitation Amount  Y = Yearly M = Monthly	Text	char	1	100% if MC064 > 0	Required
162	MC915A	ICD Indicator	Indicates use of ICD-9 or ICD-10 code sets. Code sets cannot be mixed on a record  9 = ICD-9 Diagnosis and procedure codes 0 = ICD-10 Diagnosis and procedure codes	Integer	unsigned int	1	100% if MC037 = 21	Required
163	MC986	Subscriber State	State or province of subscriber's residence  See <a href="#">Appendix K - External Code Sources</a>	Text	char	2	100%	Required
164	MC987	Subscriber ZIP Code	Five digit USPS ZIP Code of me subscriber's residence  See <a href="#">Appendix K - External Code Sources</a>	Integer	char	5	100%	Required
165	MC990	Subscriber Date of Birth	Subscriber's date of birth	Date	YYYY-MM-DD	10	100%	Required
166	MC992	HIOS ID	Identifier representing submitting entities within in the Health Insurance Oversight System, the federal government's primary data collection vehicle for the health insurance 'Exchanges' Marketplaces. HIOS collects data from health plan issuers that want to become certified health plan (QHP) issuers.	Text	varchar	30	99%	Required

## Pharmacy Claims Data

### File Guidelines

All fields shall be coded with the values specified in the Pharmacy claims data file.

- All fields must be included in the data submission
- Use values in Data Element ID column as column names
- If a value is not present for Date, Integer or Numeric fields, pass a NULL value (| |)
- If a blank is a valid value for a field, place the word “BLANK” in the field (|BLANK|)
- If a value is unavailable and is not the word “BLANK” for Text fields, pass a NULL value (| |)
- If a [data exception has been applied](#), pass a NULL value (| |) in the field
- If a required field contains only values representing Unknown, Other, or Not Applicable, the submission will be failed and a data exception required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
1	DH	Record Prefix	Record Prefix  Place the value DD in the Pharmacy Claims Data detail record.	Text	char	2	100%	Required
2	PC999	Unique Row ID	Each row must contain a unique ID or row number	Integer	unsigned int	10	100%	Required
3	PC001	Submitter	Code representing payer submitting payments. Use NAIC codes for private carrier. Use five-character alpha numeric code for other submitting entities.	Text	char	5	100%	Required
4	PC002	National Plan ID	Centers for Medicare and Medicaid Services (CMS) National Plan Identification Number (Plan ID). Do not report any value here until National Plan ID is fully implemented. This is a unique identifier as outlined by CMS for Plans or Sub plans.	Integer	unsigned int	30	0%	Optional
5	PC003	Insurance Type/Product Code	Insurance type or product identification code that indicates the type of insurance coverage the individual has.  See Appendix A - Insurance Type/Product Code	Text	varchar	6	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
6	PC004	Payer Claim Control Number	Claim number used by the submitting entity to internally track the claim. In general, the claim number is associated with all service lines of the claim. It must apply to the entire claim and be unique within the submitting entity's system	Text	varchar	35	100%	Required
7	PC005	Line Number	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim. This field is used in algorithms to determine the final payment for the service. If the submitting entity's processing system assigns an internal line counter for the adjudication process, that number may be submitted in place of the line number submitted by the provider	Integer	unsigned int	4	0%	Optional
8	PC005A	Version Number	Final version number of the claim service line.  See Exhibit D: Adjustments/Versioning Requirements. Note: Versioning will be implemented in later phases. The threshold will change from optional to required at implementation.	Integer	unsigned int	4	0%	Optional
9	PC005B	Version Number Date	Date of latest version of claim service line in Year/Month (YYMM) format.  See Exhibit D: Adjustments/Versioning Requirements. Note: Versioning will be implemented in later phases. The threshold will change from optional to required at implementation.	Integer	char	4	0%	Optional
10	PC006	Insured Group Number or Policy Number	Group or policy number associated with the entity who has purchased the insurance. For self-insured individuals, this relates to the purchaser. For the majority of enrollment and claims data, the group relates to the employer	Text	varchar	30	99%	Required
11	PC008	Plan Specific Contract Number	Contract number assigned to subscriber.	Integer	unsigned int	20	50%	Required
12	PC009	Member Suffix or Sequence Number (Person Code)	Unique number of the member within the contract. Must be an identifier that is unique to the member. This column is the unique identifying column for membership and related medical and pharmacy claims, e.g. the value for person 1 = 001, person 2 = 002, etc.	Integer	char	3	98%	Required
13	PC011	Individual Relationship Code	Member's relationship to the subscriber or the insured	Integer	char	2	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			See Appendix B - Relationship Code					
14	PC012	Member Gender	Gender of the member  M = Male F = Female U = Unknown	Text	char	1	99%	Required
15	PC013	Member Date of Birth	Member's date of birth	Date	YYYY-MM-DD	10	99%	Required
16	PC015	Member State or Province	State or province of member's residence  See Appendix K - External Code Sources	Text	char	2	99%	Required
17	PC016	Member ZIP Code	Five digit USPS ZIP Code of member's residence  See Appendix K - External Code Sources	Integer	char	5	99%	Required
18	PC017	Paid Date	Paid date of the claim line. Report the date that appears on the check and/or remit and/or explanation of benefits and corresponds to any and all types of payment	Date	YYYY-MM-DD	10	99%	Required
19	PC018	Pharmacy Number	Pharmacy Number - National Council for Prescription Drug Programs (NCPDP) or the National Association of Boards of Pharmacy (NABP) number of the dispensing pharmacy  See Appendix K - External Code Sources	Text	varchar	30	99%	Required
20	PC019	Pharmacy EIN /Federal Tax ID Number	Pharmacy Tax Identification Number - the Federal Tax ID of the Pharmacy. An Employer Identification Number (EIN) is also known as a Federal Tax Identification Number, and is used to identify a business entity. Alpha numeric characters only—omit spaces and hyphens.	Text	varchar	15	20%	Required
21	PC020	Pharmacy Name	Name of Pharmacy	Text	varchar	100	90%	Required
22	PC021	National Provider ID Number - Service Provider	National Provider Identification (NPI) number for the entity or individual directly providing the service. This field will be used to create a master provider index for Arkansas medical service and prescribing providers  See Appendix K - External Code Sources	Text	varchar	10	98%	Required
23	PC022	Pharmacy Location City	City of Pharmacy location	Text	varchar	30	98%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
24	PC023	Pharmacy Location State	State or province of Pharmacy location  See Appendix K - External Code Sources	Text	char	2	98%	Required
25	PC024	Pharmacy ZIP Code	Five digit USPS ZIP Code of Pharmacy location  See Appendix K - External Code Sources	Integer	char	5	98%	Required
26	PC024A	Pharmacy Country Code	ISO Country Code of the Pharmacy location  See Appendix K - External Code Sources	Integer	unsigned int	3	90%	Required
27	PC026	Drug Code	National Drug Code (NDC)	Text	char	11	98%	Required
28	PC027	Drug Name	Name of the drug as supplied	Text	varchar	80	95%	Required
29	PC028	Fill Number	Prescription Status Indicator. For example, 00 = new prescription, 01 = first refill, etc.	Integer	char	2	99%	Required
30	PC029	Generic Drug Indicator	Generic Drug indicator  1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Integer	unsigned int	1	100%	Required
31	PC030	Dispense as Written Code	Drug dispense code  1 = Physician dispense as written 2 = Member dispense as written 3 = Pharmacy dispense as written 4 = No generic available 5 = Brand dispensed as generic 6 = Override 7 = Substitution not allowed, brand drug mandated by law 8 = Substitution allowed, generic drug not available in marketplace 9 = Other 0 = Not dispensed as written	Integer	unsigned int	1	98%	Required
32	PC031	Compound Drug Indicator	Compound Drug indicator  1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Integer	unsigned int	1	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
33	PC032	Date Prescription Filled	Date the pharmacy filled and dispensed prescription to the patient	Date	YYYY-MM-DD	10	99%	Required
34	PC033	Quantity Dispensed	Number of metric units dispensed	Numeric	int	20	99%	Required
35	PC034	Days Supply	Number of days the prescription will last if taken as prescribed	Integer	unsigned int	4	99%	Required
36	PC035	Charge Amount	Total charges for the service as reported by the provider. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	99%	Required
37	PC036	Paid Amount	Amount paid by the submitting entity for the claim line as reported by the provider. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	99%	Required
38	PC037	Ingredient Cost/List Price	Amount defined as the List Price or Ingredient Cost. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	99%	Required
39	PC039	Dispensing Fee	Amount of dispensing fee for the claim line. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	99%	Required
40	PC040	Copay Amount	Amount of Copay member/patient is responsible to pay. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
41	PC041	Coinsurance Amount	Amount of coinsurance member/patient is responsible to pay. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	99%	Required
42	PC042	Deductible Amount	Amount of deductible member/patient is responsible to pay on the claim line. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	99%	Required-
43	PC043	Prescribing Provider ID	Prescribing Provider Number from submitting entity	Text	varchar	30	98%	Required
44	PC044	Prescribing Physician First Name	Prescribing Physician first name	Text	varchar	25	98%	Required
45	PC045	Prescribing Physician Middle Name	Prescribing Physician middle name	Text	varchar	25	50%	Required
46	PC046	Prescribing Physician Last Name	Prescribing Physician last name	Text	varchar	60	98%	Required
47	PC047	Prescribing Physician DEA Number	Prescribing Drug Enforcement Administration (DEA) number for provider	Text	char	9	80%	Required
48	PC048	National Provider ID - Prescribing	National Provider Identification (NPI) number for the entity or individual directly prescribing drug. This field will be used to create a master provider index for Arkansas medical service and prescribing providers  See Appendix K - External Sources	Integer	char	10	98%	Required
49	PC049	Prescribing Physician Plan Number	Submitting entity-assigned Provider Plan ID.	Text	varchar	30	98%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
50	PC050	Prescribing Physician License Number	State license number for the provider identified in PC043. For a doctor this is the medical license for a non-doctor this is the practice license. Do not use zero-fill. If not available, or not applicable, such as for a group or corporate entity, do not report any value here	Text	varchar	30	0%	Optional
51	PC051	Prescribing Physician Street Address	Prescribing Physician street address line 1	Text	varchar	100	50%	Required
52	PC052	Prescribing Physician Street Address 2	Prescribing Physician street address line 2	Text	varchar	100	5%	Required
53	PC053	Prescribing Physician City	City of the Prescribing Physician's address	Text	varchar	30	50%	Required
54	PC054	Prescribing Physician State	State or province of the Prescribing Physician's address  See Appendix K - External Code Sources	Text	char	2	50%	Required
55	PC055	Prescribing Physician ZIP Code	Five digit USPS ZIP Code of Prescribing Physician address  See Appendix K - External Code Sources	Integer	char	5	50%	Required
56	PC057	Mail Order Pharmacy Indicator	Mail Order Option indicator  1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Integer	unsigned int	1	100%	Required
57	PC058	Script number	Unique Prescription Number	Text	varchar	20	100%	Required
58	PC059	Member PCP ID	Member's PCP provider NPI Number	Integer	char	10	0%	Optional
59	PC060	Single/Multiple Source Indicator	Drug Source Indicator. Defines the availability of the pharmaceutical  1 = Multi-source brand 2 = Multi-source brand with generic equivalent 3 = Single source brand 4 = Single source brand with generic equivalent 5 = Unknown	Integer	unsigned int	1	98%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
60	PC062	Billing Provider EIN/Federal Tax Identification Number	Billing Provider's Employer Identification Number (EIN)/Federal Tax Identification Number.  An Employer Identification Number (EIN) is also known as a Federal Tax Identification Number, and is used to identify a business entity. Alpha numeric characters only—omit spaces and hyphens	Text	varchar	15	50%	Required
61	PC064	Date Prescription Written	Date prescription was prescribed as indicated by date on prescription or date called-in by physician's office	Date	YYYY-MM-DD	10	98%	Required
62	PC069	Member Total Out of Pocket Amount	The sum of copay, coinsurance, and deductible representing the total amount the member is responsible to pay to the provider as part of their costs for services on this claim. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value.	Numeric	±decimal	10,2	98%	Required
63	PC070	Rebate Indicator	Drug Rebate Eligibility indicator for Medicaid, Medicare Managed Care plans  1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Integer	unsigned int	1	0%	Optional
64	PC073	Formulary Indicator	Formulary inclusion identifier  1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Integer	unsigned int	1	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
65	PC074	Route of Administration	<p>Pharmaceutical Route of Administration Indicator that defines method of drug administration</p> <p>01 = Buccal  02 = Dental  03 = Inhalation  04 = Injection  05 = Intraperitoneal  06 = Irrigation  07 = Mouth/Throat  08 = Mucous Membrane  09 = Nasal  10 = Ophthalmic  11 = Oral  12 = Other/Misc  13 = Otic  14 = Perfusion  15 = Rectal  16 = Sublingual  17 = Topical  18 = Transdermal  19 = Translingual  20 = Urethral  21 = Vaginal  22 = Enteral  99 = Other  00 = Not Specified</p>	Integer	char	2	80%	Required
66	PC075	Drug Unit of Measure	<p>Units of Measure for drug dispensed.</p> <p>EA = Each  F2 = International Units  GM = Grams  ML = Milliliters</p>	Text	char	2	0%	Optional
67	PC107	Carrier Specific Unique Member ID	<p>Member's Unique ID</p> <p>Value must be hashed or masked prior to submission to the APCD. Hashing should be consistent across time so the hashed value representing the Member ID does not change</p>	Text	varchar	50	100%	Required
68	PC108	Carrier Specific Unique Subscriber	Subscriber's Unique ID	Text	varchar	50	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
		ID	Value must be hashed or masked prior to submission to the APCD. Hashing should be consistent across time so the hashed value representing the Subscriber ID does not change.					
69	PC110	Claim Line Type	Status of the claim header or claim line.  O = Original D = Delete/Drop R = Replacement  <a href="#">See Exhibit D: Adjustments/Versioning Requirements</a>	Text	char	1	0%	Optional
70	PC124	Denial Reason	Denial Reason Code  Placeholder for future requirements	Text	char	5	0%	Optional
71	PC953	Subscriber State	State or province of subscriber's residence  <a href="#">See Appendix K - External Sources</a>	Text	char	2	100%	Required
72	PC954	Subscriber ZIP Code	Five digit USPS ZIP Code of the subscriber's residence  <a href="#">See Appendix K - External Sources</a>	Integer	char	5	100%	Required
73	PC955	Subscriber Date of Birth	Subscriber's date of birth	Date	YYYY-MM-DD	10	50%	Required
74	PC956	Subscriber Gender	Gender of the subscriber  M = Male F = Female U = Unknown	Text	char	1	50%	Required
75	PC963	Dispensing Status	Partial fill or the completion of a partial fill indicator  P = Partial fill C = Completion of fill	Text	char	1	0%	Optional
76	PC964	Drug Strength	Drug Strength (e.g. 500MG, 0.5% etc.)	Text	varchar	20	0%	Optional
77	PC965	USC Code	USC Code (Universal System of Classification)	Text	varchar	5	0%	Optional

## Dental Claims Data

### File Guidelines

All fields shall be coded with the values specified in the Dental claims data file.

- All fields must be included in the data submission
- Use values in Data Element ID column as column names
- If a value is not present for Date, Integer or Numeric fields, pass a NULL value (| |)
- If a blank is a valid value for a field, place the word “BLANK” in the field (|BLANK|)
- If a value is unavailable and is not the word “BLANK” for Text fields, pass a NULL value (| |)
- If a [data exception has been applied](#), pass a NULL value (| |) in the field
- If a required field contains only values representing Unknown, Other, or Not Applicable, the submission will be failed and a data exception required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
1	DH	Record Prefix	Record Prefix  Place the value DD in the Dental Claims Data detail record.	Text	char	2	100%	Required
2	DC999	Unique Row ID	Each row must contain a unique ID or row number	Integer	unsigned int	10	100%	Required
3	DC001	Submitter	Code representing payer submitting payments. Use NAIC codes for private carrier. Use five character alpha numeric code for other submitting entities.	Text	char	5	100%	Required
4	DC002	National Plan ID	Centers for Medicare and Medicaid Services (CMS) National Plan Identification Number (Plan ID). Do not report any value here until National Plan ID is fully implemented. This is a unique identifier as outlined by CMS for Plans or Sub plans.	Numeric	unsigned int	30	0%	Optional
5	DC003	Insurance Type/Product Code	Insurance type or product identification code that indicates the type of insurance coverage the individual has.  See Appendix A - Insurance Type/Product Code	Text	varchar	6	98%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
6	DC004	Payer Claim Control Number	Claim number used by the submitting entity to internally track the claim. In general the claim number is associated with all service lines of the bill. It must apply to the entire claim and be unique within the submitting entity's system	Text	varchar	35	100%	Required
7	DC005	Line Counter	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim. This field is used in algorithms to determine the final payment for the service. If the submitting entity's processing system assigns an internal line counter for the adjudication process, that number may be submitted in place of the line number submitted by the provider	Integer	unsigned int	4	100%	Required
8	DC005A	Version Number	Final version number of the claim service line.  See Exhibit D: Adjustments/Versioning Requirements. Note: Versioning will be implemented in later phases. The threshold will change from optional to required at implementation.	Integer	unsigned int	4	0%	Optional
9	DC005B	Version Number Date	Date of latest version of claim service line in Year/Month (YYMM) format.  See Exhibit D: Adjustments/Versioning Requirements. Note: Versioning will be implemented in later phases. The threshold will change from optional to required at implementation.	Text	char	4	0%	Optional
10	DC006	Insured Group or Policy Number	Group or policy number associated with the entity that has purchased the insurance. For self-insured individuals this relates to the purchaser. For the majority of enrollment and claims data the group relates to the employer	Text	varchar	30	98%	Required
11	DC008	Plan Specific Contract Number	Submitting entity assigned contract number for the subscriber. Set as blank if unavailable. Set as blank if contract number = subscriber's social security number	Integer	unsigned int	20	100%	Required
12	DC009	Member Suffix or Sequence Number (Person Code)	Unique number of the member within the contract. Must be an identifier that is unique to the member. This column is the unique identifying column for membership and related medical and pharmacy claims, e.g. the value for person 1 is 001, person 2 = 002, etc.	Text	varchar	3	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
13	DC011	Individual Relationship Code	Member's relationship to the subscriber or the insured  See Appendix B - Relationship Code	Integer	char	2	100%	Required
14	DC012	Member Gender	Gender of the member  M = Male F = Female U = Unknown	Text	char	1	100%	Required
15	DC013	Member Date of Birth	Member's date of birth	Date	YYYY-MM-DD	10	100%	Required
16	DC016	Member ZIP Code	Five digit USPS ZIP Code of member's residence  See Appendix K - External Sources	Integer	char	5	98%	Required
17	DC017	Paid Date	Paid date of the claim line. Report the date that appears on the check and/or remit and/or explanation of benefits and corresponds to any and all types of payment	Date	YYYY-MM-DD	10	100%	Required
18	DC018	Service Provider Number	Submitting entity assigned or legacy rendering/attending provider number. This field will be used to create a master provider index for Arkansas providers encompassing both medical service providers and prescribing providers. Submit facility for institutional claims; physician or healthcare professional for professional claims	Text	varchar	30	98%	Required
19	DC019	Service Provider EIN / Federal Tax ID Number	Federal tax payer's identification number for rendering/attending provider. This field will be used to create a master provider index for Arkansas providers encompassing both medical service providers and prescribing providers. An Employer Identification Number (EIN) is also known as a Federal Tax Identification Number, and is used to identify a business entity. Alpha numeric characters only—omit spaces and hyphens	Text	varchar	15	50%	Required
20	DC020	National Service Provider ID	National Provider Identification (NPI) number for the entity or individual directly providing the service. This field will be used to create a master provider index for medical service and prescribing providers  See Appendix K - External Sources	Integer	char	10	98%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
21	DC021	Service Provider Entity Type Qualifier	HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as "Person"  1 = Person 2 = Non-Person entity	Integer	unsigned int	1	100%	Required
22	DC022	Service Provider First Name	Service Provider first name. Set to blank if provider is a facility or an organization	Text	varchar	25	98%	Required
23	DC023	Service Provider Middle Name	Service provider middle name. Set to blank if provider is a facility or an organization	Text	varchar	25	2%	Required
24	DC024	Service Provider Last Name or Organization Name	Service provider last name. If not individual, place organization name in this field	Text	varchar	100	98%	Required
25	DC025	Service Provider Suffix	Service provider suffix is used to capture any generational identifiers associated with an individual clinician's name (e.g., Jr., Sr., III). <b>Do not code the clinician's credentials (e.g., MD, LCSW) in this field.</b> Set to blank if the provider is a facility or an organization	Text	varchar	10	10%	Required
26	DC026	Service Provider Taxonomy	Taxonomy Code - Standard code that defines this provider for this line of service. Taxonomy values allow for the reporting of hygienists, assistants and laboratory technicians, where applicable, as well as Dentists, Orthodontists, etc.  See Appendix K - External Sources	Text	varchar	10	0%	Optional
27	DC027	Service Provider City	City of Service Provider address	Text	varchar	30	98%	Required
28	DC028	Service Provider State or Province	State or province of the Service Provider's address  See Appendix K - External Sources	Text	char	2	98%	Required
29	DC029	Service Provider ZIP Code	Five digit USPS ZIP Code of Service Provider's address  See Appendix K - External Sources	Integer	char	5	98%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
30	DC030	Facility Type - Professional	Type of professional facility where the service was performed. The field should be set to blank for institutional claims  See Appendix E - Facility Type	Integer	unsigned int	2	98%	Required
31	DC032	HCPCS/CDT Code	Common Dental Terminology Code  See Appendix K - External Sources	Text	varchar	5	100%	Required
32	DC033	Procedure Modifier - 1	Common Dental Terminology Code Modifier - Report a valid Procedure modifier when a modifier clarifies/improves the reporting accuracy of the associated procedure code.  See Appendix K - External Sources	Text	char	2	98%	Required
33	DC034	Procedure Modifier - 2	Common Dental Terminology Code Modifier - Report a valid Procedure modifier when a modifier clarifies/improves the reporting accuracy of the associated procedure code  See Appendix K - External Sources	Text	char	2	50%	Required
34	DC035	Date of Service From	Date of Service for this service line	Date	YYYY-MM-DD	10	YYYY-MM-DD	Required
35	DC036	Date of Service Thru	Last date of service for this service line. It can equal Date of Service From when a single date of service is reported	Date	YYYY-MM-DD	10	YYYY-MM-DD	Required
36	DC037	Charge Amount	Total charges for the service line as reported by the provider. Code decimal point. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	98%	Required
37	DC038	Paid Amount	Total paid for the service line as reported by the provider. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
38	DC039	Copay Amount	Pre-set, fixed dollar amount payable by a member, often on a per visit/service basis. Code decimal point. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	98%	Required
39	DC040	Coinsurance Amount	Patient's share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. The patient pays coinsurance plus any deductibles owed. For example, if the health insurance or plan's allowed amount for an office visit is \$100 and the patient has met the deductible, the coinsurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	98%	Required
40	DC041	Deductible Amount	This is an amount that is required to be paid by a member before health plan benefits will begin to reimburse for services. It is usually an annual amount of all health care costs that is not covered by the member's insurance plan. Code decimal point. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	98%	Required
41	DC042	Product ID Number	Submitter-assigned product identifier.	Text	varchar	30	100%	Required
42	DC044	Billing Provider EIN / Federal Tax ID Number	Billing Provider's Federal Tax Identification Number  An Employer Identification Number (EIN) is also known as a Federal Tax Identification Number, and is used to identify a business entity. Do not use hyphen or alpha prefix. Alpha numeric characters only—omit spaces and hyphens	Text	varchar	15	50%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
43	DC046	Allowed Amount	The maximum amount contractually allowed, and that a submitting entity will pay to a provider for a particular procedure or service. Code decimal point. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. \$0.00 is a valid value	Numeric	±decimal	10,2	100%	Required
44	DC047	Tooth Number/Letter	Tooth Number or Letter Identification See Appendix K - External Sources	Text	varchar	20	90%	Required
45	DC048	Dental Quadrant	Dental Quadrant See Appendix K - External Sources	Text	char	2	90%	Required
46	DC049	Tooth Surface	Tooth Surface Identification See Appendix K - External Sources	Text	varchar	10	90%	Required
47	DC056	Carrier Specific Unique Member ID	Member's Unique ID Value must be hashed or masked prior to submission to the APCD. Hashing should be consistent across time so the hashed value representing the Member ID does not change.	Text	varchar	50	100%	Required
48	DC057	Carrier Specific Unique Subscriber ID	Subscriber Unique ID Value must be hashed or masked prior to submission to the APCD. Hashing should be consistent across time so the hashed value representing the Subscriber ID does not change.	Text	varchar	50	100%	Required
49	DC059	Claim Line Type	Claim Line Activity Type Code that defines final version status of claim line.  O = Original D = Drop/Delete R = Replacement  See Exhibit D: Adjustments/Versioning Requirements.	Text	char	1	0%	Optional
50	DC064	Denial Reason	Denial Reason Code  Placeholder for future requirements	Text	varchar	5	0%	Optional



## Provider Data

### File Guidelines

All fields shall be coded with the values specified in the Provider Data file.

- All fields must be included in the data submission
- Use values in Data Element ID column as column names
- If a value is not present for Date, Integer or Numeric fields, pass a NULL value (| |)
- If a blank is a valid value for a field, place the word “BLANK” in the field (|BLANK|)
- If a value is unavailable and is not the word “BLANK” for Text fields, pass a NULL value (| |)
- If a [data exception has been applied](#), pass a NULL value (| |) in the field
- If a required field contains only values representing Unknown, Other, or Not Applicable, the submission will be failed and a data exception required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
1	DH	Record Prefix	Record Prefix  Place the value DD in the Provider Data detail record.	Text	char	2	100%	Required
2	PV999	Unique Row ID	Each row must contain a unique ID or row number	Integer	unsigned int	10	100%	Required
3	PV114	Submitter	Code representing payer submitting payments. Use NAIC codes for private carrier. Use five character alpha numeric code for other submitting entities.	Text	char	5	100%	Required
4	PV001	Provider ID	Unique identified identifier for the provider as assigned by the reporting entity/carrier	Text	varchar	30	100%	Required
5	PV002	Provider EIN / Federal Tax ID	Federal Tax ID for provider. An Employer Identification Number (EIN) is also known as a Federal Tax Identification Number, and is used to identify a business entity. Alpha numeric characters only—omit spaces and hyphens	Text	varchar	15	98% if PV003 = 2,3,4,5,6,7,0	Required
6	PV003	Entity Type	Entity Type Report the value that defines type of entity associated with PV002. The value reported here drives intake edits for quality purposes  0 = Other; any type of entity not otherwise defined that performs health care services 1 = Person; physician, clinician, orthodontist, and any individual that is licensed/certified to perform health care services 2 = Facility; hospital, health center, long term care, rehabilitation and any	Integer	unsigned int	1	98%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			<p>building that is licensed to transact health care services</p> <p>3 = Professional Group; collection of licensed/certified health care professionals that are practicing health care services under the same entity name and Federal Tax Identification Number</p> <p>4 = Retail Site; brick-and-mortar licensed/certified place of transaction that is not solely a health care entity, i.e., pharmacies, independent laboratories, vision services</p> <p>5 = E-Site; internet-based order/logistic system of health care services, typically in the form of durable medical equipment, pharmacy or vision services. Address assigned should be the address of the company delivering services or order fulfillment</p> <p>6 = Financial parent; financial governing body that does not perform health care services itself but directs and finances health care service entities, usually through a Board of Directors</p> <p>7 = Transportation; any form of transport that conveys a patient to/from a health care provider</p>					
7	PV004	Provider First Name	Provider first name. Set to blank if provider is a facility or an organization	Text	varchar	25	100%	Required
8	PV005	Provider Middle Name	Provider's middle name. Set to blank if provider is a facility or an organization	Text	varchar	25	100%	Required
9	PV006	Provider Last Name	Provider's last name.	Text	varchar	60	100%	Required
10	PV007	Provider Suffix	The service provider suffix is used to capture any generational identifiers associated with an individual clinician's name (e.g., Jr., Sr., III). Do not code the clinician's credentials (e.g., MD, LCSW) in this field. Set to blank if the provider is a facility or an organization	Text	varchar	10	10%	Required
11	PV008	Provider Office Street Address	Provider office address line 1 for NPI in PV023	Text	varchar	100	100%	Required
12	PV009	Provider Office Street Address 2	Provider office address line 2 for NPI in PV023	Text	varchar	100	25%	Required
13	PV010	Provider Office City	City of provider practice physical location for NPI in PV023	Text	varchar	30	100%	Required
14	PV011	Provider Office State	State or province of provider practice physical location for NPI in PV023  See Appendix K - External Code Sources	Text	char	2	100%	Required
15	PV012	Provider Office ZIP Code	Five digit USPS ZIP Code of provider practice physical address for NPI in PV023  See Appendix K - External Code Sources	Integer	char	5	100%	Required
1	PV013	Mailing Street	Provider mailing address line 1	Text	varchar	100	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
6		Address						
17	PV014	Mailing Street Address 2	Provider mailing address line 2	Text	varchar	100	50%	Required
18	PV015	Mailing City	City of provider practice mailing address	Text	varchar	35	25%	Required
19	PV016	Mailing State Code	State or province of provider practice mailing address See Appendix K - External Code Sources	Text	varchar	2	100%	Required
20	PV017	Mailing Country Code	Country code of the Provider/Entity mailing address. Use 3-digit ISO Country Codes See Appendix K - External Code Sources	Text	varchar	3	100%	Required
21	PV018	Mailing ZIP Code	ZIP Code of the Provider mailing address. Use USPS five-digit ZIP Code See Appendix K - External Code Sources	Integer	char	5	100%	Required
22	PV019	Provider Specialty	Primary specialty associated with provider. Use CMS provider specialty codes: <a href="https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf">https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf</a>	Text	varchar	10	100%	Required
23	PV020	Provider second specialty	Second specialty associated with provider. Use CMS provider specialty codes: <a href="https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf">https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf</a>	Text	varchar	10	2%	Required
24	PV021	Provider third specialty	Third specialty identified for provider. Use CMS provider specialty codes: <a href="https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf">https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf</a>	Text	varchar	10	2%	Required
25	PV022	Provider DEA Number	A Drug Enforcement Administration (DEA) number assigned to a health care provider (such as a medical practitioner, dentist, or veterinarian) by the U.S. Drug Enforcement Administration allowing them to write prescriptions for controlled substances	Text	varchar	12	100%	Required
26	PV023	National Provider ID	Record the National Provider Identification (NPI) number for the entity or individual. This field will be used to create a master provider index for Arkansas medical service and prescribing providers	Integer	char	10	98%	Required
27	PV024	Provider State License Number	Arkansas specific license number.	Text	varchar	20	0%	Optional
28	PV025	Provider Degree	Contains academic credentials (e.g., LCSW, DO, MD) for the individual and is populated based on information from the payer or licensure files. This is a	Text	varchar	10	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			practitioner identifiable field					
29	PV026	Taxonomy Code	This field is used to standardize the specialty coding of provider records	Text	varchar	10	0%	Optional
30	PV027	Unique Physician Identifier	This field contains the UPIN code used by CMS. Report the UPIN for the Provider identified in PV001.	Text	varchar	20	98% where PV003 = 1	Required
31	PV028	Submitter	Code representing entity submitting payments assigned in onboarding process	Text	char	5	0%	Optional
32	PV031	Provider Type	Provider type code  Report the value that defines the provider type.  See Appendix J - Provider Entity Codes	Integer	char	2	100%	Required
33	PV032	Provider Gender Code	Gender of Provider identified in PV001. Does not apply if provider is not an individual  M = Male F = Female O = Other U = Unknown	Text	char	1	100% where PV003 = 1	Required
34	PV033	Provider Birth Year/Month	Provider's date of birth in century, year, month (YYYYMM) format.	Integer	char	6	100%	Required
35	PV034	Provider Country Code	Country code of origin for provider. Use 3-digit ISO Country CodesSee Appendix K - External Code Sources	Integer	unsigned int	3	100%	Required
36	PV037	Medicare ID	Provider's Medicare Number, other than UPIN Report the Medicare ID (OSCAR, Certification, Other, Unspecified, NSC or PIN) of the provider or entity in PV001. Do not report UPIN here, see PV027.	Text	varchar	30	0%	Optional
37	PV038	Begin Date	Provider Start Date Report the date the provider or facility becomes eligible/contracted to perform any services for the submitting entity.	Date	YYYY-MM-DD	10	98%	Required
38	PV039	End Date	Provider End Date  Report the Date the provider or facility is no longer eligible to perform services for the submitting entity. Do not report any value here for providers that are still actively eligible to provide services	Date	YYYY-MM-DD	10	98%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
39	PV045	Offers e-Visits	eVisit Option indicator.  1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Integer	unsigned int	1	0% if PV003 = 1, 2, 3, 4	Optional
40	PV047	Medical/Healthcare Home ID	Medical Home Identification Number  Report the identifier of the patient-centered medical home the provider is linked-to here. The value in this element must have a corresponding Provider ID (PV002) in this or a previously submitted provider file.	Text	varchar	15	0%	Optional
41	PV048	PCP Flag	Provider is a PCP indicator Required when PV003 = 1  1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Integer	unsigned int	1	100%	Required
42	PV056	Last Activity Date	Date of last activity/change on Provider file.	Date	YYYY-MM-DD	10	50%	Required
43	PV057	Organization Name	Full name of provider organization. Set to blank if provider is individual only.	Text	varchar	100	100%	Required
44	PV100	Medical School	Medical school institutional name	Text	varchar	100	0%	Optional
45	PV101	Medical School Completion Date	Date provider (PV023) completed medical school	Date	YYYY-MM-DD	10	0%	Optional
46	PV102	Residency	Provider (PV023) residency program	Text	varchar	100	0%	Optional
47	PV103	Residency Completion Date	Date provider (PV023) completed residency	Date	YYYY-MM-DD	100	0%	Optional
48	PV104	Fellowship	Provider (PV023) fellowship program	Text	varchar	100	0%	Optional
49	PV105	Fellowship Completion Date	Date provider (PV023) completed fellowship	Date	YYYY-MM-DD	10	0%	Optional
50	PV106	Board Certification 1	First board certification focus	Text	varchar	100	0%	Optional
51	PV107	Board Certification 1 From	Date when provider was certified in first certification area	Date	YYYY-MM-DD	10	0%	Optional
5	PV108	Board	Date when first board certification expired. Leave blank if current. Leave blank	Date	YYYY-	10	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
2		Certification 1 To	if active		MM-DD			
53	PV109	Board Certification 1 Renewal Date	Date when first board certification is to be renewed	Date	YYYY-MM-DD	10	0%	Optional
54	PV110	Board Certification 2	Second board certification focus	Text	varchar	100	0%	Optional
55	PV111	Board Certification 2 From	Date when provider was certified in second certification area	Date	YYYY-MM-DD	10	0%	Optional
56	PV112	Board Certification 2 To	Date when second board certification expired. Leave blank if current. Leave blank if active	Date	YYYY-MM-DD	10	0%	Optional
57	PV113	Board Certification 2 Renewal Date	Date when second board certification is to be renewed	Date	YYYY-MM-DD	10	0%	Optional

---

## Data Submission Example

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The sample data below illustrates the data file composition with header and trailer records. Note: Header and trailer records are represented in their entirety. Member enrollment data represented is a sample.

```
HH|HD001|HD002|HD003|HD004|HD005|HD006|HD007|HD008 } Header Record
HD|28362||ME|20150101|20150201|5|1|1 } Header Data Record
DH|ME999|ME001|ME002|ME003|ME004|ME005|ME006|ME007|ME008|ME009 } Detail Data Header Record
DD|123456|1|28362|432|CI|36203AB1|ELF|12092284|01|M
DD|123456|2|28362|432|CI|36203AB1|ELF|12092284|01|M
DD|138627|3|28362|432|CI|37208AB1|FAM|120088273|01|F
DD|736996|4|28362|432|CI|36103zQ7|EMP|122672184|01|F
DD|408821|5|28362|432|CI|47109GT5|EPN|12092284|01|M
TH|TR001|TR002|TR003|TR004|TR005|TR006|TR007 } Trailer Header Record
TD|12345||ME|20150101|20150201|20150301|20150401 } Trailer Data Record
```

## EXHIBIT B – ENCRYPTION PROTOCOLS

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### Data Submission Encryption Protocols

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All data files submitted to the Arkansas APCD are to be encrypted using Public Key Cryptography (also known as asymmetric cryptography):

- Key Generation:
  - RSA key(s) of 2048-bit length, minimum, encrypt-and-sign capable
  - DSA key(s) of 2048-bit length, minimum, sign capable
- File Encryption
  - “Encrypt+sign” the unencrypted file into an “encrypted+signed” file
  - “Encrypt” with the recipient’s RSA key
  - “Sign” with the sender’s RSA key
  - Resulting “encrypted+signed” file extension should be “.gpg”
- “Detach-sign” the “encrypted+signed” file using the sender’s DSA key
  - Resulting “Detached-signature” file extension should be “.sig”
- Zip the “encrypted+signed” and “detached-signature” files into one archive
  - Name the .zip archive as follows:
    1. Carrier\_FileType\_FilePeriod\_RSA-keyID\_DSA-keyID.zip
    2. e.g., “MCR\_CLAIMS\_2014A\_RSA-A4E5919D\_DSA-C55BD3C3.zip”
  - Resulting zipped archive file extension should be “.zip”

---

### Encryption Software Recommendations

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The ACHI-APCD team requires all submitters to use the following software recommendations for file encryption:

- Windows Operating Systems
  - Gpg4Win
    - Kleopatra (key generation, import, export, and management)
    - GPA (key generation and management)
    - GPG command-line encryption operations
  - GpgEx
    - Context-menu encrypt, sign, verify, and decrypt
    - NOTE: Installed as part of the aforementioned Gpg4Win distribution
  - 7-Zip (64-bit, 32-bit)
    - Context-menu zipping and unzipping of files
    - 7z command-line zipping/encryption operations
    - Optional AES-256 symmetric encryption via password
- Linux Operating Systems
  - GnuPG
    - Kleopatra (key generation, import, export, management)
    - GPA (key generation, management)
    - GPG command-line encryption operations
    - Ubuntu install: sudo apt-get install gnupg
  - Seahorse
    - Context-menu encrypt, sign, verify, decrypt
    - NOTE: May not be installed when GnuPG is installed; if so, then see following install

- Ubuntu install: `sudo apt-get install seahorse-plugins`
- 7-Zip
  - Context-menu zipping and unzipping of files
  - 7z command-line zipping/encryption operations
  - Optional AES-256 symmetric encryption via password
  - Ubuntu install: `sudo apt-get install p7zip-full`

---

## Command Line Examples

---

To encrypt and sign an unencrypted file, submitters will use the following procedures:

- `gpg --recipient A4E5919D --local-user C55BD3C3 --sign --output "encrypted+signed.gpg" --encrypt "plaintext.txt"`
- `gpg --local-user C55BD3C3 --output "detached-signature.sig" --detach-sign "encrypted+signed.gpg"`
- `7z a -tzip "MCR_CLAIMS_2014A_RSA-A4E5919D_DSA-C55BD3C3.zip" "encrypted+signed.gpg"`
- `7z a -tzip "MCR_CLAIMS_2014A_RSA-A4E5919D_DSA-C55BD3C3.zip" "detached-signature.sig"`

## EXHIBIT C – SAMPLE DATA EXCEPTION REQUEST FORM

This table represents the types of information required for data exceptions. Please contact the APCD Technical Support team at [arapcd@uams.edu](mailto:arapcd@uams.edu) to obtain an APCD Data Exception Request form.

The data exception form is a Microsoft Excel workbook with tabs for each data category: Member/Enrollment data, Medical claims, Pharmacy claims, Dental claims, and Provider data.

#	DSG Data Element ID*	DSG Data Element Name*	Exception Reason	Future Availability	Future Availability Date	Impact to APCD /Workarounds (internal Use Only)
1	ME060	Employment Status	Not Collected.	Y	06-30-2017	
2	ME007	Coverage Level Code	Required values not available.	N		

\*Pre-populated columns.

## EXHIBIT D – ADJUSTMENTS/VERSIONING REQUIREMENTS

Adjustments and versioning processes are not required for the initial historical submission of data files to the Arkansas APCD. The Arkansas Insurance Department (AID) and the ACHI-APCD team will work with submitting entities to develop APCD-specific versioning processes for the July 2016 DSG change deadline.

## APPENDICES

### Appendix A: Insurance Type Product Code

Value	Description
AW	Arkansas Workers' Compensation Commission Coverage
CAP	Capitated Plan
CI	Commercial Insurance Company
DNT	Dental
HM	Health Maintenance Organization (HMO)
HN	Health Maintenance Organization (HMO) Medicare Risk/Medicare Part C
HS	Special Low Income Medicare Beneficiary
IN	Indemnity
MA	Medicare Part A
MB	Medicare Part B
MCD	Medicaid
MD	Medicare Part D
MDV	Medicare Advantage
MH	Medigap Part A
MHO	Medicare Advantage HMO
MI	Medigap Part B
MPO	Medicare Advantage Preferred Provider Organization (PPO)
PR	Preferred Provider Organization (PPO)
PS	Point of Service (POS)
SP	Supplemental Policy

## Appendix B: Relationship Code

Value	Description
01	Spouse
04	Grandfather or Grandmother
05	Grandson or Granddaughter
07	Nephew or Niece
10	Foster Child
15	Ward
17	Stepson or Stepdaughter
18	Self
19	Child
20	Employee
21	Unknown
22	Handicapped Dependent
23	Sponsored Dependent
24	Dependent of a Minor Dependent
29	Significant Other
32	Mother
33	Father
34	Other Adult
36	Emancipated Minor
39	Organ Donor
40	Cadaver Donor
41	Injured Plaintiff
43	Child Where Insured Has No Financial Responsibility
53	Life Partner

## Appendix C: Discharge Status

Value	Description
01	Discharged to home or self-care
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF)
04	Discharged/transferred to nursing facility (NF)
05	Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Discharged/transferred to home under care of a Home IV provider
09	Admitted as an inpatient to this hospital
20	Expired
30	Still patient or expected to return for outpatient services
40	Expired at home
41	Expired in a medical facility
42	Expired, place unknown
43	Discharged/transferred to a federal hospital
50	Hospice – home
51	Hospice – medical facility
61	Discharged/transferred within this institution to a hospital based Medicare-approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility, including distinct parts of a hospital
63	Discharge/transferred to a long-term care hospital
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare

## Appendix D: Type of Bill

INPATIENT HOSPITAL	
VALUE	DESCRIPTION
111	REGULAR INPATIENT
112	FIRST PORTION: CONTINUOUS STAY INPATIENT CLAIM
113	SUBSEQUENT PORTION: CONTINUOUS STAY INPATIENT CLAIM
114	FINAL PORTION: CONTINUOUS STAY INPATIENT CLAIM
115	INPATIENT: LATE CHARGE(S) ONLY CLAIM
116	INPATIENT: ADJUSTMENT OR PRIOR CLAIM NEEDED
117	INPATIENT: REPLACEMENT OF PRIOR CLAIM
118	INPATIENT: VOID/CANCEL OF PRIOR CLAIM

HOSPITAL INPATIENT (MEDICARE PART B ONLY)	
VALUE	DESCRIPTION
121	HOSPITAL INPATIENT (MEDICARE PART B ONLY): ADMIT THROUGH DISCHARGE
122	HOSPITAL INPATIENT (MEDICARE PART B ONLY): INTERIM, FIRST CLAIM
123	HOSPITAL INPATIENT (MEDICARE PART B ONLY): INTERIM, CONTINUING CLAIM
124	HOSPITAL INPATIENT (MEDICARE PART B ONLY): INTERIM, FINAL CLAIM
125	HOSPITAL INPATIENT (MEDICARE PART B ONLY): LATE CHARGE(S) ONLY CLAIM
127	HOSPITAL INPATIENT (MEDICARE PART B ONLY): REPLACEMENT OF PRIOR CLAIM
128	HOSPITAL INPATIENT (MEDICARE PART B ONLY): VOID/CANCEL OF PRIOR CLAIM

OUTPATIENT HOSPITAL	
VALUE	DESCRIPTION
131	REGULAR OUTPATIENT
132	FIRST INTERIM: CONTINUING OUTPATIENT CLAIM
133	SUBSEQUENT INTERIM: CONTINUING OUTPATIENT CLAIM
134	FINAL INTERIM: OUTPATIENT CLAIM
135	OUTPATIENT: LATE CHARGE(S) ONLY CLAIM
136	OUTPATIENT: ADJUSTMENT OF PRIOR CLAIM
137	OUTPATIENT: REPLACEMENT OF PRIOR CLAIM
138	OUTPATIENT: VOID/CANCEL OF PRIOR CLAIMS

<b>OUTPATIENT DIAGNOSTIC (NON TREATMENT PLAN)</b>	
<b>VALUE</b>	<b>DESCRIPTION</b>
141	OUTPATIENT DIAGNOSTIC: ADMIT THROUGH DISCHARGE
142	OUTPATIENT DIAGNOSTIC: INTERIM, FIRST CLAIM
143	OUTPATIENT DIAGNOSTIC: INTERIM, CONTINUING CLAIM
144	OUTPATIENT DIAGNOSTIC: INTERIM, FINAL CLAIM
145	OUTPATIENT DIAGNOSTIC: LATE CHARGE(S) ONLY CLAIM
146	OUTPATIENT DIAGNOSTIC: ADJUSTMENT OF PRIOR CLAIM
147	OUTPATIENT DIAGNOSTIC: REPLACEMENT OF PRIOR CLAIM
148	OUTPATIENT DIAGNOSTIC: VOID/CANCEL OF PRIOR CLAIM

<b>HOSPITAL SWING BEDS</b>	
<b>VALUE</b>	<b>DESCRIPTION</b>
181	HOSPITAL SWING BEDS: ADMIT THROUGH DISCHARGE
182	HOSPITAL SWING BEDS: INTERIM, FIRST CLAIM
183	HOSPITAL SWING BEDS: INTERIM, CONTINUING CLAIM
184	HOSPITAL SWING BEDS: INTERIM, FINAL CLAIM
185	HOSPITAL SWING BEDS: LATE CHARGE(S) ONLY CLAIM
187	HOSPITAL SWING BEDS: REPLACEMENT OF PRIOR CLAIM
188	HOSPITAL SWING BEDS: VOID/CANCEL OF PRIOR CLAIM

<b>SKILLED NURSING</b>	
<b>VALUE</b>	<b>DESCRIPTION</b>
211	SKILLED NURSING: ADMIT THROUGH DISCHARGE
212	SKILLED NURSING: INTERIM, FIRST CLAIM
213	SKILLED NURSING: INTERIM, CONTINUING CLAIM
214	SKILLED NURSING: FINAL CLAIM
215	SKILLED NURSING: LATE CHARGE(S) ONLY CLAIM
217	SKILLED NURSING: REPLACEMENT OF PRIOR CLAIM
218	SKILLED NURSING: VOID/CANCEL OF PRIOR CLAIM

<b>SKILLED NURSING (MEDICARE PART B ONLY)</b>	
<b>VALUE</b>	<b>DESCRIPTION</b>
221	SKILLED NURSING (MEDICARE PART B ONLY): ADMIT THROUGH DISCHARGE
222	SKILLED NURSING (MEDICARE PART B ONLY): INTERIM, FIRST CLAIM
223	SKILLED NURSING (MEDICARE PART B ONLY): INTERIM, CONTINUING CLAIM
224	SKILLED NURSING (MEDICARE PART B ONLY): FINAL CLAIM
225	SKILLED NURSING (MEDICARE PART B ONLY): LATE CHARGE(S) ONLY CLAIM
227	SKILLED NURSING (MEDICARE PART B ONLY): REPLACEMENT OF PRIOR CLAIM
228	SKILLED NURSING (MEDICARE PART B ONLY): VOID/CANCEL OF PRIOR CLAIM

<b>SKILLED NURSING OUTPATIENT</b>	
<b>VALUE</b>	<b>DESCRIPTION</b>
231	SKILLED NURSING OUTPATIENT: ADMIT THROUGH DISCHARGE
232	SKILLED NURSING OUTPATIENT: INTERIM, FIRST CLAIM
233	SKILLED NURSING OUTPATIENT: INTERIM, CONTINUING CLAIM
234	SKILLED NURSING OUTPATIENT: FINAL CLAIM
235	SKILLED NURSING OUTPATIENT: LATE CHARGE(S) ONLY CLAIM
237	SKILLED NURSING OUTPATIENT: REPLACEMENT OF PRIOR CLAIM
238	SKILLED NURSING OUTPATIENT: VOID/CANCEL OF PRIOR CLAIM

<b>HOME HEALTH INPATIENT (NOT UNDER A PLAN OF TREATMENT) – DESCRIPTION CHANGE</b>	
<b>VALUE</b>	<b>DESCRIPTION</b>
321	HOME HEALTH INPATIENT (NOT UNDER A PLAN OF TREATMENT): ADMIT THROUGH DISCHARGE
322	HOME HEALTH INPATIENT (NOT UNDER A PLAN OF TREATMENT): INTERIM, FIRST CLAIM
323	HOME HEALTH INPATIENT (NOT UNDER A PLAN OF TREATMENT): INTERIM, CONTINUING CLAIM
324	HOME HEALTH INPATIENT (NOT UNDER A PLAN OF TREATMENT): INTERIM, FINAL CLAIM
325	HOME HEALTH INPATIENT (NOT UNDER A PLAN OF TREATMENT): LATE CHARGE(S) ONLY CLAIM
327	HOME HEALTH INPATIENT (NOT UNDER A PLAN OF TREATMENT): REPLACEMENT OF PRIOR CLAIM
328	HOME HEALTH INPATIENT (NOT UNDER A PLAN OF TREATMENT): VOID/CANCEL OR PRIOR CLAIM

<b>COORDINATED HOME CARE (MEDICARE A TREATMENT PLAN INCLUDING DME) – DISCONTINUED AS OF OCTOBER 1, 2013</b>	
<b>VALUE</b>	<b>DESCRIPTION</b>
331	COORDINATED HOME CARE: ADMIT THROUGH DISCHARGE
332	COORDINATED HOME CARE: INTERIM, FIRST CLAIM
333	COORDINATED HOME CARE: INTERIM, CONTINUING CLAIM
334	COORDINATED HOME CARE: INTERIM, FINAL CLAIM
335	COORDINATED HOME CARE: LATE CHARGE(S) ONLY CLAIM
337	COORDINATED HOME CARE: REPLACEMENT OF PRIOR CLAIM
338	COORDINATED HOME CARE: VOID/CANCEL OF PRIOR CLAIM

<b>HOME HEALTH SERVICES (NOT UNDER A PLAN OF TREATMENT) – DESCRIPTION CHANGE</b>	
<b>VALUE</b>	<b>DESCRIPTION</b>
341	HOME HEALTH SERVICES (NOT UNDER A PLAN OF TREATMENT): ADMIT THROUGH DISCHARGE
342	HOME HEALTH SERVICES (NOT UNDER A PLAN OF TREATMENT): INTERIM, FIRST CLAIM
343	HOME HEALTH SERVICES (NOT UNDER A PLAN OF TREATMENT): INTERIM, CONTINUING CLAIM
344	HOME HEALTH SERVICES (NOT UNDER A PLAN OF TREATMENT): INTERIM, FINAL CLAIM
345	HOME HEALTH SERVICES (NOT UNDER A PLAN OF TREATMENT): LATE CHARGE(S) ONLY CLAIM
347	HOME HEALTH SERVICES (NOT UNDER A PLAN OF TREATMENT): REPLACEMENT OF PRIOR CLAIM
348	HOME HEALTH SERVICES (NOT UNDER A PLAN OF TREATMENT): VOID/CANCEL OF PRIOR CLAIM

<b>RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTION – HOSPITAL INPATIENT</b>	
<b>VALUE</b>	<b>DESCRIPTION</b>
411	RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTIONS - HOSPITAL INPATIENT: ADMIT THROUGH DISCHARGE
412	RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTIONS - HOSPITAL INPATIENT: INTERIM FIRST CLAIM
413	RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTIONS - HOSPITAL INPATIENT: INTERIM, CONTINUING CLAIM
414	RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTIONS - HOSPITAL INPATIENT: INTERIM, FINAL CLAIM
415	RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTIONS - HOSPITAL INPATIENT: LATE CHARGE(S) ONLY CLAIM
417	RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTIONS - HOSPITAL INPATIENT: REPLACEMENT OF

	PRIOR CLAIM
418	RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTIONS - HOSPITAL INPATIENT: VOID/CANCEL OF PRIOR CLAIM

RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTIONS – OUTPATIENT SERVICES	
VALUE	DESCRIPTION
43X	RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTIONS – OUTPATIENT SERVICES

INTERMEDIATE CARE – LEVEL I	
VALUE	DESCRIPTION
65X	RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTIONS – OUTPATIENT SERVICES

INTERMEDIATE CARE – LEVEL II	
VALUE	DESCRIPTION
66X	RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTIONS – OUTPATIENT SERVICES

CLINIC RURAL HEALTH	
VALUE	DESCRIPTION
711	CLINIC RURAL HEALTH: ADMIT THROUGH DISCHARGE
712	CLINIC RURAL HEALTH: INTERIM, FIRST CLAIM
713	CLINIC RURAL HEALTH: INTERIM, CONTINUING CLAIM
714	CLINIC RURAL HEALTH: INTERIM, FINAL CLAIM
715	CLINIC RURAL HEALTH: LATE CHARGE(S) ONLY CLAIM
717	CLINIC RURAL HEALTH: REPLACEMENT OF PRIOR CLAIM

HOSPITAL BASED OR INDEPENDENT RENAL DIALYSIS	
VALUE	DESCRIPTION
721	HOSPITAL BASED OR INDEPENDENT RENAL DIALYSIS: ADMIT THROUGH DISCHARGE
722	HOSPITAL BASED OR INDEPENDENT RENAL DIALYSIS: INTERIM, FIRST CLAIM
723	HOSPITAL BASED OR INDEPENDENT RENAL DIALYSIS: INTERIM, CONTINUING CLAIM
724	HOSPITAL BASED OR INDEPENDENT RENAL DIALYSIS: INTERIM, FINAL CLAIM
725	HOSPITAL BASED OR INDEPENDENT RENAL DIALYSIS: LATE CHARGE(S) ONLY CLAIM
727	HOSPITAL BASED OR INDEPENDENT RENAL DIALYSIS: REPLACEMENT OF PRIOR CLAIM
728	HOSPITAL BASED OR INDEPENDENT RENAL DIALYSIS: VOID/CANCEL OF PRIOR CLAIM

FREE STANDING CLINIC	
VALUE	DESCRIPTION
73X	FREE STANDING CLINIC

CLINIC OUTPATIENT REHABILITATION FACILITY (ORF)	
VALUE	DESCRIPTION

741	CLINIC OUTPATIENT REHABILITATION FACILITY (ORF): ADMIT THROUGH DISCHARGE
742	CLINIC OUTPATIENT REHABILITATION FACILITY (ORF): INTERIM, FIRST CLAIM
743	CLINIC OUTPATIENT REHABILITATION FACILITY (ORF): INTERIM, CONTINUING CLAIM
744	CLINIC OUTPATIENT REHABILITATION FACILITY (ORF): INTERIM, FINAL CLAIM
745	CLINIC OUTPATIENT REHABILITATION FACILITY (ORF): LATE CHARGE(S) ONLY CLINIC OUTPATIENT REHABILITATION FACILITY (ORF): REPLACEMENT OF PRIOR CLAIM
747	CLINIC OUTPATIENT REHABILITATION FACILITY (ORF): REPLACEMENT OF PRIOR CLAIM
748	CLINIC OUTPATIENT REHABILITATION FACILITY (ORF): VOID/CANCEL OF PRIOR CLAIM

CLINIC – COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF)	
VALUE	DESCRIPTION
751	CLINIC OUTPATIENT REHABILITATION FACILITY (ORF): VOID/CANCEL OF PRIOR CLAIM
752	CLINIC – COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF): INTERIM, FIRST CLAIM
753	CLINIC – COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF): INTERIM, CONTINUING CLAIM
754	CLINIC – COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF): INTERIM, FINAL CLAIM
755	CLINIC – COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF): LATE CHARGE(S) ONLY CLAIM
757	CLINIC – COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF): REPLACEMENT OF PRIOR CLAIM
758	CLINIC – COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF): VOID/CANCEL OF PRIOR CLAIM

CLINIC – COMMUNITY MENTAL HEALTH CENTER	
VALUE	DESCRIPTION
76X	CLINIC – COMMUNITY MENTAL HEALTH CENTER

CLINIC – FEDERALLY QUALIFIED HEALTH CENTER	
VALUE	DESCRIPTION
77X	CLINIC – FEDERALLY QUALIFIED HEALTH CENTER

LICENSED FREE STANDING EMERGENCY MEDICAL FACILITY	
VALUE	DESCRIPTION
78X	LICENSED FREE STANDING EMERGENCY MEDICAL FACILITY

CLINIC - OTHER	
VALUE	DESCRIPTION
79X	CLINIC - OTHER

SPECIALTY FACILITY HOSPICE (NON-HOSPITAL BASED)	
VALUE	DESCRIPTION
811	SPECIALTY FACILITY HOSPICE (NON-HOSPITAL BASED): ADMIT THROUGH DISCHARGE
812	SPECIALTY FACILITY HOSPICE (NON-HOSPITAL BASED): INTERIM, FIRST CLAIM
813	SPECIALTY FACILITY HOSPICE (NON-HOSPITAL BASED): INTERIM, CONTINUING CLAIM

814	SPECIALTY FACILITY HOSPICE (NON-HOSPITAL BASED): INTERIM, FINAL CLAIM
815	SPECIALTY FACILITY HOSPICE (NON-HOSPITAL BASED): LATE CHARGE(S) ONLY
817	SPECIALTY FACILITY HOSPICE (NON-HOSPITAL BASED): REPLACEMENT OF PRIOR CLAIM
818	SPECIALTY FACILITY HOSPICE (NON-HOSPITAL BASED): VOID/CANCEL OF PRIOR CLAIM

SPECIALTY FACILITY HOSPICE (HOSPITAL BASED)	
VALUE	DESCRIPTION
821	SPECIALTY FACILITY HOSPICE (HOSPITAL BASED): ADMIT THROUGH DISCHARGE
822	SPECIALTY FACILITY HOSPICE (HOSPITAL BASED): INTERIM, FIRST CLAIM
823	SPECIALTY FACILITY HOSPICE (HOSPITAL BASED): INTERIM, CONTINUING CLAIM
824	SPECIALTY FACILITY HOSPICE (HOSPITAL BASED): INTERIM, FINAL CLAIM
825	SPECIALTY FACILITY HOSPICE (HOSPITAL BASED): LATE CHARGE(S) ONLY
827	SPECIALTY FACILITY HOSPICE (HOSPITAL BASED): REPLACEMENT OF PRIOR CLAIM
828	SPECIALTY FACILITY HOSPICE (HOSPITAL BASED): VOID/CANCEL OF PRIOR CLAIM

SPECIALTY FACILITY AMBULATORY SURGERY	
VALUE	DESCRIPTION
831	SPECIALTY FACILITY AMBULATORY SURGERY: ADMIT THROUGH DISCHARGE
832	SPECIALTY FACILITY AMBULATORY SURGERY: INTERIM, FIRST CLAIM
833	SPECIALTY FACILITY AMBULATORY SURGERY: INTERIM, CONTINUING CLAIM
834	SPECIALTY FACILITY AMBULATORY SURGERY: INTERIM, FINAL CLAIM
835	SPECIALTY FACILITY AMBULATORY SURGERY: LATE CHARGE(S) ONLY CLAIM
837	SPECIALTY FACILITY AMBULATORY SURGERY: REPLACEMENT OF PRIOR CLAIM
838	SPECIALTY FACILITY AMBULATORY SURGERY: VOID/CANCEL OF PRIOR CLAIM

SPECIALTY FACILITY – FREE STANDING BIRTHING CENTER – RECLASSIFIED TO OUTPATIENT ONLY	
VALUE	DESCRIPTION
84X	SPECIALTY FACILITY – FREE STANDING BIRTHING CENTER

SPECIALTY FACILITY – CRITICAL ACCESS HOSPITAL	
VALUE	DESCRIPTION
851	SPECIALTY FACILITY – CRITICAL ACCESS HOSPITAL: ADMIT THROUGH DISCHARGE
852	SPECIALTY FACILITY – CRITICAL ACCESS HOSPITAL: INTERIM, FIRST CLAIM
853	SPECIALTY FACILITY – CRITICAL ACCESS HOSPITAL: INTERIM, CONTINUING CLAIM
854	SPECIALTY FACILITY – CRITICAL ACCESS HOSPITAL: INTERIM, FINAL CLAIM
855	SPECIALTY FACILITY – CRITICAL ACCESS HOSPITAL: LATE CHARGE(S) ONLY CLAIM
857	SPECIALTY FACILITY – CRITICAL ACCESS HOSPITAL: REPLACEMENT OF PRIOR CLAIM
838	SPECIALTY FACILITY – CRITICAL ACCESS HOSPITAL: VOID/CANCEL OF PRIOR CLAIM

SPECIALTY FACILITY – RESIDENTIAL FACILITY	
VALUE	DESCRIPTION

86X	SPECIALTY FACILITY – RESIDENTIAL FACILITY
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SPECIALTY FACILITY – OTHER – RECLASSIFIED TO OUTPATIENT ONLY	
VALUE	DESCRIPTION
89X	SPECIALTY FACILITY – OTHER

To determine all other Type of Bills, use the following:

1<sup>st</sup> Digit = Type of Facility

2<sup>nd</sup> Digit = Bill classification (3 different categories) facilities excluding clinics and special facilities clinics only. Special facilities only.

3<sup>rd</sup> Digit = Frequency

TYPE OF FACILITY	1ST DIGIT
HOSPITAL	1
SKILLED NURSING	2
HOME HEALTH	3
CHRISTIAN SCIENCE (HOSPITAL)	4
CHRISTIAN SCIENCE (EXTENDED CARE)	5
INTERMEDIATE CARE	6
CLINIC	7
SPECIALTY FACILITY	8
RESERVED FOR NATIONAL USE	9

BILL CLASSIFICATION (EXCEPT CLINICS AND SPECIAL FACILITIES)	2ND DIGIT
INPATIENT (INCLUDING MEDICARE PART A)	1
INPATIENT (MEDICARE PART B ONLY)	2
OUTPATIENT	3
OTHER (FOR HOSPITAL REFERENCED DIAGNOSTIC SERVICES, OR HOME HEALTH NOT UNDER PLAN OF TREATMENT)	4
INTERMEDIATE CARE-LEVEL I	5
INTERMEDIATE CARE-LEVEL II	6
SUBACUTE INPATIENT (REVUE CODE 19X REQUIRED)	7
SWING BEDS	8
RESERVED FOR NATIONAL USE	9

BILL CLASSIFICATION (CLINICS ONLY)	2ND DIGIT
RURAL HEALTH	1
HOSPITAL BASED OR INDEPENDENT RENAL DIALYSIS CENTER	2
FREE STANDING	3
OUTPATIENT REHABILITATION FACILITY (ORF)	4
COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORFS)	5
COMMUNITY MENTAL HEALTH CENTER	6
RESERVED FOR NATIONAL USE	7-8
OTHER	9

BILL CLASSIFICATION (SPECIAL FACILITIES ONLY)	2ND DIGIT
HOSPICE (NON-HOSPITAL BASED)	1
HOSPICE (HOSPITAL BASED)	2
AMBULATORY SURGERY CENTER	3
FREE STANDING BIRTHING CENTER	4
RURAL PRIMARY CARE HOSPITAL	5
RESERVED FOR NATIONAL USE	6-8
OTHER	9

FREQUENCY	3RD DIGIT
NON-PAYMENT/ZERO CLAIM	0
ADMIT THROUGH DISCHARGE	1
INTERIM, FIRST CLAIM	2
INTERIM, CONTINUING CLAIM	3
INTERIM, LAST CLAIM	4
LATE CHARGE(S) ONLY CLAIM	5
REPLACEMENT OF PRIOR CLAIM	7
VOID/CANCEL OF PRIOR CLAIM	8
RESERVED FOR NATIONAL ASSIGNMENT	9

## Appendix E: Facility Type

Value	Description
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgery Center
25	Birth Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
35	Boarding Home
41	Ambulance – Land
42	Ambulance – Air or Water
50	Federally Qualified Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Unlisted Facility

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## Appendix F: Procedure Modifier Codes

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Utilize the latest Alpha Numeric HCPCS Procedure Modifier Code set.

HCPCS Procedure Modifier Code set can be downloaded online at

<https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS-Items/2015-Alpha-Numeric-HCPCS-File>

The following table lists ambulance origin and destination modifiers that are used with transportation service codes. Use the first digit to indicate the place of origin, and the second digit to indicate the destination.

Value	Ambulance Origin and Destination Modifier
D	Diagnostic or therapeutic site other than 'P' or 'H' when these codes are used as origin codes
E	Residential, domiciliary, custodial facility (other than a 1819 facility)
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between types of ambulance
J	Non-hospital-based dialysis facility
N	Skilled nursing facility (SNF) (1819 facility)
P	Physician's office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	Scene of accident or acute event
X	(Destination code only) intermediate stop at physician's office on the way to the hospital (included HMO non-hospital facility, clinic, etc.)

## Appendix G: Language

Value	Description
625,627,628	Spanish
620-622,624	French
623	French Creole
619	Italian
629-630	Portuguese
607,613	German
609	Yiddish
608,610-612	Other West Germanic languages
614-618	Scandinavian
637	Greek
639	Russian
645	Polish
649-651	Serbo-Croatian
640-644,646-648,652	Other Slavic languages
655	Armenian
656	Persian
667	Gujarati
663	Hindi
671	Urdu
662,664-666,668-670,672-678	Other Indic languages
601-606,626,631-636,638,653-654,657-661	Other Indo-European languages
708-715	Chinese
723	Japanese
724	Korean
726	Mon-Khmer, Cambodian
722	Hmong
720	Thai
725	Laotian
728	Vietnamese
684-707,716-719,721,727,729	Other Asian languages
742	Tagalog
730-741,743-776	Other Pacific Island languages
864	Navajo
800-863,865-955,959-966,977-982	Other Native American languages
682	Hungarian
777	Arabic
778	Hebrew
780-799	African languages
679-681,683,696-697,779,956-958,967-976,983-999	All other languages

## Appendix H: Race

Value	Description
1006-6	Abenaki
1579-2	Absentee Shawnee
1490-2	Acoma
2126-1	Afghanistani
2060-2	African
2058-6	African American
1994-3	Agdaagux
1212-0	Agua Caliente
1045-4	Agua Caliente Cahuilla
1740-0	Ahtna
1654-3	Ak-Chin
1993-5	Akhiok
1897-8	Akiachak
1898-6	Akiak
2007-3	Akutan
1187-4	Alabama Coushatta
1194-0	Alabama Creek
1195-7	Alabama Quassarte
1899-4	Alakanuk
1383-9	Alamo Navajo
1744-2	Alanvik
1737-6	Alaska Indian
1735-0	Alaska Native
1739-2	Alaskan Athabascan
1741-8	Alatna
1900-0	Aleknagik
1966-1	Aleut
2008-1	Aleut Corporation
2009-9	Aleutian
2010-7	Aleutian Islander
1742-6	Alexander
1008-2	Algonquian
1743-4	Allakaket
1671-7	Allen Canyon
1688-1	Alpine
1392-0	Alsea
1968-7	Alutiiq Aleut
1845-7	Ambler
1004-1	American Indian
1002-5	American Indian or Alaska Native
1846-5	Anaktuvuk
1847-3	Anaktuvuk Pass
1901-8	Andreafsky
1814-3	Angoon
1902-6	Aniak
1745-9	Anvik

Value	Description
1010-8	Apache
2129-5	Arab
1021-5	Arapaho
1746-7	Arctic
1849-9	Arctic Slope Corporation
1848-1	Arctic Slope Inupiat
1026-4	Arikara
1491-0	Arizona Tewa
2109-7	Armenian
1366-4	Aroostook
2028-9	Asian
2029-7	Asian Indian
1028-0	Assiniboine
1030-6	Assiniboine Sioux
2119-6	Assyrian
2011-5	Atka
1903-4	Atmautluak
1850-7	Atqasuk
1265-8	Atsina
1234-4	Attacapa
1046-2	Augustine
1124-7	Bad River
2067-7	Bahamian
2030-5	Bangladeshi
1033-0	Bannock
2068-5	Barbadian
1712-9	Barrio Libre
1851-5	Barrow
1587-5	Battle Mountain
1125-4	Bay Mills Chippewa
1747-5	Beaver
2012-3	Belkofski
1852-3	Bering Straits Inupiat
1904-2	Bethel
2031-3	Bhutanese
1567-7	Big Cypress
1905-9	Bill Moore's Slough
1235-1	Biloxi
1748-3	Birch Creek
1417-5	Bishop
2056-0	Black
2054-5	Black or African American
1035-5	Blackfeet
1610-5	Blackfoot Sioux
1126-2	Bois Forte
2061-0	Botswanan
1853-1	Brevig Mission

Value	Description
1418-3	Bridgeport
1568-5	Brighton
1972-9	Bristol Bay Aleut
1906-7	Bristol Bay Yupik
1037-1	Brotherton
1611-3	Brule Sioux
1854-9	Buckland
2032-1	Burmese
1419-1	Burns Paiute
1039-7	Burt Lake Band
1127-0	Burt Lake Chippewa
1412-6	Burt Lake Ottawa
1047-0	Cabazon
1041-3	Caddo
1054-6	Cahto
1044-7	Cahuilla
1053-8	California Tribes
1907-5	Calista Yupik
2033-9	Cambodian
1223-7	Campo
1068-6	Canadian and Latin American Indian
1069-4	Canadian Indian
1384-7	Canoncito Navajo
1749-1	Cantwell
1224-5	Capitan Grande
2092-5	Carolinian
1689-9	Carson
1076-9	Catawba
1286-4	Cayuga
1078-5	Cayuse
1420-9	Cedarville
1393-8	Celilo
1070-2	Central American Indian
1815-0	Central Council of Tlingit and Haida Tribes
1465-4	Central Pomo
1750-9	Chalkyitsik
2088-3	Chamorro
1908-3	Chefornak
1080-1	Chehalis
1082-7	Chemakuan
1086-8	Chemehuevi
1985-1	Chenega
1088-4	Cherokee
1089-2	Cherokee Alabama
1100-7	Cherokee Shawnee
1090-0	Cherokees of Northeast Alabama
1091-8	Cherokees of Southeast Alabama

Value	Description
1909-1	Chevak
1102-3	Cheyenne
1612-1	Cheyenne River Sioux
1106-4	Cheyenne-Arapaho
1108-0	Chickahominy
1751-7	Chickaloon
1112-2	Chickasaw
1973-7	Chignik
2013-1	Chignik Lagoon
1974-5	Chignik Lake
1816-8	Chilkat
1817-6	Chilkoot
1055-3	Chimariko
2034-7	Chinese
1855-6	Chinik
1114-8	Chinook
1123-9	Chippewa
1150-2	Chippewa Cree
1011-6	Chiricahua
1752-5	Chistochina
1153-6	Chitimacha
1753-3	Chitina
1155-1	Choctaw
1910-9	Chuathbaluk
1984-4	Chugach Aleut
1986-9	Chugach Corporation
1718-6	Chukchansi
1162-7	Chumash
2097-4	Chuukese
1754-1	Circle
1479-5	Citizen Band Potawatomi
1911-7	Clark's Point
1115-5	Clatsop
1165-0	Clear Lake
1156-9	Clifton Choctaw
1056-1	Coast Miwok
1733-5	Coast Yurok
1492-8	Cochiti
1725-1	Cocopah
1167-6	Coeur D'Alene
1169-2	Coharie
1171-8	Colorado River
1394-6	Columbia
1116-3	Columbia River Chinook
1173-4	Colville
1175-9	Comanche
1755-8	Cook Inlet

Value	Description
1180-9	Coos
1178-3	Coos, Lower Umpqua, Siuslaw
1756-6	Copper Center
1757-4	Copper River
1182-5	Coquilles
1184-1	Costanoan
1856-4	Council
1186-6	Coushatta
1668-3	Cow Creek Umpqua
1189-0	Cowlitz
1818-4	Craig
1191-6	Cree
1193-2	Creek
1207-0	Croatan
1912-5	Crooked Creek
1209-6	Crow
1613-9	Crow Creek Sioux
1211-2	Cupeno
1225-2	Cuyapaipe
1614-7	Dakota Sioux
1857-2	Deering
1214-6	Delaware
1222-9	Diegueno
1057-9	Digger
1913-3	Dillingham
2070-1	Dominica Islander
2069-3	Dominican
1758-2	Dot Lake
1819-2	Douglas
1759-0	Doyon
1690-7	Dresslerville
1466-2	Dry Creek
1603-0	Duck Valley
1588-3	Duckwater
1519-8	Duwamish
1760-8	Eagle
1092-6	Eastern Cherokee
1109-8	Eastern Chickahominy
1196-5	Eastern Creek
1215-3	Eastern Delaware
1197-3	Eastern Muscogee
1467-0	Eastern Pomo
1580-0	Eastern Shawnee
1233-6	Eastern Tribes
1093-4	Echota Cherokee
1914-1	Eek
1975-2	Egegik

Value	Description
2120-4	Egyptian
1761-6	Eklutna
1915-8	Ekuk
1916-6	Ekwok
1858-0	Elim
1589-1	Elko
1590-9	Ely
1917-4	Emmonak
2110-5	English
1987-7	English Bay
1840-8	Eskimo
1250-0	Esselen
2062-8	Ethiopian
1094-2	Etowah Cherokee
2108-9	European
1762-4	Evansville
1990-1	Eyak
1604-8	Fallon
2015-6	False Pass
2101-4	Fijian
2036-2	Filipino
1615-4	Flandreau Santee
1569-3	Florida Seminole
1128-8	Fond du Lac
1480-3	Forest County
1252-6	Fort Belknap
1254-2	Fort Berthold
1421-7	Fort Bidwell
1258-3	Fort Hall
1422-5	Fort Independence
1605-5	Fort McDermitt
1256-7	Fort Mcdowell
1616-2	Fort Peck
1031-4	Fort Peck Assiniboine Sioux
1012-4	Fort Sill Apache
1763-2	Fort Yukon
2111-3	French
1071-0	French American Indian
1260-9	Gabrieleno
1764-0	Gakona
1765-7	Galena
1892-9	Gambell
1680-8	Gay Head Wampanoag
1236-9	Georgetown (Eastern Tribes)
1962-0	Georgetown (Yupik-Eskimo)
2112-1	German
1655-0	Gila Bend

Value	Description
1457-1	Gila River Pima-Maricopa
1859-8	Golovin
1918-2	Goodnews Bay
1591-7	Goshute
1129-6	Grand Portage
1262-5	Grand Ronde
1130-4	Grand Traverse Band of Ottawa/Chippewa
1766-5	Grayling
1842-4	Greenland Eskimo
1264-1	Gros Ventres
2087-5	Guamanian
2086-7	Guamanian or Chamorro
1767-3	Gulkana
1820-0	Haida
2071-9	Haitian
1267-4	Haliwa
1481-1	Hannahville
1726-9	Havasupai
1768-1	Healy Lake
1269-0	Hidatsa
2037-0	Hmong
1697-2	Ho-chunk
1083-5	Hoh
1570-1	Hollywood Seminole
1769-9	Holy Cross
1821-8	Hoonah
1271-6	Hoopa
1275-7	Hoopa Extension
1919-0	Hooper Bay
1493-6	Hopi
1277-3	Houma
1727-7	Hualapai
1770-7	Hughes
1482-9	Huron Potawatomi
1771-5	Huslia
1822-6	Hydaburg
1976-0	Igiugig
1772-3	Iliamna
1359-9	Illinois Miami
1279-9	Inaja-Cosmit
1860-6	Inalik Diomede
1442-3	Indian Township
1360-7	Indiana Miami
2038-8	Indonesian
1861-4	Inupiaq
1844-0	Inupiat Eskimo
1281-5	Iowa

Value	Description
1282-3	Iowa of Kansas-Nebraska
1283-1	Iowa of Oklahoma
1552-9	Iowa Sac and Fox
1920-8	Iqurmuit (Russian Mission)
2121-2	Iranian
2122-0	Iraqi
2113-9	Irish
1285-6	Iroquois
1494-4	Isleta
2127-9	Israeli
2114-7	Italian
1977-8	Ivanof Bay
2048-7	Iwo Jiman
2072-7	Jamaican
1313-6	Jamestown
2039-6	Japanese
1495-1	Jemez
1157-7	Jena Choctaw
1013-2	Jicarilla Apache
1297-1	Juaneno
1423-3	Kaibab
1823-4	Kake
1862-2	Kaktovik
1395-3	Kalapuya
1299-7	Kalispel
1921-6	Kalskag
1773-1	Kaltag
1995-0	Karluk
1301-1	Karuk
1824-2	Kasaan
1468-8	Kashia
1922-4	Kasigluk
1117-1	Kathlamet
1303-7	Kaw
1058-7	Kawaiisu
1863-0	Kawerak
1825-9	Kenaitze
1496-9	Keres
1059-5	Kern River
1826-7	Ketchikan
1131-2	Keweenaw
1198-1	Kialegee
1864-8	Kiana
1305-2	Kickapoo
1520-6	Kikiallus
2014-9	King Cove
1978-6	King Salmon

Value	Description
1309-4	Kiowa
1923-2	Kipnuk
2096-6	Kiribati
1865-5	Kivalina
1312-8	Klallam
1317-7	Klamath
1827-5	Klawock
1774-9	Kluti Kaah
1775-6	Knik
1866-3	Kobuk
1996-8	Kodiak
1979-4	Kokhanok
1924-0	Koliganek
1925-7	Kongiganak
1992-7	Koniag Aleut
1319-3	Konkow
1321-9	Kootenai
2040-4	Korean
2093-3	Kosraean
1926-5	Kotlik
1867-1	Kotzebue
1868-9	Koyuk
1776-4	Koyukuk
1927-3	Kwethluk
1928-1	Kwigillingok
1869-7	Kwiguk
1332-6	La Jolla
1226-0	La Posta
1132-0	Lac Courte Oreilles
1133-8	Lac du Flambeau
1134-6	Lac Vieux Desert Chippewa
1497-7	Laguna
1777-2	Lake Minchumina
1135-3	Lake Superior
1617-0	Lake Traverse Sioux
2041-2	Laotian
1997-6	Larsen Bay
1424-1	Las Vegas
1323-5	Lassik
2123-8	Lebanese
1136-1	Leech Lake
1216-1	Lenni-Lenape
1929-9	Levelock
2063-6	Liberian
1778-0	Lime
1014-0	Lipan Apache
1137-9	Little Shell Chippewa

Value	Description
1425-8	Lone Pine
1325-0	Long Island
1048-8	Los Coyotes
1426-6	Lovelock
1618-8	Lower Brule Sioux
1314-4	Lower Elwha
1930-7	Lower Kalskag
1199-9	Lower Muscogee
1619-6	Lower Sioux
1521-4	Lower Skagit
1331-8	Luiseno
1340-9	Lumbee
1342-5	Lummi
1200-5	Machis Lower Creek Indian
2052-9	Madagascar
1344-1	Maidu
1348-2	Makah
2042-0	Malaysian
2049-5	Maldivian
1427-4	Malheur Paiute
1350-8	Maliseet
1352-4	Mandan
1780-6	Manley Hot Springs
1931-5	Manokotak
1227-8	Manzanita
2089-1	Mariana Islander
1728-5	Maricopa
1932-3	Marshall
2090-9	Marshallese
1454-8	Marshantucket Pequot
1889-5	Mary's Igloo
1681-6	Mashpee Wampanoag
1326-8	Matinecock
1354-0	Mattaponi
1060-3	Mattole
1870-5	Mauneluk Inupiat
1779-8	Mcgrath
1620-4	Mdewakanton Sioux
1933-1	Mekoryuk
2100-6	Melanesian
1356-5	Menominee
1781-4	Mentasta Lake
1228-6	Mesa Grande
1015-7	Mescalero Apache
1838-2	Metlaktla
1072-8	Mexican American Indian
1358-1	Miami

Value	Description
1363-1	Miccosukee
1413-4	Michigan Ottawa
1365-6	Micmac
2085-9	Micronesian
2118-8	Middle Eastern or North African
1138-7	Mille Lacs
1621-2	Miniconjou
1139-5	Minnesota Chippewa
1782-2	Minto
1368-0	Mission Indians
1158-5	Mississippi Choctaw
1553-7	Missouri Sac and Fox
1370-6	Miwok
1428-2	Moapa
1372-2	Modoc
1729-3	Mohave
1287-2	Mohawk
1374-8	Mohegan
1396-1	Molala
1376-3	Mono
1327-6	Montauk
1237-7	Moor
1049-6	Morongo
1345-8	Mountain Maidu
1934-9	Mountain Village
1159-3	Mowa Band of Choctaw
1522-2	Muckleshoot
1217-9	Munsee
1935-6	Naknek
1498-5	Nambe
2064-4	Namibian
1871-3	Nana Inupiat
1238-5	Nansemond
1378-9	Nanticoke
1937-2	Napakiak
1938-0	Napaskiak
1936-4	Napaumute
1380-5	Narragansett
1239-3	Natchez
2079-2	Native Hawaiian
2076-8	Native Hawaiian or Other Pacific Islander
1240-1	Nausu Waiwash
1382-1	Navajo
1475-3	Nebraska Ponca
1698-0	Nebraska Winnebago
2016-4	Nelson Lagoon
1783-0	Nenana

Value	Description
2050-3	Nepalese
2104-8	New Hebrides
1940-6	New Stuyahok
1939-8	Newhalen
1941-4	Newtok
1387-0	Nez Perce
2065-1	Nigerian
1942-2	Nightmute
1784-8	Nikolai
2017-2	Nikolski
1785-5	Ninilchik
1241-9	Nipmuc
1346-6	Nishinam
1523-0	Nisqually
1872-1	Noatak
1389-6	Nomalaki
1873-9	Nome
1786-3	Nondalton
1524-8	Nooksack
1874-7	Noorvik
1022-3	Northern Arapaho
1095-9	Northern Cherokee
1103-1	Northern Cheyenne
1429-0	Northern Paiute
1469-6	Northern Pomo
1787-1	Northway
1391-2	Northwest Tribes
1875-4	Nuiqsut
1788-9	Nulato
1943-0	Nunapitchukv
1622-0	Oglala Sioux
2043-8	Okinawan
1016-5	Oklahoma Apache
1042-1	Oklahoma Cado
1160-1	Oklahoma Choctaw
1176-7	Oklahoma Comanche
1218-7	Oklahoma Delaware
1306-0	Oklahoma Kickapoo
1310-2	Oklahoma Kiowa
1361-5	Oklahoma Miami
1414-2	Oklahoma Ottawa
1446-4	Oklahoma Pawnee
1451-4	Oklahoma Peoria
1476-1	Oklahoma Ponca
1554-5	Oklahoma Sac and Fox
1571-9	Oklahoma Seminole
1998-4	Old Harbor

Value	Description
1403-5	Omaha
1288-0	Oneida
1289-8	Onondaga
1140-3	Ontonagon
1405-0	Oregon Athabaskan
1407-6	Osage
1944-8	Oscarville
2500-7	Other Pacific Islander
2131-1	Other Race
1409-2	Otoe-Missouria
1411-8	Ottawa
1999-2	Ouzinkie
1430-8	Owens Valley
1416-7	Paiute
2044-6	Pakistani
1333-4	Pala
2091-7	Palauan
2124-6	Palestinian
1439-9	Pamunkey
1592-5	Panamint
2102-2	Papua New Guinean
1713-7	Pascua Yaqui
1441-5	Passamaquoddy
1242-7	Paugussett
2018-0	Pauloff Harbor
1334-2	Pauma
1445-6	Pawnee
1017-3	Payson Apache
1335-9	Pechanga
1789-7	Pedro Bay
1828-3	Pelican
1448-0	Penobscot
1450-6	Peoria
1453-0	Pequot
1980-2	Perryville
1829-1	Petersburg
1499-3	Picuris
1981-0	Pilot Point
1945-5	Pilot Station
1456-3	Pima
1623-8	Pine Ridge Sioux
1624-6	Pipestone Sioux
1500-8	Piro
1460-5	Piscataway
1462-1	Pit River
1946-3	Pitkas Point
1947-1	Platinum

Value	Description
1443-1	Pleasant Point Passamaquoddy
1201-3	Poarch Band
1243-5	Pocomoke Acohonock
2094-1	Pohnpeian
1876-2	Point Hope
1877-0	Point Lay
1501-6	Pojoaque
1483-7	Pokagon Potawatomi
2115-4	Polish
2078-4	Polynesian
1464-7	Pomo
1474-6	Ponca
1328-4	Poospatuck
1315-1	Port Gamble Klallam
1988-5	Port Graham
1982-8	Port Heiden
2000-8	Port Lions
1525-5	Port Madison
1948-9	Portage Creek
1478-7	Potawatomi
1487-8	Powhatan
1484-5	Prairie Band
1625-3	Prairie Island Sioux
1202-1	Principal Creek Indian Nation
1626-1	Prior Lake Sioux
1489-4	Pueblo
1518-0	Puget Sound Salish
1526-3	Puyallup
1431-6	Pyramid Lake
2019-8	Qagan Toyagungin
2020-6	Qawalangin
1541-2	Quapaw
1730-1	Quechan
1084-3	Quileute
1543-8	Quinault
1949-7	Quinhagak
1385-4	Ramah Navajo
1790-5	Rampart
1219-5	Rampough Mountain
1545-3	Rappahannock
1141-1	Red Cliff Chippewa
1950-5	Red Devil
1142-9	Red Lake Chippewa
1061-1	Red Wood
1547-9	Reno-Sparks
1151-0	Rocky Boy's Chippewa Cree
1627-9	Rosebud Sioux

Value	Description
1549-5	Round Valley
1791-3	Ruby
1593-3	Ruby Valley
1551-1	Sac and Fox
1143-7	Saginaw Chippewa
2095-8	Saipanese
1792-1	Salamatof
1556-0	Salinan
1558-6	Salish
1560-2	Salish and Kootenai
1458-9	Salt River Pima-Maricopa
1527-1	Samish
2080-0	Samoan
1018-1	San Carlos Apache
1502-4	San Felipe
1503-2	San Ildefonso
1506-5	San Juan
1505-7	San Juan De
1504-0	San Juan Pueblo
1432-4	San Juan Southern Paiute
1574-3	San Manual
1229-4	San Pasqual
1656-8	San Xavier
1220-3	Sand Hill
2023-0	Sand Point
1507-3	Sandia
1628-7	Sans Arc Sioux
1508-1	Santa Ana
1509-9	Santa Clara
1062-9	Santa Rosa
1050-4	Santa Rosa Cahuilla
1163-5	Santa Ynez
1230-2	Santa Ysabel
1629-5	Santee Sioux
1510-7	Santo Domingo
1528-9	Sauk-Suiattle
1145-2	Sault Ste. Marie Chippewa
1893-7	Savoonga
1830-9	Saxman
1952-1	Scammon Bay
1562-8	Schaghticoke
1564-4	Scott Valley
2116-2	Scottish
1470-4	Scotts Valley
1878-8	Selawik
1793-9	Seldovia
1657-6	Sells

Value	Description
1566-9	Seminole
1290-6	Seneca
1291-4	Seneca Nation
1292-2	Seneca-Cayuga
1573-5	Serrano
1329-2	Setauket
1795-4	Shageluk
1879-6	Shaktoolik
1576-8	Shasta
1578-4	Shawnee
1953-9	Sheldon's Point
1582-6	Shinnecock
1880-4	Shishmaref
1584-2	Shoalwater Bay
1586-7	Shoshone
1602-2	Shoshone Paiute
1881-2	Shungnak
1891-1	Siberian Eskimo
1894-5	Siberian Yupik
1607-1	Siletz
2051-1	Singaporean
1609-7	Sioux
1631-1	Sisseton Sioux
1630-3	Sisseton-Wahpeton
1831-7	Sitka
1643-6	Siuslaw
1529-7	Skokomish
1594-1	Skull Valley
1530-5	Skykomish
1794-7	Slana
1954-7	Sleetmute
1531-3	Snohomish
1532-1	Snoqualmie
1336-7	Soboba
1146-0	Sokoagon Chippewa
1882-0	Solomon
2103-0	Solomon Islander
1073-6	South American Indian
1595-8	South Fork Shoshone
2024-8	South Naknek
1811-9	Southeast Alaska
1244-3	Southeastern Indians
1023-1	Southern Arapaho
1104-9	Southern Cheyenne
1433-2	Southern Paiute
1074-4	Spanish American Indian
1632-9	Spirit Lake Sioux

Value	Description
1645-1	Spokane
1533-9	Squaxin Island
2045-3	Sri Lankan
1144-5	St. Croix Chippewa
2021-4	St. George
1963-8	St. Mary's
1951-3	St. Michael
2022-2	St. Paul
1633-7	Standing Rock Sioux
1203-9	Star Clan of Muscogee Creeks
1955-4	Stebbins
1534-7	Steilacoom
1796-2	Stevens
1647-7	Stewart
1535-4	Stillaguamish
1649-3	Stockbridge
1797-0	Stony River
1471-2	Stonyford
2002-4	Sugpiaq
1472-0	Sulphur Bank
1434-0	Summit Lake
2004-0	Suqpiq
1536-2	Suquamish
1651-9	Susanville
1245-0	Susquehanna
1537-0	Swinomish
1231-0	Sycuan
2125-3	Syrian
1705-3	Table Bluff
1719-4	Tachi
2081-8	Tahitian
2035-4	Taiwanese
1063-7	Takelma
1798-8	Takotna
1397-9	Talakamish
1799-6	Tanacross
1800-2	Tanaina
1801-0	Tanana
1802-8	Tanana Chiefs
1511-5	Taos
1969-5	Tatitlek
1803-6	Tazlina
1804-4	Telida
1883-8	Teller
1338-3	Temecula
1596-6	Te-Moak Western Shoshone
1832-5	Tenakee Springs

Value	Description
1398-7	Tenino
1512-3	Tesuque
1805-1	Tetlin
1634-5	Teton Sioux
1513-1	Tewa
1307-8	Texas Kickapoo
2046-1	Thai
1204-7	Thlopthlocco
1514-9	Tigua
1399-5	Tillamook
1597-4	Timbi-Sha Shoshone
1833-3	Tlingit
1813-5	Tlingit-Haida
2073-5	Tobagoan
1956-2	Togiak
1653-5	Tohono O'Odham
1806-9	Tok
2083-4	Tokelauan
1957-0	Toksook
1659-2	Tolowa
1293-0	Tonawanda Seneca
2082-6	Tongan
1661-8	Tonkawa
1051-2	Torres-Martinez
2074-3	Trinidadian
1272-4	Trinity
1837-4	Tsimshian
1205-4	Tuckabachee
1538-8	Tulalip
1720-2	Tule River
1958-8	Tulukskak
1246-8	Tunica Biloxi
1959-6	Tuntutuliak
1960-4	Tununak
1147-8	Turtle Mountain
1294-8	Tuscarora
1096-7	Tuscola
1337-5	Twenty-Nine Palms
1961-2	Twin Hills
1635-2	Two Kettle Sioux
1663-4	Tygh
1807-7	Tyonek
1970-3	Ugashik
1672-5	Uintah Ute
1665-9	Umatilla
1964-6	Umkumiate
1667-5	Umpqua

Value	Description
1884-6	Unalakleet
2025-5	Unalaska
2006-5	Unangan Aleut
2026-3	Unga
1097-5	United Keetowah Band of Cherokee
1118-9	Upper Chinook
1636-0	Upper Sioux
1539-6	Upper Skagit
1670-9	Ute
1673-3	Ute Mountain Ute
1435-7	Utu Utu Gwaitu Paiute
1808-5	Venetie
2047-9	Vietnamese
1247-6	Waccamaw-Siousan
1637-8	Wahpekute Sioux
1638-6	Wahpeton Sioux
1675-8	Wailaki
1885-3	Wainwright
1119-7	Wakiakum Chinook
1886-1	Wales
1436-5	Walker River
1677-4	Walla-Walla
1679-0	Wampanoag
1064-5	Wappo
1683-2	Warm Springs
1685-7	Wascopum
1598-2	Washakie
1687-3	Washoe
1639-4	Wazhaza Sioux
1400-1	Wenatchee
2075-0	West Indian
1098-3	Western Cherokee
1110-6	Western Chickahominy
1273-2	Whilkut
2106-3	White
1148-6	White Earth
1887-9	White Mountain
1019-9	White Mountain Apache
1888-7	White Mountain Inupiat
1692-3	Wichita
1248-4	Wicomico
1120-5	Willapa Chinook
1694-9	Wind River
1024-9	Wind River Arapaho
1599-0	Wind River Shoshone
1696-4	Winnebago
1700-4	Winnemucca

Value	Description
1702-0	Wintun
1485-2	Wisconsin Potawatomi
1809-3	Wiseman
1121-3	Wishram
1704-6	Wiyot
1834-1	Wrangell
1295-5	Wyandotte
1401-9	Yahooskin
1707-9	Yakama
1709-5	Yakama Cowlitz
1835-8	Yakutat
1065-2	Yana
1640-2	Yankton Sioux
1641-0	Yanktonai Sioux
2098-2	Yapese
1711-1	Yaqui
1731-9	Yavapai
1715-2	Yavapai Apache
1437-3	Yerington Paiute
1717-8	Yokuts
1600-6	Yomba
1722-8	Yuchi
1066-0	Yuki
1724-4	Yuman
1896-0	Yupik Eskimo
1732-7	Yurok
2066-9	Zairean
1515-6	Zia
1516-4	Zuni
9999-9	Unknown

## Appendix I: Ethnicity

Ethnicity codes are based on Arkansas Medicaid ethnicity codes.

State Codes Effective October 2010		
State Codes	Description	Federal Codes
03	Not Hispanic or Latino – American Indian or Alaska Native	3
04	Not Hispanic or Latino – Asian	4
05	Not Hispanic or Latino – Black or African American	2
06	Not Hispanic or Latino – Native Hawaiian or Other Pacific Islander	6
07	Not Hispanic or Latino – White	1
08	Not Hispanic or Latino – American Indian or Alaska Native and White	8
09	Not Hispanic or Latino – Asian and White	8
10	Not Hispanic or Latino – Black or African American and White	8
11	Not Hispanic or Latino – American Indian or Alaska Native and Black or African American	8
12	Not Hispanic or Latino – More than one race but not race codes 8 - 11	8
13	Hispanic or Latino – American Indian or Alaska Native	7
14	Hispanic or Latino – Asian	7
15	Hispanic or Latino – Black or African American	7
16	Hispanic or Latino – Native Hawaiian or Other Pacific Islander	7
17	Hispanic or Latino – White	7
18	Hispanic or Latino – American Indian or Alaska Native and White	7
19	Hispanic or Latino – Asian and White	7
20	Hispanic or Latino – Black or African American and White	7
21	Hispanic or Latino – American Indian or Alaska Native and Black or African American	7
22	Hispanic or Latino – More than one race but not race codes 18 - 21	7
23	Unknown – American Indian or Alaska Native	3
24	Unknown – Asian	4
25	Unknown – Black or African American	2
26	Unknown – Native Hawaiian or Other Pacific Islander	6
27	Unknown – White	1
28	Unknown – American Indian or Alaska Native and White	8
29	Unknown – Asian and White	8
30	Unknown – Black or African American and White	8
31	Unknown – American Indian or Alaska Native and Black or African American	8
32	Unknown – More than one race but not race codes 28 - 31	8
33	Not Hispanic or Latino – Other or Blank (no race selected)	9
34	Hispanic or Latino – Other or Blank (no race selected)	5
35	Unknown – Other or Blank (no race selected)	9

<b>Federal Codes Effective October 2010</b>	
<b>Federal Codes</b>	<b>Federal Ethnicity – Race Description</b>
1	White
2	Black or African American
3	American Indian or Alaska Native
4	Asian
5	Hispanic or Latino (no race information available)
6	Native Hawaiian or Other Pacific Islander
7	Hispanic or Latino and one or more races
8	More than one race (Hispanic or Latino not indicated)
9	Unknown

<b>State and Federal Codes Used Before October 2010</b>		
<b>State Codes</b>	<b>Description</b>	<b>Federal Codes</b>
1	White	1
2	Black	2
3	American Native	3
3A	Alaskan	3
3I	American Indian	3
4	Other	6
5	Unknown	9
6	Spanish American	5
7	Oriental	4
8	Oriental Native	4
8C	Cambodian	4
8H	Hmong	4
8L	Laotian	4
8V	Vietnamese	4
9C	Cuban	5
9H	Haitian	5
9	Hispanic	5
1	White	1
2	Black	2
3	American Native	3
3A	Alaskan	3
3I	American Indian	3
4	Other	6
5	Unknown	9
6	Spanish American	5
7	Oriental	4
8	Oriental Native	4

## Appendix J: Provider Type Codes

Value	Description
01	Academic Institution
02	Adult Foster Care
03	Ambulance Services
04	Hospital Based Clinic
05	Stand-Alone, Walk-In/Urgent Care Clinic
06	Other Clinic
07	Community Health Center - General
08	Community Health Center - Urgent Care
09	Government Agency
10	Health Care Corporation
11	Home Health Agency
12	Acute Hospital
13	Chronic Hospital
14	Rehabilitation Hospital
15	Psychiatric Hospital
16	DPH Hospital
17	State Hospital
18	Veterans Hospital
19	DMH Hospital
20	Sub-Acute Hospital
21	Licensed Hospital Satellite Emergency Facility
22	Hospital Emergency Center
23	Nursing Home
24	Freestanding Ambulatory Surgery Center
25	Hospital Licensed Ambulatory Surgery Center
26	Non-Health Corporations
27	School Based Health Center
28	Rest Home
29	Licensed Hospital Satellite Facility
30	Hospital Licensed Health Center
31	Other Facility
40	Physician (PV034 = 1)
50	Physician Group (PV034 = 3)
60	Nurse (PV034 = 1)
70	Clinician (PV034 = 1)
80	Technician (PV034 = 1)
90	Pharmacy/Site or Mail Order (PV034 = 4 or 5)
99	Other Individual or Group (PV034 = 1 or 3)

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## Appendix K: External Code Sources

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Look-up	Link
State codes, ZIP Codes and other geographic associations	<a href="https://www.usps.com/">https://www.usps.com/</a>
Provider names associated with National Provider Identifier (NPI) number	<a href="https://nppes.cms.hhs.gov/NPPES/">https://nppes.cms.hhs.gov/NPPES/</a>
Health care provider taxonomy codes	<a href="http://www.wpc-edi.com/reference/">http://www.wpc-edi.com/reference/</a>
Definitions of ICD-9 and ICD-10 diagnosis codes	<a href="http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html">http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html</a>
Definitions of ICD-9 and ICD-10 Procedure codes	
Definitions of HCPCS, CPTs and Modifier codes	
Dental procedure and identifier codes	<a href="http://www.ada.org/">http://www.ada.org/</a>
Standard professional billing elements	<a href="http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf">http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf</a>
Claim adjustment reason codes	<a href="http://www.wpc-edi.com/reference/">http://www.wpc-edi.com/reference/</a>
ISO country codes	<a href="http://www.iso.org/iso/country_codes.htm">http://www.iso.org/iso/country_codes.htm</a>
National Council for Prescription Drug Programs (NCPDP)	<a href="http://www.ncpdp.org">http://www.ncpdp.org</a>
National Association of Boards of Pharmacy (NABP)	<a href="http://www.nabp.net">http://www.nabp.net</a>

## Appendix L: Plan and Group Definitions

Plan/Group	Definition	Source
Federal Government Plan (FGP)	A governmental plan established or maintained for its employees by the United States Government or by any agency or instrumentality of the government	A.C.A. 23-86-303.13
Governmental Plan (GPL)	A plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing	A.C.A. 23-86-303.14
Health Maintenance Organization (HMO)	(A) A federally qualified health maintenance organization as defined in section 1301(a) of the Public Health Service Act, 42 U.S.C. § 300e(a);  (B) An organization recognized under state law as a health maintenance organization; or  (C) A similar organization regulated under state law for solvency in the same manner and to the same extent as a health maintenance organization	A.C.A. 23-86-303.20
Individual Market (IND)	The market for health insurance coverage offered to individuals other than in connection with a group health plan	A.C.A. 23-86-303.22
Large Employer (LRG)	In connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least fifty-one (51) employees on business days during the preceding calendar year and who employs at least two (2) employees on the first day of the plan year	A.C.A. 23-86-303.24
Small Employer (SMG)	In connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two (2) but not more than fifty (50) employees on business days during the preceding calendar year and who employs at least two (2) employees on the first day of the plan year	A.C.A. 23-86-303.34
Small-Group Market (SMM)	The health insurance market under which individuals obtain health insurance coverage directly or through any arrangement on behalf of themselves and their dependents through a group health plan maintained by a	A.C.A. 23-86-303.35

Plan/Group	Definition	Source
	small employer	
Third-Party Administrator (TPA)	<p>Any person, firm, or partnership that collects or charges premiums from or adjusts or settles claims on residents of this state in connection with life or accident and health coverage provided by a self-funded plan or a multiple employer trust or multiple employer welfare arrangement. "Third-party administrator" includes administrative-services-only contracts offered by insurers and health maintenance organizations but does not include the following persons:</p> <p>(1) An employer, for its employees or for the employees of a subsidiary or affiliated corporation of the employer;</p> <p>(2) A union, for its members;</p> <p>(3) An insurer or health maintenance organization licensed to do business in this state;</p> <p>(4) A creditor, for its debtors, regarding insurance covering a debt between them;</p> <p>(5) A credit card-issuing company that advances for or collects premiums or charges from its credit card holders as long as that company does not adjust or settle claims;</p> <p>(6) An individual who adjusts or settles claims in the normal course of his or her practice or employment and who does not collect charges or premiums in connection with life or accident and health coverage; or</p> <p>(7) An agency licensed by the Insurance Commissioner and performing duties pursuant to an agency contract with an insurer authorized to do business in this state.</p>	A.C.A. 23-92-201
Self-Funded Plans (SLF)	<p>A self-insurance arrangement whereby an employer provides health or disability benefits to employees with its own funds.</p> <p>The Arkansas Insurance Department has no regulatory authority over a self-funded plan because it is not an insurance policy. Complaints and grievances over a self-funded health plan would be handled by ERISA.</p>	Administrative Services Only (ASO)

## REVISION HISTORY

VERSION	CHANGE MGMT. #	DATE	OWNER	DESCRIPTION
0.1.2014	0	7/22/2014	Sheila Dodson	Initial rough draft. Note comments in document containing questions to be addressed before final version is complete
1.0.2014	1	9/8/2014	Rachel Phillips Kenley Money	Put in APCD format. Incorporated edits
2.0.2014	2	11/12/2014	Brady Rice	Incorporated recommendations from Linda Green, Freedman Health
2.1.2014	3	11/12/2014	Brady Rice	Added Column ID so that sort order will group similar/related elements
2.1.2014	4	12/3/2014	Kenley Money	Added new Pharmacy variable, PC900_2, Spend Down amount for Medicaid
2.1.2014	5	12/17/2014	Kenley Money	Update email processing and messaging requirements
1.0.2015	6	1/21/2015	Kenley Money	Add subscriber address, city, state, ZIP code, and spend down for Medical Claims
1.1.2015	7	2/16/2015	Kenley Money	Update Provider file requirements to match table mapping. Deleted redundant fields including Medicaid ID, Provider Category, Provider Plan ID, Delegated Provider Record Flag
1.1.2015	8	2/19/2015	Kenley Money	Added instruction about representing missing data values with NULL instead of unknown
1.1.2015	9	2/24/2015	Kenley Money	Added Product ID Number to Medical Claims
1.1.2015	10	3/28/2015	Kenley Money	Replaced Appendix D Bill Types with complete list
1.1.2015	11	4/3/2015	Kenley Money	Removed the condition 'over 18 years of age' from ME062, Marital status
2.1.2015	12	5/6/2015	Brady Rice	Modifications made during meetings with Kimberly Hartsfield. Removed Pharmacy variable, PC900_2, Spend Down amount for Medicaid
3.0.2015	13	5/18/2015	Kenley Money	Revisions to align DSG with statutory requirements from Act 1233 of 2015 <ol style="list-style-type: none"> <li>1. Removed value, condition, and occurrence codes</li> <li>2. Removed name, address, and city variables</li> <li>3. Added unique identifier fields</li> <li>4. Updated or removed fields based on subject matter expert review</li> <li>5. Revised Exception Process section. Update Exception Request form to add Value column and Exception Approved Date</li> </ol>
3.0.2015	14	5/26/2015	Kenley Money	Added validation requirements Reordered tables

VERSION	CHANGE MGMT. #	DATE	OWNER	DESCRIPTION
3.0.2015	15	5/30/2015	Kenley Money	Added adjustment/versioning process
3.0.2015	16	6/7/2015	Kenley Money	Added naming convention for Benchmarking and Validation reports and look-up tables
3.0.2015	17	6/15/2015	Craig Wilson	Aligned with rule language
3.0.2015	18	6/30/2015	Kenley Money	Added test data requirements
3.0.2015	19	7/8/2015	Kenley Money, Brady Rice	Removed reference to member eligibility snapshot format for historical data. Replaced with request for all records
3.0.2015	20	7/8/2015	Kenley Money	Added Exhibit E – Provider Element update instructions
3.0.2015	21	7/24/2015	Kenley Money	<ul style="list-style-type: none"> <li>Put header/trailer record requirement back in document</li> <li>Resorted by Data Element ID</li> <li>Replaced payer code with NAIC code where applicable</li> </ul>
3.0.2015	22	7/30/2015	Kenley Money	Revised Control Counts section
3.0.2015	23	8/3/2015	Kenley Money	Updated with subject matter expert feedback
3.0.2015	24	8/6/2015	Kenley Money, Rachel Phillips	Edits for submission with Rule 100
3.1.2015	25	8/7/2015	Kenley Money	<ul style="list-style-type: none"> <li>Provided new header and trailer row requirements</li> <li>Added Data Submission example</li> <li>Enrollment Data - added instruction to use values in Data Element ID column as column names</li> <li>Medical Claims Data - added instruction to use values in Data Element ID column as column names</li> <li>Pharmacy Claims Data - added instruction to use values in Data Element ID column as column names</li> <li>Dental Claims Data - added instruction to use values in Data Element ID column as column names</li> <li>Provider Data - added instruction to use values in Data Element ID column as column names</li> <li>Dental Claims - corrected Data Element ID. Updated PC999 to DC999</li> <li>Pharmacy Claims - corrected Data Element ID</li> <li>Updated PC01753 to PC017</li> </ul>
3.1.2015	26	8/12/2015	Kenley Money	<ul style="list-style-type: none"> <li>Added ME120 – Actuarial Status</li> <li>Added ME122 – Grandfather Status to supplement ME121 – Metallic Value</li> <li>Replaced two fields on Header Record to hold information about the number of datasets submitted for any given file submission</li> </ul>
3.1.2015	27	8/13/2015	Kenley Money	Removed hyphens and underscores from Data Element ID values

VERSION	CHANGE MGMT. #	DATE	OWNER	DESCRIPTION
3.1.2015	28	8/17/2015	Kenley Money	<ul style="list-style-type: none"> <li>Removed redundant descriptor for header and trailer records</li> <li>Removed dashes from submission date format in File Naming Convention protocols</li> <li>Replaced abbreviation ENR with ELG to represent Member Enrollment data</li> </ul>
3.1.2015	29	8/18/2015	Kenley Money	Clarified carriage return/line feed requirements for data files
3.1.2015	30	8/19/2015	Kenley Money	Corrected submitting entity private key reference
3.1.2015	31	8/25/2015	Kenley Money	PC073 = Changed field name from Formulary Code to Formulary Indicator
3.1.2015	32	8/25/2015	Kenley Money	Removed denied claim requirement in Medical claims, Pharmacy claims, and Dental claims. Left Denial Reason field as optional placeholder. Noted in Frequently Asked Questions
3.1.2015	33	8/26/2015	Kenley Money	Updated data exception process to reference exception form on website.
3.1.2015	34	9/8/2015	Kenley Money	Added definition of “submitting entity” and “Arkansas resident” to Frequently Asked Questions section
3.1.2015	35	9/8/2015	Kenley Money	<p>In Enrollment Data Required Submission Information - Replaced the word ‘for’ with ‘from’ and removed “based on home address ZIP code” from the requirement to now state that “All covered and termed members who are Arkansas residents associated with subscribers holding certificates of coverage from submitting entities.”</p> <ul style="list-style-type: none"> <li>Replaced Bullet 2 with Arkansas Resident definition from Rule 100</li> </ul>
3.1.2015	36	9/8/2015	Kenley Money	Changed provider fields describing, submitter, board and licensure data to optional
3.1.2015	37	9/8/2015	Kenley Money	<ul style="list-style-type: none"> <li>Removed PC066 – Other Insurance Paid Amount, PC067- Medicare Paid Amount, ME066-COBRA Status.</li> <li>Replaced the reference to member with subscriber in ME123 – Monthly Premium</li> </ul>
3.1.2015	38	9/9/2015	Kenley Money	<ul style="list-style-type: none"> <li>Clarified validation reporting requirement in Control Count description</li> <li>Added the following fields: <ul style="list-style-type: none"> <li>MC020 – Admission Type</li> <li>MC038 – Claim Status</li> <li>MC075 – Drug Code</li> </ul> </li> <li>Changed the Data Element ID name for MC992 from Product ID Number to HIOS ID</li> </ul>

VERSION	CHANGE MGMT. #	DATE	OWNER	DESCRIPTION
				<ul style="list-style-type: none"> <li>Updated references to control counts with validation reporting association</li> <li>PC074 – added value 99 – Other</li> <li>Added explanation and Sample Element IDs and Element Names to Sample Data Exception Request Form</li> </ul>
3.1.2015	39	9/9/2015	Kenley Money	<p>Removed the following diagnosis and procedure codes to align with APCD Core:</p> <p>MC058M - Other ICD-9-CM or ICD-10-CM Procedure Code – 13</p> <p>MC142 - Other Diagnosis – 13</p> <p>MC143 - Other Diagnosis – 14</p> <p>MC144 - Other Diagnosis – 15</p> <p>MC145 - Other Diagnosis – 16</p> <p>MC146 - Other Diagnosis – 17</p> <p>MC147 - Other Diagnosis – 18</p> <p>MC148 - Other Diagnosis – 19</p> <p>MC149 - Other Diagnosis – 20</p> <p>MC150 - Other Diagnosis – 21</p> <p>MC151 - Other Diagnosis – 22</p> <p>MC152 - Other Diagnosis – 23</p> <p>MC153 - Other Diagnosis – 24</p> <p>MC167 - Present on Admission Code (POA) - 13</p> <p>MC168 - Present on Admission Code (POA) - 14</p> <p>MC169 - Present on Admission Code (POA) - 15</p> <p>MC170 - Present on Admission Code (POA) - 16</p> <p>MC171 - Present on Admission Code (POA) - 17</p> <p>MC172 - Present on Admission Code (POA) - 18</p> <p>MC173 - Present on Admission Code (POA) - 19</p> <p>MC174 - Present on Admission Code (POA) - 20</p> <p>MC175 - Present on Admission Code (POA) - 21</p> <p>MC176 - Present on Admission Code (POA) - 22</p> <p>MC177 - Present on Admission Code (POA) - 23</p> <p>MC178 - Present on Admission Code (POA) - 24</p> <p>MC205M - Other ICD-9-CM or ICD-10-CM Procedure Date – 13</p>
3.1.2015	40	09/11/2015	Kenley Money Rachel Phillips	<ul style="list-style-type: none"> <li>ME159A – Dropped because it was a duplicate of ME083</li> <li>PC008 – Changed default when contract number = subscriber's social security number from “blank” to NA</li> <li>PC069 – Changed data element name from Patient Total Out of Pocket Amount to Member Total Out of Pocket Amount</li> <li>PC049 – Removed requirement, “Leave blank if not contracted with submitting entity.”</li> </ul>

VERSION	CHANGE MGMT. #	DATE	OWNER	DESCRIPTION
				<ul style="list-style-type: none"> <li>Added EIN format requirements. Increased column width to 12. Provided supplemental description: PC062, ME034, ME084, MC025, MC088, PC019, DC019, DC044, and PV002</li> <li>PC059 – Changed data element name Recipient PCP ID to Member PCP ID</li> <li>Removed MC998, PC998, and DC998. APCD Unique IDs are not required on Medical claims, Pharmacy claims, or Dental claims data layouts</li> <li>Removed ME000, MC000, PC000, DC000, PV000 fields</li> </ul>
3.1.2015	41	9/12/2015	Rachel Phillips Kenley Money	<ul style="list-style-type: none"> <li>Overview Data Requirements Section - Updated reference to APCD Council core data elements</li> <li>Onboarding Documentation Requirements: Replaced “Data Dictionary” with “Submitting Entity Data Dictionary/Codebook”</li> <li>APCD Technical Support updated for contact information, hours of operation, and process description</li> <li>Removed all “waiver” references</li> <li>Updated general references to Member ID and Subscriber ID to represent data element names, Carrier Specific Unique Member ID and Carrier Specific Unique Subscriber ID</li> <li>Provider Data Required Submission Information – content rearranged for clarity</li> <li>Provider Data Required Submission Information – replaced update criteria with complete replacement criteria</li> <li>Removed Exhibit E: “Provider Data Add/Update Rules.” No longer required with complete replacement update criteria</li> <li>Data Submission Requirements, File Submission Requirements sections were revised for clarity</li> <li>ME998 – Updated Data Element name from “Unique ID” to “APCD Unique ID”</li> <li>Changed title of Data Evaluation section to Data Validation</li> <li>Supplemented data quality reporting references by adding “validation”</li> <li>Data Exception Process section renamed to Data Exceptions</li> <li>On Data Exception Request Form table, integrated DSG Data Element Value into Exception Reason.</li> <li>Data Exception Request Form revised to remove Value column and Exception Approved Date</li> <li>Consolidated Post-APCD Build Data Requests section with the Data Exceptions section</li> <li>File Formatting Requirements section – Removed data exception requirement for blank values</li> <li>File Guideline and Layout Legend – The type definition for</li> </ul>

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				<p>Numeric was revised from “Identifies values containing digits from 0 to 9 and, optionally, a sign and a decimal point” to state “Identifies values containing digits from 0 to 9 and assign a decimal point where required.”</p> <ul style="list-style-type: none"> <li>• HD001 – corrected Length to “5”</li> <li>• TR001 – corrected Length to “5”</li> <li>• HD009 – Updated Required Value to “4”</li> <li>• ME007 – Updated definition for value EPN to “Employee with dependents”</li> <li>• ME078, ME082, ME083 – Removed references to &lt;&gt; entity codes for MCD, MCR, AWC, and self-funded entities in Threshold column</li> <li>• Updated the File Guidelines for Member enrollment data Pharmacy claims data, Medical claims data, Dental claims data, and Provider data in Exhibit A for clarity</li> <li>• Data Submission Example – updated example to label header, detail, and trailer records</li> <li>• Replaced threshold instruction “else optional” with “else blank” in Medical claims fields relating to inpatient stays</li> <li>• Removed optional threshold parameters for ME018, ME019, ME020</li> <li>• Changed threshold for PV056 to 50%</li> <li>• Removed PV036 – Provider SSN</li> <li>• PV037 – Provider Medicare ID made Optional</li> <li>• Added Technical Support Phone Number</li> </ul>
3.1.2015	42	09/14/2015	Rachel Phillips	<ul style="list-style-type: none"> <li>• Revised File Naming Convention protocol to improve file tracking for data submissions with multiple files. Added heading, File Name Component Definitions, and provided examples for clarity</li> <li>• HD007 and HD008 – Reduced field width from 3 to 2</li> <li>• Increased width of ICD diagnosis codes and procedure codes to 7 to accommodate future ICD-10 compliance</li> <li>• Reduced ZIP code length to 5 (ZIP+4 not required)</li> </ul>
3.2.2015	43	9/16/2015	Kenley Money	<p>Revised/updated data element types and formats</p> <p>Corrected field widths for following data elements</p> <ul style="list-style-type: none"> <li>• ME003 – 4 to 6</li> <li>• ME034 – 12 to 15</li> <li>• ME035 – 20 to 10</li> <li>• ME046 – 20 to 10</li> <li>• ME049 – 10 to 10,2</li> <li>• ME050 – 10 to 10,2</li> <li>• ME112 – 10 to 10,2</li> <li>• ME113 – 10 to 10,2</li> </ul>

VERSION	CHANGE MGMT. #	DATE	OWNER	DESCRIPTION
				<ul style="list-style-type: none"> <li>• ME120 – 10 to 10,2</li> <li>• ME123 – 10 to 10,2</li> <li>• ME132 – 10 to 10,2</li> <li>• ME157A – 2 to 3</li> <li>• ME173A – 2 to 25</li> <li>• MC008 – 30 to 20</li> <li>• MC009 – 20 to 3</li> <li>• MC026 – 20 to 10</li> <li>• MC039 through MC053 – 5 to 7</li> <li>• MC058 through MC058L – 5 to 7</li> <li>• MC062 - 10 to 10,2</li> <li>• MC063 - 10 to 10,2</li> <li>• MC063C - 10 to 10,2</li> <li>• MC064 through MC067 - 10 to 10,2</li> <li>• MC077 – 20 to 10</li> <li>• MC095 – 10 to 10,2</li> <li>• MC098 – 10 to 10,2</li> <li>• MC099 – 10 to 10,2</li> <li>• MC112 – 30 to 10</li> <li>• MC121 – 10 to 10,2</li> <li>• MC124 – 15 to 5</li> <li>• MC134 – 20 to 10</li> <li>• PC004 – 40 to 35</li> <li>• PC021 – 20 to 10</li> <li>• PC035 through PC042 – 10 to 10,2</li> <li>• PC048 – 20 to 10</li> <li>• PC059 – 20 to 10</li> <li>• PC069 – 10 to 10,2</li> <li>• PC075 – 20 to 2</li> <li>• DC004 – 40 to 35</li> <li>• DC008 – 9 to 20</li> <li>• DC009 – 20 to 3</li> <li>• DC020 – 20 to 10</li> <li>• DC037 through DC041 – 10 to 10,2</li> <li>• DC046 – 10 to 10,2</li> <li>• DC064 – 30 to 5</li> </ul>
3.2.2015	44	9/16/2015	Kenley Money	<ul style="list-style-type: none"> <li>• Corrected incomplete sentence on page 5 in Required Submission Information</li> <li>• PV033 – “Provider Date of Birth” changed to “Provider Birth Year/Month”</li> <li>• PV033 – Changed format for Provider date of birth from YYYY-MM-DD to YYYYMM</li> </ul>

VERSION	CHANGE MGMT. #	DATE	OWNER	DESCRIPTION
	45	9/17/2015	Rachel Phillips	<ul style="list-style-type: none"> <li>• Modified all EIN-element descriptions for clarity</li> <li>• Added Provider Definition to data</li> <li>• Provided clarity to Data Value Naming Components</li> <li>• Updated the File Guidelines to clarify NULL and BLANK requirements</li> <li>• Data Element ID definition clarified</li> <li>• Clarified threshold dependency for ME065, ME120, MC018-MC023, MC036, MC036, MC039, MC054, MC058, MC058A - MC058L</li> <li>• MC026 – Change from 20 to 10</li> <li>• PV114 added submitter field for Provider file</li> <li>• Clarified threshold dependency for MC068, MC069, MC071, MC072, MC092, MC120, MC122, MC139, MC154-MC166, MC205-MC205L, MC212, and MC915A</li> </ul>
				<ul style="list-style-type: none"> <li>• MC077 – Length change from 20 to 10</li> <li>• MC134 – Length change from 20 to 10</li> <li>• HD009 – Updated Required Length to 10</li> <li>• TR002 and HD002 – Threshold changed to 0%</li> <li>• ME122 – Length changed to 1</li> <li>• MC005A, MC005B, MC138, DC005A, DC059, DC005B, PC110, PC005A, and PC005B – changed to optional and 0% threshold</li> <li>• DC110 – Deleted because it was a duplicate of data element DC059 ME040 definition updated for clarity per submitting entity feedback</li> <li>• PC056 - Deleted per submitting entity feedback</li> <li>• Length change for PC002, PC004, PC009, PC019, PC021, PC035, PC036, PC037, PC039-PC042, PC047, PC048, PC059, PC062, PC069, and PC124</li> <li>• Moved Revision History section to end of document</li> <li>• Added FAQ 19 – County assignment</li> <li>• Updated Data Categories for Submission – Enrollment Data, File content to: <b>Ongoing, periodic submissions:</b> Each enrollment file submitted should contain enrollment data for the applicable time period based on submitting entity feedback</li> <li>• Added provider speciality code crosswalk instruction to PV019, PV020. PV021</li> </ul>

This is a dynamic document that will be reviewed and updated on an ongoing basis. Each change will be recorded in the Revision History section.