ARKANSAS HEALTHCARE TRANSPARENCY INITIATIVE – ARKANSAS APCD DATA SUBMISSION GUIDE

December 1, 2021

Technical Change – February 23, 2022

Version: 8.0.2022

RELEASE NOTES

The changes documented in this updated version of the Arkansas All-Payer Claims Database (APCD) Data Submission Guide (DSG) are the result of collaboration between the Arkansas Insurance Department (AID), the Arkansas APCD authority; the Arkansas Center for Health Improvement (ACHI), the Arkansas APCD administrator; APCD Council (apcdcouncil.org); and submitting entities.

February 2022 Technical Change items include (see revisions 29 through 36):

1. Field value length changes
2. Bill Type value correction
3. Corrected dependency
4. Ethnicity code appendix correction
5. Clarification for empty vs blank fields

No data will have to be resubmitted to address the changes above.

Major changes from previous DSG publication (December 2021):

1. **Alignment with the Common Data Layout —** Responding to submitting entity input, the Arkansas APCD team has begun the process to align the Arkansas data submission guide (DSG) with the APCD Council Common Data Layout (CDL). The CDL is intended to harmonize required data to reduce state-specific custom DSG requirements. Arkansas begins this process by updating select fields shared between the Arkansas APCD and the CDL and adding several fields from the CDL not currently in the Arkansas DSG. The population of these fields will be managed through the data exception process.
2. **Include institutional values to inpatient only fields –** Several medical claim data elements defined as inpatient only are being expanded to include all institutional claims, not just inpatient. These changes are documented through updated dependency rules.
3. **Add ZIP4 —** Some CDL fields currently carried in the Arkansas DSG have slightly different requirements or formatting. The formatting requirements for the USPS ZIP code will now require the four digit ZIP4 code if available to align with the CDL.
4. **Point of origin appendix —** Point of origin is a new field added to align with the CDL. An appendix is now included to support this field.
5. **Definition alignment and clarification—** Definitions for several fields have been updated to ensure consistency clarity across file types. Fields affected include Provider ID fields, Submitting Entity ID fields (ME001, MC001, PC001, DC001, PV114, LU005, PB001). Additionally, the introductions on several appendices have been expanded to clarify the handling of non-listed values.
6. **Employer ZIP code definition change –** Employer Location ZIP Code (ME078) has been updated to require the ZIP Code belonging to the employer location where the member works, not the main or corporate office location.
7. **Optional fields now required —** Race, ethnicity, and language fields are now required fields. Submitting entities should submit an exception if these data are not available.
8. **Language code reference –** Language code reference has been changed to the ISO 639-3: 2007 standard code set.
9. **Ethnicity code references –** Three reference tables had been included supporting ethnicity values. Two have been removed leaving the following value set for ongoing use: State Codes Effective October 2010.
10. **Arkansas Medicaid Aid Category Codes –** A new field has been added to each file type – Member, Medical Claims, Pharamcy Claims, and Dental Claims – that will contain the Arkansas Medicaid State Aid

Category code. This value was previously only found on the Member data in field ME040. Field ME040 will be changed to contain the Arkansas Medicaid Federal Aid Category code. This applies to Arkansas Medicaid data only.

11. **Placeholder fields –** Five placeholder fields have been added to each file type. These fields are reserved for future DSG changes.
12. **Other changes –** Data element ID changes, data element name changes, updated links.

Be sure to review the Revision History for a detailed list of changes and additions.

Submitting entities who have already submitted historical data files as of calendar years 2013-2021 do not have to resubmit historical data with these new fields or value sets. The Arkansas APCD team will execute the necessary data transformation processes to add these fields to the historical data already received. These changes are required as part of the data submissions to be received after **March 31, 2022**, and before **June 30, 2022**, for this DSG version.

REVISION HISTORY

The Revision History contains a complete list of all changes made for the latest DSG version.

Finally, the Arkansas APCD team extends an enormous thank you to AID and the submitting entities for their patience, input, and participation. All input and feedback is welcome.

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.

VERSION	CHANGE MGMT. #	DATE	OWNER	DESCRIPTION	PAGE NUMBER
8.0.2022	1	7/1/2021	ACHI	UPDATE. Updated with the latest DSG version and instruction.	2
8.0.2022	2	7/1/2021	ACHI	UPDATE. Added clarifying statements to assist submitting entities with data value mapping. (this revision is throughout the document)	19,21,23,25,26,30, 184,187,197,202,
8.0.2022	3	7/1/2021	ACHI	UPDATE. Expanded definition to align with the CDL. Submitters should not change how they are populating this field. Fields: HD001, CC001, TR001, ME001, MC001, PC001, DC001, PV114, LU005, SP001, PB001	54,56,57,58,59,60, 61,62,63,64,66,79, 108,124,137,143, 146,149
8.0.2022	4	7/1/2021	ACHI	UPDATE. USPS ZIP code should now include ZIP4 if available. Fields: ME017, ME078, ME110, MC016, MC035, MC210, MC987, PC016, PC024, PC055, PC954, DC016, DC029, DC058, PV012, PV018, PB016, PB024, PB055, PB954	67,71,72,81,83, 100,101,109,110, 114,117,125,127, 132,138,151,155, 158
8.0.2022	5	7/1/2021	ACHI	UPDATE. Data will now be required. Fields: ME021, ME022, ME025, ME026, ME033, ME154A, ME155A, ME156A, ME157A, MC166A, MC112	68,73,74,92
8.0.2022	6	7/1/2021	ACHI	UPDATE. Data will now be required. Name changed from Health Care Home to Medical Home Fields: ME035, ME036	69
8.0.2022	7	7/1/2021	ACHI	UPDATE. Updated data element name. Field: ME046	69
8.0.2022	8	7/1/2021	ACHI	UPDATE. Changed reference language code set for improved reference and use. Fields: ME033, ME157A, Appendix G	68,73,203
8.0.2022	9	7/1/2021	ACHI	UPDATE. ZIP code from member's employer location now required. Previous definition required employer ZIP code only which did not always represent member's employment location.	71

Version	Change Mgmt. #	Date	Owner	Description	Page Number
				Data element name revised to better represent definition. Field: ME078	
8.0.2022	10	7/1/2021	ACHI	UPDATE. Add new values to align with CDL. Field: ME122	72
8.0.2022	11	9/30/2021	ACHI	NEW. Placeholder field added to accommodate future Arkansas APCD DSG changes. Fields: ME850, ME851, ME852, ME853, ME854, MC850, MC851, MC852, MC853, MC854, PC850, PC851, PC852, PC853, PC854, DC850, DC851, DC852, DC853, DC854, PV850, PV851, PV852, PV853, PV854, PB850, PB851, PB852, PB853, PB854	76,104,122,134, 141,165
8.0.2022	12	7/1/2021	ACHI	UPDATE. Remove MC036 - Bill Type threshold requirement to expand from inpatient to institution level information. Fields: MC023, MC039, MC058-MC058L, MC092, MC154-MC166	81,83,86,87,91,94, 95,96,97,98,99
8.0.2022	13	7/1/2021	ACHI	UPDATE. Updated provider ID definition to ensure consistency across all provider ID fields. Fields: MC024, MC076, PC043, DC018, PV001, PB043	81,90,113,126, 137,154
8.0.2022	14	7/1/2021	ACHI	UPDATE. Changed data element name to align with definition. Field: MC112	92
8.0.2022	15	7/1/2021	ACHI	NEW. New field added for Arkansas Medicaid data only. Note, ME040 - Product code previously contained the Arkansas Medicaid State Aid Category code. ME040 will contain Arkansas Medicaid Federal Aid Category code on data Arkansas Medicaid data received after March 31, 2021. Fields: ME910, MC910, PC910, DC910, PB910	76,104,122,133
8.0.2022	16	7/1/2021	ACHI	UPDATE**.** Added value R to dependency. This is a documentation change only. The value is already present in the validation process Field: PC702	118
8.0.2022	17	7/1/2021	ACHI	NEW. New field added to support state specific projects and to align with APCD Council CDL. Fields: ME024, ME159A, MC021, MC966, PC113, PC038, DC113, DC911, DC915A	75,104,121,122, 133
8.0.2022	18	7/1/2021	ACHI	UPDATE: Changed ME170A from the member to subscriber. This field value should be the subscriber's employer code.	74

Version	Change Mgmt. #	Date	Owner	Description	Page Number
8.0.2022	19	7/1/2021	ACHI	UPDATE. Added definition information to ME040 about the Arkansas Medicaid Federal Aid Category Code.	69
8.0.2022	20	7/1/2021	ACHI	Unused	
8.0.2022	21	7/1/2021	ACHI	UPDATE. Changed data element ID. The previous number, PB113, is now being used for Payment Arrangement Type to align with the same field in Medical claims – MC113, Pharmacy claims – PC113, Dental claims – DC113.	163
8.0.2022	22	7/1/2021	ACHI	UPDATE. Added specificity to initial DSG 8.0 submission date requirement.	ii
8.0.2022	23	7/1/2021	ACHI	UPDATE. Removed original outdated link. Added new link. Appendix E	197
8.0.2022	24	7/1/2021	ACHI	UPDATE. Added leading zero to single digit values per CMS requirements. Appendix E	197
8.0.2022	25	7/1/2021	ACHI	UPDATE. Changed definition to reflect current CMS definition. Appendix E	197
8.0.2022	26	7/1/2021	ACHI	NEW. Added taxonomy code reference to align with CDL. Appendix K	228
8.0.2022	27	7/1/2021	ACHI	NEW. Supporting appendix for new field to align with the APCD Council Common Data Layout. Appendix P	242
8.0.2022	28	7/1/2021	ACHI	UPDATE. Removed two value set tables: Federal Codes Effective October 2010 and State and Federal Codes Used Before October 2010. Appendix I	226
8.0.2022	29	2/14/2022	ACHI	Reduced required field length from 6 to 2 to accommodate newly required values for ethnicity fields ME025, ME026, ME156A, ME166A.	68, 73, 74
8.0.2022	30	2/14/2022	ACHI	Removed the Federal Codes column from Appendix I: Ethnicity. State values are required, not Federal.	225
8.0.2022	31	2/14/2022	ACHI	Reduced required field length from 4 to 3 to accommodate newly required values for language fields ME033, ME157A.	68, 73

Version	Change Mgmt. #	Date	Owner	Description	Page Number
8.0.2022	32	2/14/2022	ACHI	Corrected reference to Bill Type value from 014 to 14 for Point of Origin field MC021.	104
8.0.2022	33	2/14/2022	ACHI	Removed 'or NULL' from reference for ME163A. This field must be populated. NOTE: This functionality has been in place since 2018. This is a documentation correction.	17, 18, 19
8.0.2022	34	2/14/2022	ACHI	Replaced the instruction to 'leave blank' with 'leave empty' to comply with submission standards for fields MC910, PC910, DC910	104, 122, 133
8.0.2022	35	2/14/2022	ACHI	Corrected typographic error in dependency for DC915A. Dependency should be "100% when DC911 is not null".	133
8.0.2022	36	2/18/2022	ACHI	Removed duplicate PB038 and adjusted row numbers up.	165

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GLOSSARY OF TERMS

Term	Definition
ACA	The comprehensive healthcare reform law from March 2010, officially named the Patient Protection and Affordable Care Act, often shortened to Affordable Care Act, or ACA
ACHI	Arkansas Center for Health Improvement
The Act	Act 1233 of 2015 of the Arkansas 90th General Assembly, also known as the "Arkansas Healthcare Transparency Initiative Act of 2015"
AID	Arkansas Insurance Department
APCD	Arkansas All-Payer Claims Database
Checksum	A count of the number of bits in a transmission unit that is included with the data file for APCD Data Intake verification
CMS	Centers for Medicare and Medicaid Services
Detached signature file	A digital signature certifies and timestamps files submitted as part of the APCD Data Intake process
DLZ	APCD Data Landing Zone: the secure infrastructure that receives encrypted data pulled from the APCD Secure File Transfer Protocol (SFTP) site
DRG	Diagnosis Related Group: a statistical system of classifying any inpatient stay information into groups for the purpose of payment
DSG	APCD Data Submission Guide
Encounter Data	Services rendered for managed care organizations and risk-based provider organizations. These services will be submitted in medical, pharmacy, or dental claim format.
HIE	Arkansas Health Insurance Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIRRD	Health Insurance Rate Review Division of AID
MIME-type	Multipurpose Internet Mail Extensions type
NAIC Suffix	A single alpha character used with an NAIC code to represent different data systems providing data for the same NAIC company code
NPI	National Provider Identifier: a unique identification number for covered healthcare providers
Onboarding	The process to enable data file submission for submitting entities, which includes web portal assignment and activation, encryption key exchange and protocols, and data submission guidelines
Provider	A person or entity — including physicians, nurse practitioners, and physician assistants — that render medical care
Rule 100[1] (the Rule)	AID guidelines for the submission of medical, dental, and pharmacy 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

[1] "Rule 100: Arkansas Healthcare Transparency Initiative Standards." Arkansas Insurance Department 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."

Term	Definition
SFTP	Secure File Transfer Protocol
Submitting Entity	Entity required to submit data per in Act 1233 of 2015
UAMS	University of Arkansas for Medical Sciences
URL	Uniform Resource Locator: specifies a web address for a website

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,[2] 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). The Arkansas APCD 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 which dictate how submitting entities must develop data files for either 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.

Steps for New Submitting Entities

New submitting entities will execute the following steps to participate in the Arkansas APCD.

1. Register with AID. Registration information can be found on the Arkansas APCD website, at arkansasapcd.net.
2. Review the Arkansas APCD Data Submission Guide (DSG) and onboarding materials from the Arkansas APCD website.
3. Receive web portal access from Arkansas APCD Technical Support for data submission.
4. Develop data feeds based on Arkansas APCD DSG requirements contained within this document.
5. Execute testing, addressing data validation issues identified by the Arkansas APCD Technical Support team.
6. Submit production data. See Submission Schedule section.

Data Requirements

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)
- Lookup Data (LU)
- Arkansas Medicaid Supplemental Payment Data (SP)
- Pharmacy Benefits Manager Claims (PB)

[2] *Act* 1233 of 2015

Data file layouts, data element descriptions, and other relevant data submission information for the data categories are provided in the Arkansas APCD DSG. Data categories include information about how data files should be constructed and updated over time. Data submission requirement information explains data file packaging, submission protocols, encryption requirements, and submission grouping. File layouts and data element requirements are included in Exhibit A, with encryption and claims versioning described in Exhibits B and C.

Previous DSG versions — including 4.1.2015, 5.0.2015, 5.1.2015, 6.0.2018 and 7.0.2019 — are no longer being used. As of March 31, 2022, all submissions must be made in the format outlined in Arkansas APCD DSG version 8.0.2022, until a new version is released and becomes the new standard.

If a submitting entity cannot meet the requirements outlined in the DSG, a data exception should be filed. A data exception process, relating to the submission of specific data elements defined in the DSG, is described herein. This exception process is distinct from the exemption process defined in the Rule.

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 including value requirements and threshold requirements.
- Data exception requests must be submitted to the APCD Technical Support team for data elements or values that cannot be supplied as defined in the DSG.
- Data exceptions must be approved in writing by the APCD Technical Support team.
- Submitting entities must provide lookup 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 Council guidance, and the APCD Council's Core Set of Data Elements.[3] 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, PV, LU, SP, or PB — and a three to five character value such as 001, 025A, 161A, and 058EA. Data elements are referred to by their Data Element ID throughout the DSG (e.g., ME001, MC001, ME161A, and MC058EA). This naming convention aligns with standards defined by the United States Health Information Knowledgebase.[4]

[3] "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.apcdcouncil.org/sites/apcdcouncil.org/files/media/apcd_council_core_data_elements_5-10-12.pdf.

[4] "United States Health Information Knowledgebase." Accessed at http://ushik.org/mdr/portals/.

Onboarding Documentation Requirements

Submitting entities should 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.

Submission Schedule

Submitting entities will submit data as outlined in Appendix A of Rule 100. This section of the DSG provides supporting information for submitting entities required to submit data to the Arkansas APCD in post-2015 calendar years.

- Historical and ongoing data submission requirements for the initial APCD build in 2016 are outlined in Appendix A of Rule 100. Submitting entities already submitting data to the Arkansas APCD *must* register annually. If a submitting entity discovers that they were subject to the rule and did not register as required in Rule 100, they should register as soon as possible and are subject to the required historical submission of adjudicated data.
- Submitting entities becoming subject to Rule 100 requirements after December 31, 2015, must follow this process:
    - Register with the Arkansas APCD between January 1 and March 31 of the year subsequent to the applicable year in which the entity became subject to Rule 100 requirements.
        For example, if an entity met the 2,000+ covered individual threshold in 2016, the entity would register between January 1 and March 31, 2017. The registration year is 2017.
    - Execute test data submission by the end of Q2 (defined in Appendix A of Rule 100) of the registration year.
        In other words, if the registration year of a submitting entity is 2017, the entity should test data submission (using test files described in the Test Data section) by the end of Q2, June 30, 2017.
    - Submit required data by end of Q3 (defined in Appendix A of Rule 100) of the registration year. Required data includes the previous three years of historical paid claims data ending with the applicable year in which the entity became subject to Rule 100 requirements.
        For example, required data for initial data delivery would include all data from January 1, 2014, through December 31, 2016, and would be delivered at the end of Q3, September 30, 2017.
    - Submit catch-up data (January 1 through September 30 of the registration year) at the end of Q4 (defined in Appendix A of Rule 100) of the registration year.
        Continuing with the previous example, the submitting entity would submit data for January 1, 2017, through September 30, 2017, by December 31, 2017.
    - If the entity remains subject to Rule 100 at the end of the registration year, regular quarterly data submission will begin in Q1 (March 31) of the following year to align with the schedule in Appendix A of Rule 100.
        Continuing with the previous example, the submitting entity would submit data for April 1, 2017, through June 30, 2017, by March 31, 2017.

        Note: The timelines and requirements for catch-up and regular quarterly submission apply so long as the entity remains subject to data submission requirements as a "submitting entity," as defined by Rule 100.

APCD Technical Support

Visit the Frequently Asked Questions section within this guide if you have questions. If you still have questions or concerns, direct them to the APCD Technical Support team. See contact information below.

Technical support is available to all submitting entities and data users. Issues are logged and tracked upon notification of 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 a.m. - 4 p.m. Central Time (excluding state and federal holidays).

Report issues by emailing a detailed message, including 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) 526-2244
Email: support@achiapcd.atlassian.net
Website: http://www.arkansasapcd.net

FREQUENTLY ASKED QUESTIONS

	Question	Answer
1	How often are files submitted to the Arkansas APCD?	Data submission occurs according to the schedule in Rule 100, Appendix A. See Submission Schedule.
2	Is the hashed unique identifier, ME998, required if the Carrier Specific Unique Member ID is included in the data?	Yes. The hashed unique identifier, ME998, represents the member across products, plans, and enrollment dates. The Carrier Specific Unique Member ID can change based on member activity.
3	Fields on enrollment data appear to be similar to those collected on the medical claims, pharmacy claims, and dental claims files. Can you clarify?	Many elements in the data files use similar wording and some are duplicates. These fields on the claims files must be submitted to allow the data to be joined across tables.
4	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 provider.
5	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 processer, pharmacy benefits manager, device benefit manager, etc.), several elements may not be available to report. A data exception should be submitted to identify each unavailable element. See Data Exceptions.
6	Are denied claims required in the APCD?	No. Denied claims are not required for the APCD at this time.
7	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.
8	Will claim versioning be included in the APCD processes?	Adjustments and versioning processes are not required for the initial historical or required submission of data files to the Arkansas APCD. Ongoing quarterly submissions must comply with one of the versioning options described in Exhibit C – APCD Claims Versioning.
9	Are APCD data to be encrypted?	All Arkansas APCD data files must be encrypted before submission. The APCD team will provide encryption protocols to each submitting entity for file level encryption. See Encryption Requirements for more information.
10	How many fields have to fail the data validation checks for data file submission failure?	A submitted file will fail at the file level if any single required data element fails validation.
11	Whom should I contact if I have questions about the APCD or DSG?	Questions concerning APCD data should be directed to the APCD Technical Support team. APCD Technical Support information is listed in the APCD Technical Support section.

	Question	Answer
12	When will DSG revisions be published?	Material changes to the Arkansas APCD Data Submission Guide will be published by December of each year, with required submission changes due for the following March submission. Technical changes can be published at any time. Material and technical changes are defined in Rule 100.
13	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.
14	Should the member ID and/or subscriber ID be masked by the submitting entity prior to submission?	The member ID should be masked prior to submission to the APCD and mapped to the Carrier Specific Unique Member ID. The subscriber ID should be masked prior to submission to the APCD and mapped to the Carrier Specific Unique Subscriber ID. Masking should be consistent across all data submissions so the masked values representing the member ID and subscriber ID do not change. Carrier Specific Unique Member IDs and Carrier Specific Unique Subscriber IDs must also be consistent between PBMs, TPAs and their associated submitting entities.
15	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 together and to the enrollment or member data.
16	What is the definition of an Arkansas resident?	An "Arkansas resident" is an individual for whom a submitting entity has identified an Arkansas address as that 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.
17	What is a submitting entity?	"Submitting entity" is defined in Arkansas Insurance Department Rule 100 in Section 4(21).
18	What entities are not considered an APCD submitting entity?	"Submitting entity" does not include any entity that provides the following health insurance or health benefit plans: accident-only, specified disease, hospital indemnity and other fixed indemnity, long-term care, disability income, Medicare supplement, or other supplemental benefit coverage.
19	How should county be determined?	If county information is not available in your data, it is still required. Determine the county based on street address and ZIP code and assign the county FIPS code for the APCD submission.
20	Can I access the Data Submission Guide (DSG) Q&A presentation?	Yes. DSG slide presentations are available on the Arkansas APCD website. The current presentation is for DSG version 6.0.2018. The presentation for DSG Version 8.0.2022 will be added later. Because different presentations will be available for each DSG version, be careful to select the information for the correct version.
21	Are all versions of the Data Submission Guide (DSG) available online?	Yes. Although DSG version 8.0.2022 is the current standard, all previous versions of the DSG are available on the website. Older versions are archived separately.

	Question	Answer
22	Are headers and trailers to be included in the actual data files, or are those separate from the data files?	Header and trailer records and control count records are included in the actual data files. See Header and Trailer Records.
23	Are there any specific file formats/requirements for submitting lookup tables?	Yes. See Lookup Files for more information.
24	Should submitting entities include headers with the actual data element numbers?	Yes. Submitting entities should include headers with the data element numbers.
25	Where is the registration form available on the website?	On the Arkansas APCD website, two registration forms are available — one for PBMs and another for TPAs — to utilize during the registration process. The APCD team created separate forms to streamline the two types of submitting entities. See Registration Forms on the APCD website.
26	Are submitting entities required to complete a registration form before submitting an exception form or a file?	Yes. A completed registration form should be submitted before completing an exception form or submitting data.
27	If a submitting entity were both an issuer and a TPA, should the entity register twice?	Yes. The submitting entity should register for each unique NAIC Company Code. This can be accomplished using one registration form.
28	Where is the exemption form available?	The exemption form is available on the APCD homepage. Please note that exemption forms should be submitted directly to the Arkansas Insurance Department, as noted in Bulletin No.: 17-2015. Additionally, an entity should complete a registration form prior to submitting an exemption request.
29	How is the submitting threshold determined for submitting entities? For example, some submitting entities will have NAIC Company Codes that do not meet the 2,000 covered lives threshold.	Because both the submitting entity and the covered lives threshold is determined at the Group Code level, submission is determined by the total covered lives of all individual NAIC Company Codes that fall under the Group Code. Please refer to Arkansas Insurance Department Rule 100.
30	How are entity codes assigned for TPAs and PBMs, which do not have NAIC Company Codes?	The APCD Technical Support team will assign a five- to six-digit alphanumeric entity code in such cases.
31	According to the DSG, there is a 300 MB limit for each file that will be uploaded to the APCD Web Portal. What does a submitting entity do if the file size exceeds the limit?	The Data Submission Guide provides instructions for naming files in the event that submitting entities must send the files in pieces. The APCD data intake process is designed to receive and move a submitting entity's data as soon as possible in an attempt to prevent data overload. In addition, encryption of all files will make each file smaller. Additionally, data can be delivered via SFTP instead of through the web portal. If there are problems submitting the data,

	Question	Answer
		the APCD Technical Support team will work with submitting entities to submit the data.
32	Can a submitting entity bypass the APCD Web Portal and instead submit directly via sFTP server?	Yes, with approval from Arkansas APCD. The submitting entity can work directly with the Arkansas APCD Technical Support team to request access to a direct sFTP solution.
33	If a submitting entity cannot meet the required submission deadline, should the entity submit an *exception* or an *exemption* form?	If a submitting entity is unable to meet a submission deadline, the entity must submit an **exemption** form. The exemption form was delivered via a bulletin distributed by the Arkansas Insurance Department. It is also located on the Arkansas APCD homepage. Note: Exception forms are to be used for data elements and/or data file types unavailable by the submitting entity for submission to the APCD.
34	When will the APCD team send usernames and temporary passwords to submitting entities?	The APCD team will send usernames and temporary passwords for APCD Web Portal access one to two business days after registration.
35	What is the readiness audit and what is its purpose?	The readiness audit is the process by which the submitting entity prepares a sample data file, tests web portal access, tests encryption, and tests automated data submission.
36	Can the Arkansas APCD team share hashing instructions and/or code prior to execution of the readiness audit?	Yes. Please contact the Arkansas APCD team to request unique ID hashing instructions. If you would like to see code samples, please send your request to support@achiapcd.atlassian.net. Sample code is available for JAVA, Python, SQL and C Sharp.
37	What are control counts and what are they used for?	Each submitting entity shall provide control counts with data feeds to support baseline validation and benchmarking. See the Control Count section.
38	When do submitting entities have to submit RSA and DSA public keys?	RSA and DSA public keys should be submitted after registration. The submission of these keys will trigger the readiness audit and test file submission as outlined in the Onboarding Instructions on the Arkansas APCD homepage.
39	Can submitting entities submit test files before exchanging keys with the Arkansas APCD?	Test files cannot be submitted before keys are exchanged. The APCD Technical Support team will not be able to decrypt the data files without the keys.
40	Do all test files have to pass before submitting production data?	Yes. All test files must pass data validation before production files can be submitted.
41	Other states do not require the DSA public key. Why must an DSA public key be submitted, too?	The Arkansas APCD solution utilizes both RSA and DSA keys for an added layer of security. Some data could be considered personal health information. Using both key adds additional security to the data as it is transferred to ACHI.
42	Can we use our RSA public key to encrypt our data?	No. You must use the APCD RSA key to encrypt your data files.

	Question	Answer
43	Can we resubmit files before receiving a data validation report?	It is not recommended. If files must be resubmitted, notify the APCD Technical Support team so that they can manage the report production.
44	Our encryption is IPSwitch Professional which does not create a detached signature file. Can we opt out of sending a detached signature file?	No. The Arkansas APCD data intake automation process requires a detached signature file. The DSG includes a section with recommended no-cost encryption options. See Exhibit B – Encryption Protocols.
45	What archiving method and file name can we use?	The submission package containing the encrypted and signed file and the detached signature must be in the .zip archive format and must have a .zip extension.
46	Why won't my files upload in the APCD Web Portal?	The upload process begins when the upload button is clicked. File upload progress and completion can be viewed in the Account History tab of the web portal.
47	I submitted new exceptions and my old exceptions are no longer valid. Why is that?	Revised exception requests overwrite previous requests. If only the new changes were submitted, the previously submitted exceptions would be deleted. It is important to resubmit all exceptions each time. UPDATE: This is no longer applicable with the implementation of the online exception process.
48	Should the hashed value in ME998 only contain numbers?	No. The hashed values must be 44 bytes long and end with an equal sign character (=). The field must also contain a combination of numbers, letters (uppercase and lowercase) ,and special characters, but must NOT contain quotation marks, commas, or pipes.
49	How will ICD diagnosis and procedure codes be validated?	The value in the ICD indicator column (MC915A) will be used in determining the code set to validate ICD diagnosis and procedure codes (e.g. MC041, MC042, MC058, etc.). The ICD columns will fail validation if the values do not match the code set specified by the ICD indicator column.
50	How will CPT and HCPC procedure codes be validated?	The value in the procedure code type columns (MC130, DC130) will be used in determining the code set to validate CPT, CDT, and HCPC codes in MC055 and DC032. Validation will fail if the values do not match the code set specified by the procedure code type columns.
51	Where are the instructions for file encryption and key exchange?	The instructions for encrypting data files to the Arkansas APCD standard are found on the Arkansas APCD website under Training.
52	When should all submissions be in the new 8.0.2022 format?	New and existing submitting entities should submit data in DSG version 8.0.2022 as of March 31, 2022. See Submission Schedule description.
53	Are previously approved exemptions nullified when new DSG versions are released?	No, unless the new version includes new requirements that resolve the issues resulting in an exemption. Under such a scenario, the submitting entity should reach out to AID to rescind the exemption as necessary.

	Question	Answer
54	Is an exemption or exception required if the submitting entity cannot accommodate the Carrier Specific Unique Member ID and/or Carrier Specific Subscriber ID aliases that were added in DSG version 6.0.2018?	Submitting entities do not always know when these changes occur. If known, use the alias fields. If not, submit an exception using the Arkansas APCD online tool. An exemption is not required.
55	We would like to understand the example included for the quarterly submissions. This member seems to have a termination date of 2/28/2017. Does this mean that even if the member is not active in Q2, we should report him in the extracts and the member should be reported throughout the year of 2017? If so, any terminated or active members in the reporting year would be present in all the quarterly files we submit. Is this an accurate understanding?	It would be expected to see terminated members in the data for the quarter in which they terminate. In the example referenced, the termination is in Q1 and the data is submitted in Q2. No more data would be expected for this terminated member unless they re-enroll at a later time. If a member is active, the enrollment record should be included. Additional records would be added for that member if a change occurred (relationship status change, new plan purchased, disenrollment, ZIP code change, etc.). If any field changes for the submitted member a new record is expected.
56	Should control count header and trailer records be included in the empty files?	Yes. The DSG includes this requirement: "If no data exists for a valid coverage period, an empty file should be submitted representing the coverage period. The empty file should contain the following rows: Header Header, Header Data, Control Header, Control Data, Data Header, Trailer Header, and Trailer Data. No Data Detail record should be sent."
57	Can you provide more details about the meaning of "missing coverage period"? How does it correspond to the empty file submission? Would this be applicable to our provider file?	Coverage periods are contiguous days. For example, some carriers send data monthly, others quarterly. If a monthly submission is followed and no data is available for a month, then an empty dataset should be submitted for the missing month. For example, if June 2016 is not available for the Q2 submission, submit an empty dataset with 2016-06-01 to 2016-06-30 in coverage dates. Provider files are complete replacements, therefore it would not apply.
58	When would a negative value be used/expected for PC033 – Prescription Quantity?	A negative value can be used for a return, void, or backout if the submitting entity's system uses these functions.

	Question	Answer
59	The data elements listed for file types are not necessarily always in numerical order. Should the file submissions reflect the order of data elements as they are listed in the DSG or should they reflect the numerical order?	Please submit in the order listed in the DSG. The ID column can be used to ensure the correct order.
60	How should last name and date of birth be formatted before executing the hashing altorithm for ME998?	Differences in the formatting of last name can produce inconsistent hash ID values for the same member. Remove all generational suffixes (Jr., Sr., II, Esq., etc.), titles and degrees (Dr., PhD, etc.), and punctuation or spaces from the end of the last name. Special characters that are part of the last name are appropriate to include (‘, - , space between names if not hyphenated, etc.). Capitalize all letters of the last name. Date of birth must be formatted as YYYY-MM-DD with the dashes included. The last name and date of birth must be concatenated together with no spaces between the two and no leading or trailing spaces.
61	How should last activity date (ME056) be determined?	If the data source system has a last activity date (or a date that marks when a data component changed), this date should be used for ME056 only when Arkansas APCD member data element changes or the member disenrolls (then it should be the same date as ME163A). If a non-APCD field in the source system changes, leave ME056 unchanged from previous submissions. If this is the first submission, it would record the last change or disenrollment, otherwise ME056 should remain NULL.
62	Does the pharmacy benefits manager claims data require a member/enrollment file? And, if so, are all the member fields required?	Yes. The pharmacy benefits manager (PBM) claims will be considered a new claim type and will be processed in process similar to the medical, pharmacy, and dental claims. The member data should contain the member and subscriber IDs that will link to the corresponding pharmacy benefit manager claims. The APCD Unique ID is required on the member data. It is important to note that the pharmacy benefit member and subscriber IDs must be linkable to the pharmacy claims for the same individual provided by the health insurance carrier. Note: At this time PBM claims are considered optional and not required for submission.

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DATA CATEGORIES FOR SUBMISSION

This section provides data submission requirements for each data category entity. Data submissions must meet the requirements herein.

Note: References to submitting entities are defined in the *Act* in the section below taken from the legislation. Also, references to "members" and "subscribers" within each data category are defined in the *Act* as "covered individuals."[5]

A.C.A. § 23-61-903

(9) (A) "Submitting entity" means:

- **(i)** 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, managed care organization, hospital plan, hospital medical service corporation, health maintenance organization, or fraternal benefit society, provided that the entity has covered individuals and the entity had at least two thousand (2,000) covered individuals in the previous calendar year;
- **(ii)** A health benefit plan offered or administered by or on behalf of the state or an agency or instrumentality of the state, including without limitation benefits administered by a managed care organization whether or not the managed care organization had two thousand (2,000) covered individuals in the previous year;
- **(iii)** A health benefit plan offered or administered by or on behalf of the federal government with the agreement of the federal government;
- **(iv)** The Workers' Compensation Commission;
- **(v)** Any other entity providing a plan of health insurance or health benefits subject to state insurance regulation, a third-party administrator, or a pharmacy benefits manager, provided that the entity has covered individuals and the entity had at least two thousand (2,000) covered individuals in the previous calendar year;
- **(vi)** A health benefit plan subject to the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, and that is fully insured;
- **(vii)** A risk-based provider organization licensed by the State Insurance Department; and
- **(viii)** An entity that contracts with institutions of the Department of Correction or the Department of Community Correction to provide medical, dental, or pharmaceutical care to inmates.
    - **(B)** "Submitting entity" does not include:
        - **(i)** An entity that provides health insurance or a health benefit plan that is accident-only, specified disease, hospital indemnity, long-term care, disability income, or other supplemental benefit coverage;
        - **(ii)** An employee of a welfare benefit plan as defined by federal law that is also a trust established pursuant to collective bargaining subject to the Labor Management Relations Act, 1947, Pub. L. No. 80-101; or
        - **(iii)** A health benefit plan subject to the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, that is self-funded; and

[5] *Act* 1233 of 2015

Self-Insured Employers

On March 1, 2016, the Supreme Court made a decision in the Gobeille vs. Liberty Mutual case prohibiting states from mandating the submission of healthcare claims from ERISA-based self-insured employers.

However, the Arkansas APCD encourages ERISA-based self-insured employers to submit their data to the Arkansas APCD. By including claims information, employers can identify ways to save costs and improve the health of their employees while enhancing healthcare transparency for the benefit of all Arkansans.

Enrollment Data

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.
- Member data will include multiple records per individual. These records will represent when an individual became a member, made a change to an existing plan, changed plans, or disenrolled from any or all plans. Records should represent members by plan and coverage segment (plan dates of enrollment and disenrollment) for the purpose of understanding plan participation, identifying coverage terms, and tracking coverage gaps.

File Content

- All submitting entities are required to submit a member/enrollment/eligibility file.
- 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 IDs and Carrier Specific Unique Subscriber IDs should be masked prior to submission to the APCD. Masking should be consistent across data submissions so the masked values representing these IDs do not change.
- A submitting entity's Carrier Specific Unique Member ID and Carrier Specific Unique Subscriber ID should be consistent across submissions and over time. If a new system changes or alters Carrier Specific Unique Member IDs and/or Carrier Specific Subscriber IDs, utilize the Alias ID Member and Subscriber ID fields to maintain continuity.
- A submitting entity's Carrier Specific Unique Member ID and Carrier Specific Unique Subscriber ID should be of consistent length and format across all submitted data so that these IDs will match exactly across any ELG, CLM, PHM, DNT, PBM record for a submitting entity member.
- A submitting entity's Member Date of Birth and the Subscriber Date of Birth should match between the Member records and the Claims records. Any dates in these fields equaling 1900-01-01 or earlier are considered either incorrect or a system default date. Invalid or incorrect Member Date of Birth renders ME998 – APCD Unique ID values as suspect.
- The following fields must match in format, length, and values across all coverage period submissions for the same Carrier Specific Unique Member ID: Member Suffix or Sequence Number or Person Code (ME010, MC009, PC009, DC009, PB009), Individual Relationship Code (ME012, MC011, PC011, DC011, PB011), Member Gender (ME013, MC012, PC012, DC012, PB012), and Subscriber Gender (ME151A, MC991, PC956, DC991, PB956).
- A Header Header, Header Data, Control Header, Control Data, Detail Data Header, Detail Data (when data is present), Trailer Header, and Trailer Data record must be included-in order-with this file submission.
- Historical and ongoing data submission requirements are outlined in Appendix A of Rule 100.
- **Historical/Initial Data Submission:** Enrollment data submitted with the initial historical data feed must contain information for all members enrolled as of January 1 of the year that is three years prior to the

year of qualification for the Arkansas APCD. See Submission Schedule for more information and examples. Records will be submitted based on the following criteria:

- One record per individual per plan **per coverage segment** whose plan date of enrollment (ME162A) is before, on, or after January 1 of initial submission year, with a date of dis-enrollment (ME163A) on or after January 1 of initial submission year.
- Include records for active and inactive plans within a specified date range.
- Use the most recent information for member records per plan, per coverage period.

Historical Data Submission Scenarios

Member No.	*Enrollment Date*	*Disenrollment Date*	*Plan*	*Notes*
1	1/1/2013	12/31/9999	ABC	Original enrollment is 1/1/2013. Member is currently active.
1	11/1/2014	10/31/2015	CXU	Enrolled in plan for 12 months. Dis-enrolled.
2	4/1/2014	12/31/9999	DEF	Original enrollment is 4/1/2014. Member is currently active.
3	1/1/2013	6/30/2013	CXU	Enrolled in plan for 6 months. Dis-enrolled.
3	11/1/2013	10/31/2014	CXU	Re-enrolled in plan for 12 months. Dis-enrolled.
3	2/1/2015	2/28/2015	123	Enrolled in plan for 1 month. Dis-enrolled.
4	11/1/2014	6/30/2015	123	Enrolled in plan for 8 months. Dis-enrolled.
5	9/1/2015	12/31/9999	ABC	Original enrollment is 9/1/2015. Member is currently active.
5	10/1/2015	12/31/9999	DEF	Original enrollment for second plan is 10/1/2015. Member is currently active.
6	5/1/2014	4/30/2015	CXU	Original enrollment is 5/1/2014. Disenrollment is 4/30/15.
7	8/1/2014	4/30/2015	123X	Original enrollment is 8/1/2014. Disenrollment is 4/30/15.
8	5/1/2014	12/31/9999	ABC	Original enrollment is 5/1/2014. Member is currently active.

- **Ongoing, Periodic Submissions:** Each enrollment file submitted should contain enrollment data representing member activity for the applicable time period. Records for ongoing, periodic submissions will be submitted based on the following criteria:
    - New members – Records for individuals who become a member during the submission period as defined by Rule 100. The date of enrollment (ME162A) should represent the original date the member became active for a plan, and the date of disenrollment (ME163A) should be 12/31/9999.
    - Existing members with new plans – Records for individuals who are existing members who enroll in new plans. The date of enrollment (ME162A) should represent the date of enrollment and date of disenrollment (ME163A) should be 12/31/9999 if the plan is active at the time of data submission. If the plan is not active at the time of data submission, date of disenrollment (ME163A) should reflect the date the plan ended.
    - Existing members with changes within the existing plans – Records for individuals who are current members and have made a change to their existing plan (e.g., ZIP code change, marital status change, etc.). A new record should be submitted with the new changes. The date of enrollment (ME162A) should represent the date of enrollment (even if not in this submission period), and the date of disenrollment (ME163A) should be 12/31/9999. The date of last activity (ME056) should contain the date the change was made.
    - Records should be provided for each change made in a submission period, with the last activity date representing when the change occurred. If multiple changes occurred on a single day, send the last changed record. The last activity date would reflect the date of that record change.
    - Dis-enrolled members – Records for individuals who dis-enrolled during the quarter as defined by Rule 100. The date of disenrollment (ME163A) should be populated with the date of disenrollment. The date of last activity (ME056) should contain the date of disenrollment.
    - New records/data are not expected for active or inactive members with no change during the submission period.
    - Use the most recent information for member records per plan, per coverage period

Quarterly Data Submission Scenarios

Member No.	Plan	Effective Date	Disenrollment Date	Last Activity Date	Submission Quarter	Notes
1	ABC	1/1/2013	2/28/2017	2/28/2017	Q2 2017	Enrolled in plan from 1/1/2013. Dis-enrolled 2/28/2017.
2	DEF	4/1/2014	12/31/9999	3/1/2017	Q2 2017	Member record change for existing plan in March 2017.
3	Currently inactive. No new record required unless member purchased new plan and can be linked to original member number.					
4	Currently inactive. No new record required unless member purchased new plan and can be linked to original member number.					
5	Plan 1 – Plan is currently active. No new record required unless change occurred.					
5	Plan 2 – Plan is currently active. No new record required unless change occurred.					
6	CXU	2/1/2017	12/31/9999	2/1/2017	Q2 2017	Existing member enrolled in new plan.
7	123X	3/1/2017	12/31/9999		Q2 2017	Existing member not currently enrolled in plan.Enrolled in new plan 3/1/2017. Currently active.
8	ABC	3/1/2017	12/31/9999		Q2 2017	Existing member enrolled in second plan. Currently active.
9	ABC	7/1/2017	12/31/9999		Q4 2017	New member enrolled as of 7/1/2017.
10	123X	10/1/2017	12/31/9999		Q1 2018	New member enrolled as of 4/1/2018.

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.
- Where possible, NPIs (ME035, ME046, ME124) should have corresponding provider records based on PV023 in the provider data.
- Custom codes or valid codes/values that are not listed in the DSG appendices for data elements (such as plan codes, race codes, bill type, diagnosis codes, procedure codes, CPT codes, etc.) will be considered for addition to the Arkansas APCD reference repository. Work with the Arkansas APCD team to review and assess need/relevance to determine if custom codes should be added.

Medical Claims Data

Required Submission Information

- Submitting entities shall provide paid claims and adjustment claims for institutional and professional healthcare services rendered during the update period. All claims must have an associated member record in the enrollment file.
- The historical data submission and the one-year catch-up submission (see Submission Schedule) must consist of final paid claims only. Versioned claims will be submitted for ongoing quarterly submissions.

File Content

- Files must include the variables specified in Exhibit A – Data Elements: Medical Claims Data.
- Submitting entity must provide one row per claim number and 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 should be masked prior to submission to the APCD. Masking should be consistent across data submissions so the masked values representing these IDs do not change.
- Submitting entity's Carrier Specific Unique Member ID and Carrier Specific Unique Subscriber ID should be consistent across submissions and over time. If a new system changes or alters the Carrier Specific Unique Member IDs and/or Carrier Specific Subscriber IDs, utilize the Alias ID Member ID and Subscriber ID fields to maintain continuity.
- A submitting entity's Carrier Specific Unique Member ID and Carrier Specific Unique Subscriber ID should be of consistent length and format across all submitted data so that these IDs will match exactly across any ELG, CLM, PHM, DNT, PBM record for a submitting entity member.
- A submitting entity's Member Date of Birth and Subscriber Date of Birth should match between the Member records and the Claims records. Any dates in these fields equaling 1900-01-01 or earlier are considered either incorrect or a system default date. Invalid or incorrect Member Date of Birth renders ME998 – APCD Unique ID values as suspect.
- The following fields must match in format, length, and values across all coverage period submissions for the same Carrier Specific Unique Member ID: Member Suffix or Sequence Number or Person Code (ME010, MC009, PC009, DC009, PB009), Individual Relationship Code (ME012, MC011, PC011, DC011, PB011), Member Gender (ME013, MC012, PC012, DC012, PB012), and Subscriber Gender (ME151A, MC991, PC956, DC991, PB956).
- Files must contain all claims based on paid date during the observation period for all covered services provided to eligible members.
- Payer Claim Control Number (MC004) and line numbers (MC005) must be consistent across submissions, along with other fields identified for versioning by the submitting entity.
- 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.
- A Header Header, Header Data, Control Header, Control Data, Detail Data Header, Detail Data (when data is present), Trailer Header, and Trailer Data record must be included-in order-with this file submission.

- Quarterly submission files shall contain adjustment claims for the APCD versioning process (see Exhibit C – APCD Claims Versioning).
- Historical and ongoing data submission requirements are outlined in Appendix A of Rule 100.

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.
- Custom codes for data elements (such as bill type, diagnosis codes, procedure codes, CPT codes, etc.) will be considered for addition to the Arkansas APCD reference repository. Work with the Arkansas APCD team to review and assess need/relevance to determine if custom codes can be added.
- Where possible, service provider numbers (MC024) should have corresponding provider records based on PV001 in the provider data.
- Where possible, NPIs (MC026, MC077, MC112, MC134) should have corresponding provider records based on PV023 in the provider data.
- Custom codes or valid codes/values that are not listed in the DSG appendices for data elements (such as plan codes, race codes, bill type, diagnosis codes, procedure codes, CPT codes, etc.) will be considered for addition to the Arkansas APCD reference repository. Work with the Arkansas APCD team to review and assess need/relevance to determine if custom codes should be added.

Pharmacy Claims Data

Required Submission Information

- Submitting entities shall provide paid claims and adjustment claims for pharmaceutical products and services rendered during the update period from submitting entities, including pharmaceutical benefit managers (PBM). All claims must have an associated member record in the enrollment file.
- The historical data submission and the one-year catch-up submission (see Submission Schedule) must consist of final paid claims only. Versioned claims will be submitted for ongoing quarterly submissions.

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 should be masked prior to submission to the APCD. Masking should be consistent across data submissions so the masked values representing these IDs do not change.
- Submitting entity's Carrier Specific Unique Member ID and Carrier Specific Unique Subscriber ID should be consistent across submissions and over time. If a new system changes or alters the Carrier Specific Unique Member IDs and/or Carrier Specific Subscriber IDs, utilize the Alias ID Member ID and Subscriber ID fields to maintain continuity.
- A submitting entity's Carrier Specific Unique Member ID and Carrier Specific Unique Subscriber ID should be of consistent length and format across all submitted data so that these IDs will match exactly across any ELG, CLM, PHM, DNT, PBM record for a submitting entity member.
- A submitting entity's Member Date of Birth and the Subscriber Date of Birth should match between the Member records and the Claims records. Any dates in these fields equaling 1900-01-01 or earlier are considered either incorrect or a system default date. Invalid or incorrect Member Date of Birth renders ME998 – APCD Unique ID values as suspect.
- The following fields must match in format, length, and values across all coverage period submissions for the same Carrier Specific Unique Member ID: Member Suffix or Sequence Number or Person Code (ME010, MC009, PC009, DC009, PB009), Individual Relationship Code (ME012, MC011, PC011, DC011, PB011), Member Gender (ME013, MC012, PC012, DC012, PB012), and Subscriber Gender (ME151A, MC991, PC956, DC991, PB956).
- Files shall contain all claims based on paid date during the observation period for all covered services provided to eligible members.
- Payer Claim Control Number (PC004) and line numbers (PC005) must be consistent across submissions, along with other fields identified for versioning by the submitting entity.
- A Header Header, Header Data, Control Header, Control Data, Detail Data Header, Detail Data (when data is present), Trailer Header, and Trailer Data record must be included-in order-with this file submission.
- Quarterly submission files shall contain adjustment claims for the APCD versioning process (see Exhibit C – APCD Claims Versioning).
- Historical and ongoing data submission requirements are outlined in Appendix A of Rule 100.

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.
- Custom codes for data elements (such as bill type, diagnosis codes, procedure codes, CPT codes, etc.) will be considered for addition to the Arkansas APCD reference repository. Work with the Arkansas APCD team to review and assess need/relevance to determine if custom codes can be added.
- Where possible, service provider numbers (PC043) should have corresponding provider records based on PV001 in the provider data.
- Where possible, NPIs (PC021, PC048, PC059) should have corresponding provider records based on PV023 in the provider data.
- Custom codes or valid codes/values that are not listed in the DSG appendices for data elements (such as plan codes, race codes, bill type, diagnosis codes, procedure codes, CPT codes, etc.) will be considered for addition to the Arkansas APCD reference repository. Work with the Arkansas APCD team to review and assess need/relevance to determine if custom codes should be added.

Dental Claims Data

Required Submission Information

- Submitting entities shall provide paid claims and adjustment claims[6] for all members utilizing dental services. All claims must have an associated member record in the enrollment file.
- The historical data submission and the one-year catch-up submission (see Submission Schedule) must consist of final paid claims only. Versioned claims will be submitted for ongoing quarterly submissions.

File Content

- Files must include the variables specified in Exhibit A – Data Elements: Dental Claims Data.
- Submitting entity's Carrier Specific Unique Member IDs and Carrier Specific Unique Subscriber IDs should be masked prior to submission to the APCD. Masking should be consistent across data submissions so the masked values representing these IDs do not change.
- Submitting entity's Carrier Specific Unique Member ID and Carrier Specific Unique Subscriber ID should be consistent across submissions and over time. If a new system changes or alters the Carrier Specific Unique Member IDs and/or Carrier Specific Subscriber IDs, utilize the Alias ID Member ID and Subscriber ID fields to maintain continuity.
- Submitting entities must provide one row per claim number and 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.
- A submitting entity's Carrier Specific Unique Member ID and Carrier Specific Unique Subscriber ID should be of consistent length and format across all submitted data so that these IDs will match exactly across any ELG, CLM, PHM, DNT, PBM record for a submitting entity member.
- A submitting entity's Member Date of Birth and the Subscriber Date of Birth should match between the Member records and the Claims records. Any dates in these fields equaling 1900-01-01 or earlier are considered either incorrect or a system default date. Invalid or incorrect Member Date of Birth renders ME998 – APCD Unique ID values as suspect.
- The following fields must match in format, length, and values across all coverage period submissions for the same Carrier Specific Unique Member ID: Member Suffix or Sequence Number or Person Code (ME010, MC009, PC009, DC009, PB009), Individual Relationship Code (ME012, MC011, PC011, DC011, PB011), Member Gender (ME013, MC012, PC012, DC012, PB012), and Subscriber Gender (ME151A, MC991, PC956, DC991, PB956).
- Files should contain all claims (based on paid date) during the observation period for all covered services provided to eligible members.
- Payer Claim Control Number (DC004) and line numbers (DC005) must be consistent across submissions, along with other fields identified for versioning by the submitting entity.
- A Header Header, Header Data, Control Header, Control Data, Detail Data Header, Detail Data (when data is present), Trailer Header, and Trailer Data record must be included-in order-with this file submission.
- Quarterly submission files should contain adjustment claims for the APCD versioning process (see Exhibit C – APCD Claims Versioning).
- Historical and ongoing data submission requirements are outlined in Appendix A of Rule 100.

[6] Claims data include encounter data from managed care and risk-based provider organizations for purposes of the DSG.

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.
- Custom codes for data elements (such as bill type, diagnosis codes, procedure codes, CPT codes, etc.) will be considered for addition to the Arkansas APCD reference repository. Work with the Arkansas APCD team to review and assess need/relevance to determine if custom codes can be added.
- Where possible, service provider numbers (DC018) should have corresponding provider records based on PV001 in the provider data.
- Where possible, NPIs (DC020) should have corresponding provider records based on PV023 in the provider data.
- Custom codes or valid codes/values that are not listed in the DSG appendices for data elements (such as plan codes, race codes, bill type, diagnosis codes, procedure codes, CPT codes, etc.) will be considered for addition to the Arkansas APCD reference repository. Work with the Arkansas APCD team to review and assess need/relevance to determine if custom codes should be added.

Provider Data

Required Submission Information

Submitting entities shall provide information on all providers contracted at any time from January 1, 2013, onward. Lookup 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 Serivce Provider Number 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, onward.
- **Ongoing, periodic submissions:** Each provider file submitted must be a complete updated replacement beginning January 1, 2013, onward.
- A Header Header, Header Data, Control Header, Control Data, Detail Data Header, Detail Data (when data is present), Trailer Header, and Trailer Data record must be included, in order with this file submission.
- Historical and ongoing data submission requirements are outlined in Appendix A of Rule 100.
- One record shall be submitted for each provider for each unique physical address and NPI.

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

Other Information

- All submitting entities are required to submit a provider file unless an exemption has been approved allowing the submitting entity to forego this requirement.
- Where possible, provider file records should correspond with service provider numbers and NPIs in the enrollment/member and claims data.
- 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.
- Custom codes or valid codes/values that are not listed in the DSG appendices for data elements (such as plan codes, race codes, bill type, diagnosis codes, procedure codes, CPT codes, etc.) will be considered for addition to the Arkansas APCD reference repository. Work with the Arkansas APCD team to review and assess need/relevance to determine if custom codes should be added.

Control Count Data

Each submitting entity shall provide control count records within each data file submitted to support baseline validation and benchmarking. Control count values will tie directly back to the data files submitted, enabling record quantity checking for submission validation.

Control count data will no longer be submitted as a stand-alone file. Control count data rows will be included inside each data file submitted. Two additional records will be contained within each file, after the header records and before the detail data records. These records will be prefaced with CH (Control Header) and CD (Control Detail).

File types for which control count records must be created:

- ELG – Eligibility/Member Data
- CLM – Medical Claims
- PHM – Pharmacy Claims
- DNT – Dental Claims
- PRV – Provider Data
- LU – Lookup Data
- SP – Supplemental Payment Data
- PBM – Pharmacy Benefits Manager Claims

Refer to the following sections for control count data submission requirements. Review in order.

- Row Types
- Header, Control Count, and Trailer Records
- Control Count Record Layout – Member Data
- Control Count Record Layout – Medical Claims Data
- Control Count Record Layout – Pharmacy Claims Data
- Control Count Record Layout – Dental Claims Data
- Control Count Record Layout – Provider Data
- Control Count Record Layout – Lookup Data
- Control Count Record Layout – Pharmacy Benefits Manager Data
- Member Enrollment Data File Guidelines
- Medical Claims Data File Guidelines
- Pharmacy Claims Data File Guidelines
- Dental Claims Data File Guidelines
- Provider Data File Guidelines
- Lookup Data File Guidelines

Lookup Files

Each submitting entity submitting Medical Claims data should provide a lookup file with the first production data submission. Subsequent lookup files are only required when content changes.

File Content

- Records must include the variables specified in Exhibit A – Data Elements: Lookup Data.
- A Header Header, Header Data, Control Header, Control Data, Detail Data Header, Detail Data (when data is present), Trailer Header, and Trailer Data record must be included, in order, with this file submission.
- Lookup data files provide SEs specific values and definitions for the following DSG medical claim data elements:
    - MC032 – Service Provider Specialty
    - MC212 – Billing Provider Specialty
- Only ***one*** lookup data file should be produced containing the lookup values and definitions for both data elements.
- All lookup data files should be sent with historical data and resubmitted when changed.

Other Information

- Lookup data files are required only if the provider specialty data is not provided by CMS Health Care Provider Taxonomy.
- Lookup data files should contain submitting entity specific provider specialty codes. However, if standard CMS codes are used, the values in Appendix K, Health Care Provider Taxonomy Specialty Codes, can be substituted and no lookup data files are required for submission.

Supplemental Payment Files

Arkansas Medicaid supplemental payment files include payments by Medicaid to providers, most commonly hospitals, that supplement claims-based payments. These include disproportionate share (DSH) payments and upper payment limit (UPL) payments.

File Content

- Records must include the variables specified in Exhibit A – Data Elements: Supplemental Payment Data.
- Record layout will be based on agreed-upon data elements between Arkansas Medicaid, the Arkansas APCD, and the Arkansas Insurance Department.
- A Header Header, Header Data, Control Header, Control Data, Detail Data Header, Detail Data (when data is present), Trailer Header, and Trailer Data record must be included, in order, with this file submission.

Other Information

- Supplemental payment files are only required from Arkansas Medicaid.

Pharmacy Benefit Manager Claims Data *(see note below)*

NOTE: This section is provided for future submissions from pharmacy benefit managers (PBMs) and is currently not required as of publication of the Arkansas APCD DSG Version 8.0.2022.

However, the Arkansas APCD team advises PBMs currently providing data on behalf of a health plan to use these PBM-specific requirements. This optional file does not exempt submitting entities otherwise mandated to submit data.

Required Submission Information

- Pharmacy benefit manager (PBM) submitting entities will provide paid claims and adjustment claims for pharmaceutical products and services rendered during the update period. All claims must have an associated member record in the enrollment file.
- The historical data submission and the one-year catch-up submission (see Submission Schedule) must consist of final paid claims only. Versioned claims will be submitted for quarterly submissions.

File Content

- Files must include variables in Exhibit A – Data Elements: Pharmacy Benefit Manager 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 should be masked prior to submission to the APCD. Masking should be consistent across data submissions so the masked values representing these IDs do not change.
- Submitting entity's Carrier Specific Unique Member ID and Carrier Specific Unique Subscriber ID should be consistent across submissions and over time. If a new system changes or alters the Carrier Specific Unique Member IDs and/or Carrier Specific Subscriber IDs, utilize the Alias ID Member ID fields to maintain continuity.
- A submitting entity's Carrier Specific Unique Member ID and Carrier Specific Unique Subscriber ID should be of consistent length and format across all submitted data so that any member (ELG) records containing this information will match exactly.
- Submitting entity's Carrier Specific Unique Member IDs and Carrier Specific Unique Subscriber IDs should align with the Carrier Specific Unique Member IDs and Carrier Specific Unique Subscriber IDs of the health insurance carrier for which the PBM processes claims.
- A submitting entity's Member Date of Birth and the Subscriber Date of Birth should match between the Member records and the Claims records. Any dates in these fields equaling 1900-01-01 or earlier are considered either incorrect or a system default date. Invalid or incorrect Member Date of Birth renders ME998 – APCD Unique ID values as suspect.
- The following fields must match in format, length, and values across all coverage period submissions for the same Carrier Specific Unique Member ID: Member Suffix or Sequence Number or Person Code (ME010, PB009), Individual Relationship Code (ME012, PB011), Member Gender (ME013, PB012), and Subscriber Gender (ME151A, PB956).
- Files shall contain all claims based on paid date during the observation period for all covered services provided to eligible members.
- Payer Claim Control Number (PB004) and line numbers (PB005) must be consistent across submissions, along with other fields identified for versioning by the submitting entity.
- A Header Header, Header Data, Control Header, Control Data, Detail Data Header, Detail Data (when data is present), Trailer Header, and Trailer Data record must be included-in order-with file submissions.
- Quarterly submission files shall contain adjustment claims for the APCD versioning process (see Exhibit C – APCD Claims Versioning).

- Custom codes or valid codes/values that are not listed in the DSG appendices for data elements (such as plan codes, race codes, bill type, diagnosis codes, procedure codes, CPT codes, etc.) will be considered for addition to the Arkansas APCD reference repository. Work with the Arkansas APCD team to review and assess need/relevance to determine if custom codes can be added.

Test Data

Submitting entities are required to submit test data prior to submitting production data. At minimum, submitting entities should execute onboarding testing as part of the initial set-up with the Arkansas APCD and production file testing for initial data submissions or when new requirements have been put in place (e.g. new data fields, new control count methodology, etc.).

- **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 that the submitting entity has the appropriate access through the APCD Web Portal.
- **Test File Submission:** Each submitting entity shall provide data prior to the submission of full datasets. Test files shall include at least one full month of production activity for the following data categories:
    - Member Enrollment Data
    - Medical Claims
    - Pharmacy Claims
    - Dental Claims
    - Provider Data
    - Lookup Files (for MC032 and MC212 only)
    - Arkansas Medicaid Supplemental Payment Data
    - Pharmacy Benefit Manager Claims

DATA SUBMISSION REQUIREMENTS

The Data Submission Requirements section includes the file submission process map, web portal setup, data encryption requirements, and data validation steps within the APCD data intake process.

Submission Process

Submitting entities will work with the APCD Technical Support 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 containing additional information follow the process map in Table 1: Data Submission Process Step Descriptions.

Figure 1: APCD Data Submission Process

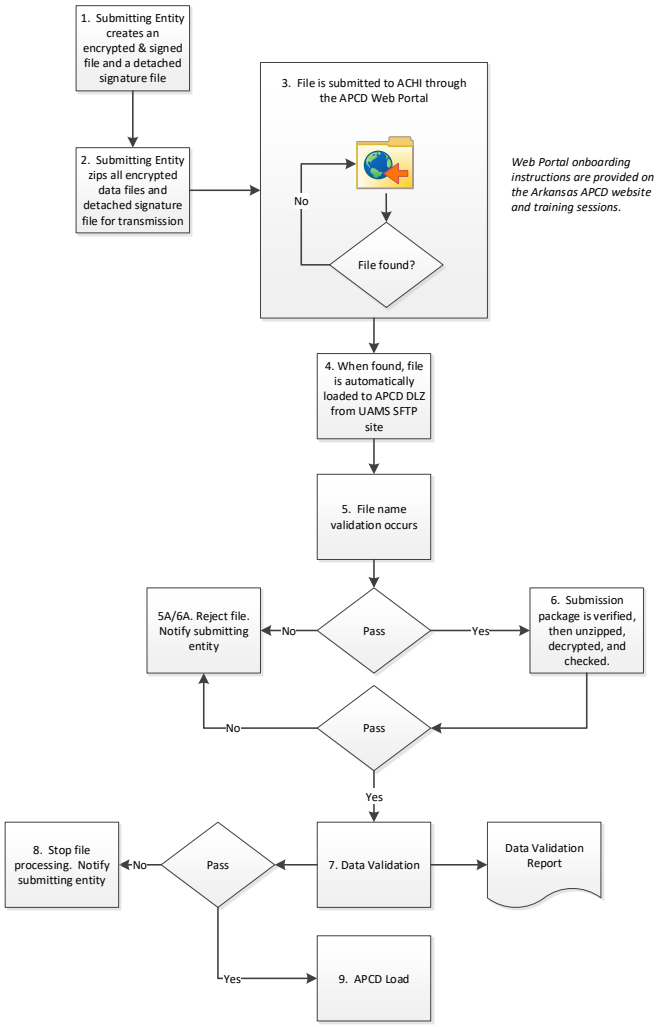

Table 1: Data Submission Process Step Descriptions

Each numbered task represents a step on the process map in Figure 1. **Process Task**	**Description**
1. Submitting entity encrypts data files with APCD public key and creates detached signature file.	A. Submitting entity creates an encrypted and signed file (extension should be .gpg or .pgp, depending on encryption used) using the ARAPCD_RSA public key and the SE's DSA Key. B. Submitting entity creates a detached signature file (extension should be .gpg.sig or .pgp.sig, depending on encryption used) from the output of step 1A using same SE DSA Key used in step 1A.
2. Submitting entity zips all encrypted data files and detached signature file for transmission.	Submitting entity zips both files created in steps 1B and 1A for transmissions. [One (1) encrypted and signed file and one (1) detached signature file.]
3. File is transferred to UAMS APCD SFTP site.	Submitting entity transfers zipped data submissions to UAMS-assigned SFTP site.
4. When found, file is automatically loaded to APCD DLZ from UAMS SFTP site.	APCD processes scan SFTP site for dropped files. When found, file is moved off the UAMS SFTP site onto the APCD data landing zone (DLZ). Automated email is sent to APCD Technical Support team confirming data receipt.
5. File name validation occurs.	The automated data intake process evaluates the file name to determine if this file should move forward into the APCD processes. If not, the file is deleted and the submitting entity is notified (step 5A/6A).
6. Submission package is verified, then unzipped, decrypted, and checked.	1. Submission package is checked for the following before the file is unzipped or decrypted: a. zip file contains exactly two files b. one of the two files has an extension of .gpg or .pgp c. the other file has an extension of .gpg.sig or .pgp.sig d. the base name of the zip file and the two files it contains all match e. the file name contains all the required pieces in the required order and format

Each numbered task represents a step on the process map in Figure 1. **Process Task**	**Description**
	2. If all of these checks pass, the file moves on to further checks. 3. File is unzipped; the encrypted and signed file is decrypted; and the signature is checked against the detached signature file. If there are no errors in decryption, and the signatures match, the file moves on to further checks. 4. Decrypted file is examined for the following: a. file and data formats b. header/trailer record information match each other and the file name information, column counts, row counts, data types If there are no errors in this step the file is considered for data validation.
5A/6A. Reject file. Notify submitting entity	If the file fails the step 5 or step 6 checks, it is rejected and the submitting entity is notified to correct and resubmit the file.
7. Data Validation Reporting	Once passed, process the file through data validation. Generate Data Validation reports for submitting entities
8. Stop file processing. Notify submitting entity	If file does not pass data validation, do not process it further. Notify submitting entity to resolve issue and resubmit file
9. APCD Load	If file passes data validation, it moves through the APCD load processes into the APCD

APCD Web Portal Setup

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.

After registration with AID (as outlined in Rule 100), the APCD Technical Support team will set up a submitting entity-specific web portal and a University of Arkansas for Medical Sciences (UAMS) SFTP site for data submission. The submitting entity will receive an email with a user name, a temporary password, and instructions for web portal access. The APCD Technical Support team will work with the submitting entity to log on and test data transfer in preparation for production file receipt.

Submitted Data Encryption Requirements

Submitted data must be encrypted at two levels to safeguard 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 ID (ME998). These data must be hashed 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 hashing is applied to APCD Unique IDs during the APCD data intake process. **The APCD Technical Support team will provide specific hashing 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. Supporting documentation and training will be provided.

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 Keys

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

- APCD RSA and DSA public keys provided by APCD Technical Support team.
- Submitting entity RSA and DSA public keys provided by the submitting entity.

File Encryption

The APCD Technical Support team will provide the APCD public key to submitting entities to encrypt the data file. Each submitting entity will provide the APCD its public DSA key to match the signature file to the encrypted file.

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

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

Report/Output Delivery

The APCD Technical Support team will provide reports to submitting entities after the data validation process is completed for each data submission. These reports will be encrypted before delivery to submitting entities. The APCD Technical Support 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 RSA key and signed with APCD DSA key.
- APCD detached-signed signature file (using the APCD DSA key) of the encrypted/signed file just created (see above bullet).

Data Validation

As described in the File Submission Requirements and Options section, all data submitted to the APCD will go through two levels of data quality assessment:

Data Intake Validation

1. File Structure Validation
    - **File name structure check** – Ensures that the file name contains the correct components in the correct order. File name components are used as the submitted file moves through automated data intake.
    - **Archive check** – Ensures the file was zipped correctly.
    - **File quantity check** – Verifies that the number of files included in the archive matches the quantity indicated in the file name.
    - **Encryption check** – Ensures file is encrypted using protocols allowable in the Arkansas APCD automated data intake processes.
    - **Detached signature file check** – Verifies 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.
    - **File format check**
        - Column count – Verifies that the number of columns in the file matches the number of DSG data element IDs in the file.
        - Header and Trailer record format and value validation:
            - HD001 and TR001 must match
            - Number of DD records must match file HD006
            - Dates must be in the correct format (must include dashes)
            - The file name entity abbreviation must match the two-character code in HD003

File Name Entity Abbreviation	Type of File (HD003, TD003)
DNT	DC
CLM	MC
ELG	ME
PHM	PC
PRV	PV
LU	LU
SP	SP
PBM	PB

Files failing File Structure Validation cannot move to Data Validation. Submitting entities will be notified if submitted files do not pass data intake and will be asked to resubmit.

2. Data Validation
    - **Data value check** – Verifies that each data element contains the correct values specified in the DSG.
    - **Data type check** – Verifies that the value data type is consistent with those specified in the DSG.
    - **Data length check** – Verifies that the value data length is consistent with those specified in the DSG.
    - **Data threshold compliance check** – Verifies that the data included in the file meets the required data threshold specified in the DSG or approved data exception form.
    - **Member ID consistency check** – A final validation will be executed when the data files reach data transformation – Carrier Specific Unique Member IDs and Carrier Specific Unique Subscriber IDs matching across current submission and against previously submitted files will be executed. If the ID matching fails, the submission fails. Note: This validation occurs after the data validation report is delivered to the submitting entity. If the ID matching fails because system changes caused IDs to change, the Arkansas APCD team will work with the submitting entity to document the change and update the validation expectation.

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

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

Pass/Fail Criteria

Data files failing the data intake process checks — or at least one DSG specified value, format, or threshold requirement — will fail the data submission process.

Data Validation Reports

The Data Validation process produces data validation reports for each file submitted. The final data validation reports will be encrypted and placed on the submitting entity-specific web portal for retrieval and review. See the Report/Output Delivery section for additional information about report delivery.

Data Load Validation

Once files have moved through data validation and into transformation and database build, they will be reviewed for contextual accuracy. If issues are identified, the APCD Technical Support team will work with the submitting entity to resolve the issue.

Data Exceptions

If required data elements or values are not available, submitting entities can apply for **data exceptions** to address data variances that cannot be corrected due to systematic issues. Data exceptions shall be submitted to the APCD Technical Support team through the Arkansas APCD Web Portal. See the Arkansas APCD Online Data Exception Request training manual.

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, the data intake process is updated 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: Exceptions granted under a governing DSG do not automatically apply to later versions. New approvals are required for justification.

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

Data Integrity Audit File

At the conclusion of the process to load submitted and validated files into the Arkansas APCD, additional validation and contextual checks are executed to ensure accurate data is available for selection. These checks include, but are not limited to, assessing the accuracy of versioning-rule application per submitting entity, and/or identifying duplicated claim lines with conflicting information.

Beginning in September 2019, the Arkansas APCD contextual checks and validation process will produce a pipe-delimited text file — the **ARAPCD Data Integrity Audit (DIA) file** — that contains claims identified as problematic for that submitting entity. All claim lines associated with these claims will be included in the DIA file, whether or not they are affected by the identified problem. This file will be sent back to the submitting entity for review. If the issue resolution requires any or all of the claims or claim lines to be corrected and resubmitted, the Arkansas APCD team will request a full record resubmission for affected claims, inclusive of all claim lines (not the entire file). The return data will be used to replace the claim data previously sent to the Arkansas APCD. It is possible that the issue cannot be resolved and no replacement claims will be resubmitted. See Appendix O: Data Integrity Audit File Configuration for file configuration information and examples.

Process:

1. The Arkansas APCD team will send to the submitting entity, via sFTP or web portal, the DIA file containing all claim lines for claims identified as problematic.
    a. The DIA file file will also contain header, control count, and trailer records.
    b. These records will be unchanged from submission, but will include data integrity audit fields: **DIA_IssueDescription** and **DIA_ReportDate.**
2. Submitting entity will review the identified issues and resubmit the applicable corrected claims in a "return DIA file."
    a. The return DIA file should be delivered in the same process as regular submission files.
        i. It should be constructed just like a regular submission file, but should use the header, control count, and trailer records from the DIA file (updated to ensure the counts relate to the submitted file).
        ii. The coverage period begin and end dates should be carried forward from the ARAPCD DIA file to the return DIA file.
        iii. The name of the return DIA file will use the same naming convention as a regular submission file (using PROD for production).
        iv. The HD010 field in the header record should retain the values **TESTDIA** or **PRODDIA**.
        v. The return DIA file with corrected claims should be transmitted to the Arkansas APCD before the next quarterly submission date.

The Arkansas APCD Technical Support team will work closely with submitting entities to put these processes in place.

DIA_IssueDescription Value Definitions

Data integrity audit file value definitions will vary depending on the issues discovered. Descriptions for common issues are listed below. Other descriptions may be used when new issues are encountered.

DIA_IssueDescription Value	Definition
Duplicate Claim Line Number	The claim line number is duplicated across multiple records for a claim with unclear versioning information to select the claim line to flag as active.
Suspect Versioning Chain	Claim lines contain duplicated data in fields utilized for submitting entity's versioning approach. No tie-breaker is found to identify the version of the claim line to flag as active.
Range Issue	Value found out of expected range. This issue will most likely occur in dollar and date fields.
Contextual Issue	Unexpected value identified. This issue will most likely occur on fields that do not have data validation checks, e.g., provider name and address fields, employer information, etc.
Inconsistent Member ID Value	Different member IDs or subscriber IDs are found on claim lines for the same claim.

File Format

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 at 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 and trailer record containing the data element ID for each variable specified in Exhibit A – Data Elements – Row Types.
- Header and trailer record inclusion requirements:
    - At the beginning of every data file, exactly one record for each of the following row types: HH, HD, CH, CD, DH
    - At least one DD row type after the DH row, unless reporting no activity for the coverage period
    - Exactly one row for each of the TH and TD rows at the end of every data file
- 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 with 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 use an alternate delimiter character.
    - The .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.
    - The .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.
    - Encrypted, compressed file packages are limited to 300 MB for files submitted via the Arkansas APCD Web Portal.
    - Each file should contain data for a single submitting entity. Do not include claims from multiple submitting entities within single submitted files.

File Naming Convention

All files submitted to the APCD must 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 Submitting entities: NAIC Company codes. NOTE: If a submitting entity provides data from multiple data systems under the same NAIC company code, add a single alpha character representing the NAIC Suffix at the end of the NIAC Company code. NAIC Suffixes should be assigned sequentially. For example: 12345A, 12345B.
  - Other submitters: A unique 5-digit alphanumeric code assigned by the APCD Technical Support team.
- **[Test, Prod, or SUPL]** – *TEST* is for test data files; *PROD* is for production data files; *SUPL* is for ad-hoc supplemental data.
- **SubmissionDate** – Date the file was produced. This date must be in the YYYYMMDD format.
- **CoveragePeriodDate** – Represents coverage period of the submission. This date must be in the *YYYYMM* format (e.g., CoveragePeriodDate = 201509 for September 2015). The date will represent the end month of the coverage date range (e.g., for data pulled between 7/01/2015 and 9/30/2015), the CoveragePeriodDate = 201509.
- **FileNo** – Two-digit number representing the number of the file as it relates to the total number of files by file type to be received.
- **FileCount** – Two-digit number representing the total number of files by file type to be received. Note: Single file submissions are preferred.

  Example:

  FileNo_FileCount example 01_09 represents file 01 of 09 expected files.

  FileNo_FileCount example 02_09 represents the second of 9 expected files. FileNo_FileCount example 01_01 represents file 01 of 01 expected file.

  See Submission Grouping Options for file name examples.

- **EntityAbbreviation** – Abbreviation representing file type.
  - DNT = Dental Claims
  - CLM = Medical Claims
  - ELG = Member Enrollment Data
  - PHM = Pharmacy Claims
  - PRV = Provider Data
  - LU = Lookup Tables
  - SP = Medicaid Supplemental Payment Data
  - PBM = Pharmacy Benefits Manager Claims

These file name components must match the following fields in the .dat file.

- **EntityCode** = HD001, TR001
- **FileNo** = HD008
- **FileCount** = HD007

Coverage Period Requirements

- Valid coverage periods are monthly, quarterly, or annual. Files may contain up to one calendar year (January 1 to December 31) of data.
- Coverage periods begin on the **first** day of the first month of the coverage period and end on the **last** day of the last month of the coverage period. These dates should be represented in the Header and Trailer records of the file and the coverage ending month and year must match the date in the file name.
- Coverage periods should be adjacent and not overlapping.
- If no data exists for a valid coverage period, an **empty** file should be submitted representing the coverage period. The empty file should contain the following rows: Header Header, Header Data, Control Header, Control Data, Data Header, Trailer Header, and Trailer Data. No Data Detail record should be sent.
- The coverage dates in the Header Data should represent the missing coverage period. The file name should include the missing coverage period.
- Submitting entities providing full file replacements have the option to stop submitting older data already contained within the Arkansas APCD. Older data should be removed by the calendar year. *Data should be dropped by year in the second quarter submission of each year (June 30).* Years should not be dropped on a rolling basis.

Type of Submission	Definition	Q1 Submission (March 31)	Q2 Submission (June 30)
Full File Replacement	SE provides all years and quarters of required data for each quarterly submission.	2013-01-01 through 2018-12-31	2014-01-01 through 2019-03-31 *2013 data not included.*

Submission Grouping Options

The Arkansas APCD data intake process accepts different data submission groupings to accommodate submitting entity reporting system processing requirements. Examples illustrating each grouping option are included in this section.

1. Yearly Grouping by Number of Records or File Size for Initial Data Submission
   (2014 Submission record quantity: 445,098; 2015 Submission record quantity: 485,848)

Year	Coverage	Quantity	FileNo	FileCount	File Name
2014	Jan-Dec	100,000	1	5	ARAPCD_99999_PROD_20160624_201412_01_05_CLM.dat
2014	Jan-Dec	100,000	2	5	ARAPCD_99999_PROD_20160624_201412_02_05_CLM.dat
2014	Jan-Dec	100,000	3	5	ARAPCD_99999_PROD_20160624_201412_03_05_CLM.dat
2014	Jan-Dec	100,000	4	5	ARAPCD_99999_PROD_20160624_201412_04_05_CLM.dat
2014	Jan-Dec	45,098	5	5	ARAPCD_99999_PROD_20160624_201412_05_05_CLM.dat
2015	Jan-Dec	100,000	1	5	ARAPCD_99999_PROD_20160624_201512_01_05_CLM.dat
2015	Jan-Dec	100,000	2	5	ARAPCD_99999_PROD_20160624_201512_02_05_CLM.dat
2015	Jan-Dec	100,000	3	5	ARAPCD_99999_PROD_20160624_201512_03_05_CLM.dat
2015	Jan-Dec	100,000	4	5	ARAPCD_99999_PROD_20160624_201512_04_05_CLM.dat
2015	Jan-Dec	85,848	5	5	ARAPCD_99999_PROD_20160624_201512_05_05_CLM.dat

2. Quarterly Grouping by Number of Records or File Size
   (Q1 2014 Submission record quantity: 445,098; Q2 2014 Submission record quantity: 485,848)

Year	Coverage	Quantity	FileNo	FileCount	File Name
2014	Jan-Mar	100,000	1	5	ARAPCD_99999_PROD_20160624_201403_01_05_CLM.dat
2014	Jan-Mar	100,000	2	5	ARAPCD_99999_PROD_20160624_201403_02_05_CLM.dat
2014	Jan-Mar	100,000	3	5	ARAPCD_99999_PROD_20160624_201403_03_05_CLM.dat
2014	Jan-Mar	100,000	4	5	ARAPCD_99999_PROD_20160624_201403_04_05_CLM.dat
2014	Jan-Mar	45,098	5	5	ARAPCD_99999_PROD_20160624_201403_05_05_CLM.dat
2014	Apr-June	100,000	1	5	ARAPCD_99999_PROD_20160930_201406_01_05_CLM.dat
2014	Apr-June	100,000	2	5	ARAPCD_99999_PROD_20160624_201406_02_05_CLM.dat
2014	Apr-June	100,000	3	5	ARAPCD_99999_PROD_20160624_201406_03_05_CLM.dat
2014	Apr-June	100,000	4	5	ARAPCD_99999_PROD_20160624_201406_04_05_CLM.dat
2014	Apr-June	85,848	5	5	ARAPCD_99999_PROD_20160624_201406_05_05_CLM.dat

3. Monthly Data Submission, Grouped by Quarter

Year	Coverage	FileNo	FileCount	File Name
2013	Jan	1	3	ARAPCD_99999_PROD_20160624_201303_01_03_CLM.dat
2013	Feb	2	3	ARAPCD_99999_PROD_20160624_201303_02_03_CLM.dat
2013	Mar	3	3	ARAPCD_99999_PROD_20160624_201303_03_03_CLM.dat
2013	Apr	1	3	ARAPCD_99999_PROD_20160624_201306_01_03_CLM.dat
2013	May	2	3	ARAPCD_99999_PROD_20160624_201306_02_03_CLM.dat
2013	Jun	3	3	ARAPCD_99999_PROD_20160624_201306_03_03_CLM.dat
2013	Jul	1	3	ARAPCD_99999_PROD_20160624_201309_01_03_CLM.dat
2013	Aug	2	3	ARAPCD_99999_PROD_20160624_201309_02_03_CLM.dat
2013	Sep	3	3	ARAPCD_99999_PROD_20160624_201309_03_03_CLM.dat
2013	Oct	1	3	ARAPCD_99999_PROD_20160624_201310_01_03_CLM.dat
2013	Nov	2	3	ARAPCD_99999_PROD_20160624_201311_02_03_CLM.dat
2013	Dec	3	3	ARAPCD_99999_PROD_20160624_201312_03_03_CLM.dat

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4. Monthly Data Submission with No Grouping

Year	Coverage	FileNo	FileCount	File Name
2013	Jan	1	1	ARAPCD_99999_PROD_20160624_201301_01_01_CLM.dat
2013	Feb	1	1	ARAPCD_99999_PROD_20160624_201302_01_01_CLM.dat
2013	Mar	1	1	ARAPCD_99999_PROD_20160624_201303_01_01_CLM.dat
2013	Apr	1	1	ARAPCD_99999_PROD_20160624_201304_01_01_CLM.dat
2013	May	1	1	ARAPCD_99999_PROD_20160624_201305_01_01_CLM.dat
2013	Jun	1	1	ARAPCD_99999_PROD_20160624_201306_01_01_CLM.dat
2013	Jul	1	1	ARAPCD_99999_PROD_20160624_201307_01_01_CLM.dat
2013	Aug	1	1	ARAPCD_99999_PROD_20160624_201308_01_01_CLM.dat
2013	Sep	1	1	ARAPCD_99999_PROD_20160624_201309_01_01_CLM.dat
2013	Oct	1	1	ARAPCD_99999_PROD_20160624_201310_01_01_CLM.dat
2013	Nov	1	1	ARAPCD_99999_PROD_20160624_201311_01_01_CLM.dat
2013	Dec	1	1	ARAPCD_99999_PROD_20160624_201312_01_01_CLM.dat

5. Quarterly Data Submission with No Grouping

Year	Coverage	FileNo	FileCount	File Name
2013	Jan-Mar	1	1	ARAPCD_99999_PROD_20160624_201303_01_01_CLM.dat
2013	Apr-Jun	1	1	ARAPCD_99999_PROD_20160624_201306_01_01_CLM.dat
2013	Jul-Sep	1	1	ARAPCD_99999_PROD_20160624_201309_01_01_CLM.dat
2013	Oct-Dec	1	1	ARAPCD_99999_PROD_20160624_201312_01_01_CLM.dat

EXHIBIT A – DATA ELEMENTS

Layout Legend and Row Types

Layout Column Definitions

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. The information contained within the Description should not contain either double or single quotation marks.
Type	**Date** – Identifies value as date. Must be represented as YYYY-MM-DD. **Integer** – Identifies value as whole number. **Numeric** – Identifies values containing digits from 0 to 9 and a dollar sign and/or a decimal point where required. If dollar amount, represent dollars and cents with decimals (e.g., 25.79). **Text** – Identifies values as having variable length alphanumeric characters.
Format*	**char** – A fixed length element of characters. Values must match the number in 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. For example, a ZIP Code value of '3415' would be submitted as '03415' because the ZIP code field has a specified field length of five. For the 'char' format, the Length definition is a requirement, and not a maximum. **varchar** – A variable length field of characters. Values cannot be longer than the number in 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. **int** – A variable length field containing numeric values. Values cannot be longer than the number in the specified length column. Records with numeric value formats cannot contain decimal points or leading zeroes. **unsigned int** – A variable length field containing a non-negative integer. **YYYY-MM-DD** – Required format for dates with year, month, and day. **decimal** – Numeric value with up to four digits to the right of the decimal. **The plus/minus (±) symbol preceding the format indicates that a negative can be submitted in the element under the specified conditions.*

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 percentage of data element values that are present and meet the validation requirements per the DSG.
Required	Indicates if a variable is required for initial APCD build. Not indicated in the Header or Trailer record layout. All data elements are required for Header and Trailer records.

Row Types

Each file must contain the following row types in the order illustrated below. See Header/Control Data/Data/Trailer Row Type Examples.

Row Type	Definition	Number Required in File
HH	Header Record Header Row	1
HD	Header Record Data Row	1
CH	Control Data Header Row	1
CD	Control Data Row	1
DH	Detail Data Header Row	1
DD	Detail Data Row(s)	Multiple. One per transaction record from submitting entity. Not required for files containing no data (see Coverage Period Requirements section).
TH	Trailer Record Header Row	1
TD	Trailer Record Data Row	1

Header/Control Data/Data/Trailer Row Type Examples

Each data file will contain the following rows in the order illustrated in the examples below. In this case the file contains two detail data rows, therefore the row count in the header data records equals two.

Header Header and Header Data Records Example

```
HH|HD001|HD002|HD003|HD004|HD005|HD006|HD007|HD008|HD009|HD010
HD|12345||CC|2015-01-01|2015-01-31|2|1|1|8.0.2022|PROD
```

Control Header and Control Data Record (Different for each file type. Member represented here) Example

```
CH|CC001|CC002|CC003|CC004|CC005|CC006|CC007|CC008|CC009|CC010
CD|12345|ELG|M|17|2|657|15|57|78|62
```

Data Header and Detail Data Record Example*

```
DH|ME999|ME001|ME002|ME003||ME006|ME016|ME107|ME998
DD|1|12345|432|CI|36203AB1|AR|12092284|Coi2/dIonwFxhuW2O33xyGm+Gu683foEFupDMUeBnuo=
DD|2|12345|432|CI|36203AB1|MO|12092284|Coi2/dIonwFxhuW2O33xyGm+Gu683foEFupDMUeBnuo=
```

Trailer Header and Trailer Data Records Example

```
TH|TR001|TR002|TR003|TR004|TR005|TR006|TR007
TD|12345||CC|2015-01-01|2015-01-31|2015-03-01|2015-04-01
```

See Exhibit A Header, Control Count, and Trailer Records for layout specifications.

*Example data is abbreviated to contain fewer fields.

Header, Control Count, and Trailer Records

Every submitted data file **must have** one HH, one HD, one CH, one CD, one DH, **at least one** DD record (when data is present), one TH, and one TD record when submitting data for a coverage period. *Files submitted with no data do not require a DD row.*

Use values in Data Element ID column as column names in the header record of the Header, Control Count, and Trailer records.

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.
- A Header Header, Header Data, Control Header, Control Data, Detail Data Header (when data is present), Trailer Header, and Trailer Data record must be included with this file submission. See Header/Control Data/Data/Trailer Row Type Examples.
- The submission environment from which the data is pulled, PROD or TEST, must be included in row.
- The Control Header and Control Data records **have different layouts depending on file type**. See Control Count Records Layout for file type layout requirements.
- Use values in Data Element ID column as column names for the Header Header Record.
- The Period Beginning Date must represent the first day of the month of the submission period. Period Ending Date must represent the last day of the month of the submission period. Data must be within the date range between the Period Beginning Date and Period Ending Date based on the file type requirements, e.g. Paid Date, Enrollment Date, etc.

Reminder: You must include the DH record before the DD rows in the submitted file.

Header Records 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 entity submitting data. The entity could be the carrier administering fully insured plans, third party administrator (TPA) administered plans, or pharmacy benefit manager (PBM) administered plans. - Use 5 to 6 alphanumeric entity code provided by Arkansas APCD team assigned during registration process (see the File Naming Convention section). - Must match entity code in the file name. - Must match TR001.	Text	varchar	6	100%
HD002	National Plan ID	Centers for Medicare & 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.	Int	unsigned int	30	0%
HD003	Type of File	MC = Medical Institutional & Professional Claims PC = Pharmacy Claims ME = Member Enrollment Data DC = Dental Claims PV = Medical/Dental/Pharmacy Provider Data LU = Lookup Table SP = Supplemental Files (Arkansas Medicaid only) PB = Pharmacy Benefits Manager Claims Must match TR003	Text	char	2	100%
HD004	Period Beginning Date	First date covered in submission period. Must match TR004. Submission periods begin on the first day of the first month of the coverage period. This value should not represent the first transaction date within the month.	Date	YYYY-MM-DD	10	100%
HD005	Period Ending Date	Last date covered in submission period. Must match ending coverage period date in file name. Must match TR005. Submission periods end on the last day of the last month in the coverage period. This value should not represent the last transaction date within the month.	Date	YYYY-MM-DD	10	100%

<table>
<tr><th>Data Element ID</th><th>Data Element</th><th>Description</th><th>Type</th><th>Format</th><th>Length</th><th>Threshold</th></tr>
<tr><td>HD006</td><td>Record Count</td><td>Total number of DD records in the submission. Count does not include header or trailer records. If the number of records within the submission do not equal the number reported in this field, the submission will fail.</td><td>Integer</td><td>unsigned int</td><td>10</td><td>100%</td></tr>
<tr><td>HD007</td><td>Submission File Count</td><td>Number of datasets to expect for this file submission. Should match the [FileCount] value in the file name.

For example:
If a submitted file required division into three manageable smaller datasets, 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.
<table>
<tr><td>File 1</td><td>File 2</td><td>File 3</td></tr>
<tr><td>HD007 = 03</td><td>HD007 = 03</td><td>HD007 = 03</td></tr>
<tr><td>HD008 = 01</td><td>HD008 = 02</td><td>HD008 = 03</td></tr>
</table>
If a single file is submitted, the header record would include these values.
<table>
<tr><td>File</td></tr>
<tr><td>HD007 = 01</td></tr>
<tr><td>HD008 = 01</td></tr>
</table></td><td>Integer</td><td>unsigned int</td><td>2</td><td>100%</td></tr>
<tr><td>HD008</td><td>Submission File Number</td><td>Number representing the dataset within file submission. Should match the [FileNo] value in the file name.

See example in HD007.</td><td>Integer</td><td>unsigned int</td><td>2</td><td>100%</td></tr>
<tr><td>HD009</td><td>DSG Version</td><td>APCD Data Submission Guide version number.

All records should contain the value 8.0.2022.</td><td>Text</td><td>varchar</td><td>10</td><td>100%</td></tr>
<tr><td>HD010</td><td>Submission Environment Identifier</td><td>Identifies the submission environment from which the file is pulled.

PROD = File submitted for production usage
TEST = File submitted as part of testing prior to production
SUPL = Supplemental files (required only if interim files are required through special request)</td><td>Text</td><td>char</td><td>4</td><td>100%</td></tr>
</table>

Control Count Records Layout

Control Count Record Layout – Member Data

ID	Data Element ID	Data Element	Data Element Description	Type	Format	Length	Threshold	Required
1	CH	CH	Record Prefix Place the value CD in the Control Count data detail record.	Text	char	2	100%	Required
2	CC001	Submitter	- Code representing entity submitting data. The entity could be the carrier administering fully insured plans, third party administrator (TPA) administered plans, or pharmacy benefit manager (PBM) administered plans. - Use 5 to 6 alphanumeric entity code provided by Arkansas APCD team assigned during registration process (see the File Naming Convention section). - Must match entity code in the file name. - Must match HD001 and TR001 in the file name specified in CC002. - Only one entity code is to be used per control count file.	Text	varchar	6	100%	Required
3	CC002	File Type	FileType Values: ELG – Eligibility/Member Data	Text	char	3	100%	Required
4	CC003	Submission Type	Submission Type Values: M = Monthly Q = Quarterly Y = Yearly O = Other	Text	char	1	100%	Required
5	CC004	UniqueMemberID	Count of distinct values in carrier specific unique member ID for file type (ME107).	Integer	unsigned int	25	100%	Required
6	CC005	UniqueSubscriberID	Count of distinct values in carrier specific unique subscriber ID for file type (ME117).	Integer	unsigned int	25	100%	Required
7	CC006	Unique Member State	Count of distinct values in the member state field (ME016).	Integer	unsigned int	25	100%	Required
8	CC007	Unique Member ZIP Code	Count of distinct values in the member ZIP Code field (ME017).	Integer	unsigned int	25	100%	Required
9	CC008	Unique Subscriber State	Count of distinct values in the subscriber state field (ME109).	Integer	unsigned int	25	100%	Required
10	CC009	Unique Subscriber ZIP Code	Count of distinct values in the subscriber ZIP Code field (ME110).	Integer	unsigned int	25	100%	Required
11	CC010	Unique APCD Unique ID	Count of distinct values in the APCD Unique ID field (ME998).	Integer	unsigned int	25	100%	Required

Control Count Record Layout – Medical Claim Data

ID	Data Element ID	Data Element	Data Element Description	Type	Format	Length	Threshold	Required
1	CH	CH	Record Prefix Place the value CD in the Control Count data detail record.	Text	char	2	100%	Required
2	CC001	Submitter	- Code representing entity submitting data. The entity could be the carrier administering fully insured plans, third party administrator (TPA) administered plans, or pharmacy benefit manager (PBM) administered plans. - Use 5 to 6 alphanumeric entity code provided by Arkansas APCD team assigned during registration process (see the File Naming Convention section). - Must match entity code in the file name. - Must match HD001 and TR001 in the file name specified in CC002. - Only one entity code is to be used per control count file.	Text	varchar	6	100%	Required
3	CC002	File Type	FileType Values: CLM – Medical claims	Text	char	3	100%	Required
4	CC003	Submission Type	Submission Type Values: M = Monthly Q = Quarterly Y = Yearly O = Other	Text	char	1	100%	Required
5	CC004	UniqueMemberID	Count of distinct values in carrier specific unique member ID for file type (MC137).	Integer	unsigned int	25	100%	Required
6	CC005	UniqueSubscriberID	Count of distinct values in carrier specific unique subscriber ID for file type (MC141).	Integer	unsigned int	25	100%	Required
7	CC011	UniqueClaimNumber	Count of distinct values in the claim number field (MC004).	Integer	unsigned int	25	100%	Required
8	CC012	UniqueClaimNumberClaimLine	Count of distinct values in the claim number+claim line field (MC004 + MC005).	Integer	unsigned int	25	100%	Required
9	CC013	UniqueServiceProviderNPI	Count of distinct values in the service provider NPI field (MC026).	Integer	unsigned int	25	100%	Required
10	CC014	UniqueServiceProviderEIN	Count of distinct values in the Service Provider EIN field (MC025).	Integer	unsigned int	25	100%	Required
11	CC015	UniqueServiceProviderID	Count of distinct values in the Service Provider ID field (MC024).	Integer	unsigned int	25	100%	Required

Control Count Record Layout – Pharmacy Claim Data

ID	Data Element ID	Data Element	Data Element Description	Type	Format	Length	Threshold	Required
1	CH	CH	Record Prefix Place the value CD in the Control Count data detail record.	Text	char	2	100%	Required
2	CC001	Submitter	- Code representing entity submitting data. The entity could be the carrier administering fully insured plans, third party administrator (TPA) administered plans, or pharmacy benefit manager (PBM) administered plans. - Use 5 to 6 alphanumeric entity code provided by Arkansas APCD team assigned during registration process (see the File Naming Convention section). - Must match entity code in the file name. - Must match HD001 and TR001 in the file name specified in CC002. - Only one entity code is to be used per control count file.	Text	varchar	6	100%	Required
3	CC002	File Type	FileType Values: PHM – Pharmacy claims	Text	char	3	100%	Required
4	CC003	Submission Type	Submission Type Values: M = Monthly Q = Quarterly Y = Yearly O = Other	Text	char	1	100%	Required
5	CC004	UniqueMemberID	Count of distinct values in carrier specific unique member ID for file type (PC107).	Integer	unsigned int	25	100%	Required
6	CC005	UniqueSubscriberID	Count of distinct values in carrier specific unique subscriber ID for file type (PC108).	Integer	unsigned int	25	100%	Required
7	CC011	UniqueClaimNumber	Count of distinct values in the claim number field (PC004).	Integer	unsigned int	25	100%	Required
8	CC012	UniqueClaimNumberClaimLine	Count of distinct values in the claim number + claim line field (PC004 + PC005).	Integer	unsigned int	25	100%	Required
9	CC013	UniqueServiceProviderNPI	Count of distinct values in the service provider NPI field (PC021).	Integer	unsigned int	25	100%	Required
10	CC014	UniqueServiceProviderEIN	Count of distinct values in the service provider EIN field (PC019).	Integer	unsigned int	25	100%	Required
11	CC016	Unique NDC Code	Count of distinct values in the NDC code field (PC026).	Integer	unsigned int	25	100%	Required
12	CC017	UniquePrescriptionNumber	Count of distinct values in the prescription number field (PC058).	Integer	unsigned int	25	100%	Required

Control Count Record Layout – Dental Claim Data

ID	Data Element ID	Data Element	Data Element Description	Type	Format	Length	Threshold	Required
1	CH	CH	Record Prefix Place the value CD in the Control Count data detail record.	Text	char	2	100%	Required
2	CC001	Submitter	- Code representing entity submitting data. The entity could be the carrier administering fully insured plans, third party administrator (TPA) administered plans, or pharmacy benefit manager (PBM) administered plans. - Use 5 to 6 alphanumeric entity code provided by Arkansas APCD team assigned during registration process (see the File Naming Convention section). - Must match entity code in the file name. - Must match HD001 and TR001 in the file name specified in CC002. - Only one entity code is to be used per control count file.	Text	varchar	6	100%	Required
3	CC002	File Type	FileType Values: DNT – Dental claims	Text	char	3	100%	Required
4	CC003	Submission Type	Submission Type Values: M = Monthly Q = Quarterly Y = Yearly O = Other	Text	char	1	100%	Required
5	CC004	UniqueMemberID	Count of distinct values in carrier specific unique member id for file type (DC056).	Integer	unsigned int	25	100%	Required
6	CC005	UniqueSubscriberID	Count of distinct values in carrier specific unique subscriber id for file type (DC057).	Integer	unsigned int	25	100%	Required
7	CC011	UniqueClaimNumber	Count of distinct values in the claim number field (DC004).	Integer	unsigned int	25	100%	Required
8	CC012	UniqueClaimNumberClaimLine	Count of distinct values in the claim number + claim line field (DC004 + DC005).	Integer	unsigned int	25	100%	Required
9	CC013	UniqueServiceProviderNPI	Count of distinct values in the service provider NPI field (DC020).	Integer	unsigned int	25	100%	Required
10	CC014	UniqueServiceProviderEIN	Count of distinct values in the Service Provider EIN field (DC019).	Integer	unsigned int	25	100%	Required

Control Count Record Layout – Provider Data

ID	Data Element ID	Data Element	Data Element Description	Type	Format	Length	Threshold	Required
1	CH	CH	Record Prefix Place the value CD in the Control Count data detail record.	Text	char	2	100%	Required
2	CC001	Submitter	- Code representing entity submitting data. The entity could be the carrier administering fully insured plans, third party administrator (TPA) administered plans, or pharmacy benefit manager (PBM) administered plans. - Use 5 to 6 alphanumeric entity code provided by Arkansas APCD team assigned in registration process (see the File Naming Convention section). - Must match entity code in the file name. - Must match HD001 and TR001 in the file name specified in CC002. - Only one entity code is to be used per control count file.	Text	varchar	6	100%	Required
3	CC002	File Type	FileType Values: PRV – Provider Data	Text	char	3	100%	Required
4	CC003	Submission Type	Submission Type Values: M = Monthly Q = Quarterly Y = Yearly O = Other	Text	char	1	100%	Required
5	CC013	UniqueServiceProviderNPI	Count of distinct values in the service provider NPI field (PV023).	Integer	unsigned int	25	100%	Required
6	CC014	UniqueServiceProviderEIN	Count of distinct values in the Service Provider EIN field (PV002).	Integer	unsigned int	25	100%	Required
7	CC015	UniqueServiceProviderID	Count of distinct values in the Service Provider ID field (PV001).	Integer	unsigned int	25	100%	Required
8	CC018	ProviderOfficeState	Count of distinct values in the provider office state field (PV011).	Integer	unsigned int	25	100%	Required
9	CC019	ProviderOfficeZIPCode	Count of distinct values in the provider office ZIP Code field (PV012).	Integer	unsigned int	25	100%	Required

Control Count Record Layout – Lookup File Data

ID	Data Element ID	Data Element	Data Element Description	Type	Format	Length	Threshold	Required
1	CH	CH	Record Prefix Place the value CD in the Control Count data detail record.	Text	char	2	100%	Required
2	CC001	Submitter	- Code representing entity submitting data. The entity could be the carrier administering fully insured plans, third party administrator (TPA) administered plans, or pharmacy benefit manager (PBM) administered plans. - Use 5 to 6 alphanumeric entity code provided by Arkansas APCD team assigned during registration process (see File Naming Convention section). - Must match entity code in the file name. - Must match HD001 and TR001 in the file name specified in CC002. - Only one entity code is to be used per control count file.	Text	varchar	6	100%	Required
3	CC002	File Type	FileType Values: LU – Provider Data	Text	char	3	100%	Required
4	CC003	Submission Type	Submission Type Values: M = Monthly Q = Quarterly Y = Yearly O = Other	Text	char	1	100%	Required
5	CC020	UniqueLookupValue	Count of distinct values in the Lookup value field (LU001).	Integer	unsigned int	25	100%	Required

Control Count Record Layout – Supplemental Payment File Data

ID	Data Element ID	Data Element	Data Element Description	Type	Format	Length	Threshold	Required
1	CH	CH	Record Prefix Place the value CD in the Control Count data detail record.	Text	char	2	100%	Required
2	CC001	Submitter	- Code representing entity submitting data. The entity could be the carrier administering fully insured plans, third party administrator (TPA) administered plans, or pharmacy benefit manager (PBM) administered plans. - Use 5 to 6 alphanumeric entity code provided by Arkansas APCD team assigned during registration process (see the File Naming Convention section). - Must match entity code in the file name. - Must match HD001 and TR001 in the file name specified in CC002. - Only one entity code is to be used per control count file.	Text	varchar	6	100%	Required
3	CC002	File Type	FileType Values: SP – Supplemental Payment	Text	char	3	100%	Required
4	CC003	Submission Type	Submission Type Values: M = Monthly Q = Quarterly Y = Yearly O = Other	Text	char	1	100%	Required
Remaining control count data elements dependent upon source field availability.								

Control Count Record Layout – Pharmacy Benefits Manager Claim Data

ID	Data Element ID	Data Element	Data Element Description	Type	Format	Length	Threshold	Required
1	CH	CH	Record Prefix Place the value CD in the Control Count data detail record.	Text	char	2	100%	Required
2	CC001	Submitter	- Code representing entity submitting data. The entity could be the carrier administering fully insured plans, third party administrator (TPA) administered plans, or pharmacy benefit manager (PBM) administered plans. - Use 5 to 6 alphanumeric entity code provided by Arkansas APCD team assigned during registration process (see the File Naming Convention section). - Must match entity code in the file name. - Must match HD001 and TR001 in the file name specified in CC002. - Only one entity code is to be used per control count file.	Text	varchar	6	100%	Required
3	CC002	File Type	FileType Values: PBM – Pharmacy Benefits Manager claims	Text	char	3	100%	Required
4	CC003	Submission Type	Submission Type Values: M = Monthly Q = Quarterly Y = Yearly O = Other	Text	char	1	100%	Required
5	CC004	UniqueMemberID	Count of distinct values in carrier specific unique member ID for file type (PB107).	Integer	unsigned int	25	100%	Required
6	CC005	UniqueSubscriberID	Count of distinct values in carrier specific unique subscriber ID for file type (PB108).	Integer	unsigned int	25	100%	Required
7	CC011	UniqueClaimNumber	Count of distinct values in the claim number field (PB004).	Integer	unsigned int	25	100%	Required
8	CC012	UniqueClaimNumberClaimLine	Count of distinct values in the claim number + claim line field (PB004 + PB005).	Integer	unsigned int	25	100%	Required
9	CC013	UniqueServiceProviderNPI	Count of distinct values in the service provider NPI field (PB021).	Integer	unsigned int	25	100%	Required
10	CC014	UniqueServiceProviderEIN	Count of distinct values in the service provider EIN field (PB019).	Integer	unsigned int	25	100%	Required
11	CC016	Unique NDC Code	Count of distinct values in the NDC code field (PB026).	Integer	unsigned int	25	100%	Required
12	CC017	UniquePrescriptionNumber	Count of distinct values in the prescription number field (PB058).	Integer	unsigned int	25	100%	Required

Trailer Records 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 entity submitting data. The entity could be the carrier administering fully insured plans, third party administrator (TPA) administered plans, or pharmacy benefit manager (PBM) administered plans. - Use 5 to 6 alphanumeric entity code provided by Arkansas APCD team assigned during registration process (see File Naming Convention section). - Must match entity code in the file name. - Must match HD001.	Text	varchar	6	100%
TR002	National Plan ID	Centers for Medicare & 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	30	0%
TR003	Type of File	MC = Medical Institutional & Professional Claims PC = Pharmacy Claims ME = Member Enrollment Data DC = Dental Claims PV = Medical/Dental/Pharmacy Provider Data LU = Lookup Table SP = Supplemental Files (Arkansas Medicaid only) PB = Pharmacy Benefits Manager Claims Must match HD003	Text	char	2	100%
TR004	Period Beginning Date	First date covered in submission period. Must match HD004. Submission periods begin on the first day of the first month of the coverage period. This value should not represent the first transaction date within the month.	Date	YYYY-MM-DD	10	100%
TR005	Period Ending Date	Last date covered in submission period. Must match ending coverage period date (YYYYMM) in file name. Must match HD005. Submission periods begin on the last day of the last month in the coverage period. This value should not represent the last transaction date within the month.	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%

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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.
- A Header Header, Header Data, Control Header, Control Data, Detail Data Header, Detail Data (when data is present), Trailer Header, and Trailer Data record must be included, in order, with this file submission. *See example below.*
- The Member Enrollment control count data layout is found in Control Count Record Layout – Member Data.
- Use values in Data Element ID column as column names for the Detail Data Header Record.
- If a value is not present for Date, Integer, or Numeric 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 will be required.
- If a date value is unavailable, leave NULL. Do not insert system default date. If a default date is encountered, the file will fail data submission validation. Dates older than 1910-01-01 will be flagged for further review.

Member Data Submission Example (DH and DD are shortened for example)

Category	Record Type	Example
Header	Header Header	HH|HD001|HD002|HD003|HD004|HD005|HD006|HD007|HD008|HD009|HD010
	Header Data	HD|28362||ME|2015-01-01|2015-02-01|1|1|1|8.0.2022|PROD
Control Count	Control Header	CH|CC001|CC002|CC003|CC004|CC005|CC006|CC007|CC008|CC009|CC010
	Control Data	CD|28362|ELG|M|17|2|657|15|57|78|62
Data	Detail Data Header	DH|ME999|ME001|ME002|ME003|ME006|ME016|ME107|ME998
	Detail Data	DD|1|28362|432|CI|36203AB1|AR|12092284|Coi2/dIonwFxhuW2O33xyGm+Gu683foEFupDMUeBnuo=
Trailer	Trailer Header	TH|TR001|TR002|TR003|TR004|TR005|TR006|TR007
	Trailer Data	TD|28362||ME|2015-01-01|2015-02-01|2015-03-01|2015-04-01

Reminder: You must include the DH record before the DD rows in the submitted file.

Member Detail Data Table Layout

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	15	100%	Required
3	ME001	Submitter	- Code representing entity submitting data. The entity could be the carrier administering fully insured plans, third party administrator (TPA) administered plans, or pharmacy benefit manager (PBM) administered plans. - Use the 5 to 6 alphanumeric entity code provided by Arkansas APCD team assigned during registration process (see the File Naming Convention section). - Must match entity code in the file name. - Must match HD001 and TR001.	Text	varchar	6	100%	Required
4	ME002	National Plan ID	Centers for Medicare & 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. See Appendix A – Insurance Type/Product Code.	Text	varchar	6	99%	Required
6	ME006	Insured Group or Policy Number	The alphanumeric group or policy number is associated with the entity that has purchased the insurance. For self-funded plans this relates to the employer paying for claims where the carrier acts as TPA. For the majority of enrollment and claims data the group relates to the employer.	Text	varchar	30	99%	Required
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	Text	char	3	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			IND = Individual SPC = Spouse and Children SPO = Spouse Only OTH = Other					
8	ME009	Plan Specific Contract Number	Submitting entity's assigned contract number for the subscriber. Set as NULL if unavailable. Set as NULL if contract number is the subscriber's social security number.	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 one is 001, the value for person two is 002, etc.). This value does not have to be in the this format (001, 002, etc.) if the claims system numbers members differently.	Integer	int	10	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 Appendix K – External Sources.	Text	char	2	100%	Required
14	ME017	Member ZIP Code	Report the 5- or 9-digit ZIP code of the member's residence. When submitting the 9-digit ZIP code do not include hyphen. If using 5 digits, *do not* fill last 4 digits with zeros. See Appendix K – External Sources.	Integer	varchar	9	99%	Required
15	ME018	Medical Services Indicator	Medical Coverage provided for this member on this policy. 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Integer	unsigned int	1	100%	Required
16	ME019	Pharmacy Services Indicator	Pharmacy coverage provided for this member on this policy. 1 = Yes 2 = No 3 = Unknown	Integer	unsigned int	1	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			4 = Other 5 = Not Applicable					
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%	Required
18	ME021	Member Race 1	Member's self-disclosed primary race. See Appendix H – Race.	Text	char	6	90%	Required
19	ME022	Member Race 2	Member's self-disclosed secondary race. See Appendix H – Race.	Text	char	6	50%	Required
20	ME025	Member Ethnicity 1	Member's primary ethnicity. See Appendix I – Ethnicity.	Text	varchar	2	90%	Required
21	ME026	Member Ethnicity 2	Member's secondary ethnicity. See Appendix I – Ethnicity.	Text	varchar	2	50%	Required
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) LRG = Large Employer/Group SMG = Small Group/Employer FGP = Federal Government Plan GPL = State Government Plan See Appendix L – Plan and Group Definitions.	Text	varchar	4	100%	Required
24	ME032	Group Name	Name of the group under which the member is covered. If an individual plan, populate with the value INDIV.	Text	varchar	128	99%	Required
25	ME033	Member language preference	Member's self-disclosed verbal language preference based on the ISO 639-3: 2007 code set. See Appendix G – Language.	Text	char	3	75%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			This reference does not include a value for 'Other' or 'Unknown'. Use the following values if the value cannot be found in the required reference: OTHR – Other language UNKN – Unknown					
26	ME034	Medical 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. Alphanumeric characters only—omit spaces and hyphens.	Text	varchar	15	25%	Required
27	ME035	Medical Home National Provider ID	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. See Appendix K – External Sources.	Integer	char	10	25%	Required
28	ME036	Medical 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	25%	Required
29	ME040	Product Identifier	Submitter-assigned product identifier for type of coverage/product purchased. NOTE: As of March 31, 2022, this field will also contain the Arkansas Medicaid Federal Aid Category Code.	Text	varchar	30	99%	Required
30	ME045	Exchange Offering	Identifies if policy was purchased through the Arkansas Health Insurance Exchange (HIE). Y = Commercial, large, small, or non-group purchased through the Exchange. N = Commercial, large, small, or non-group purchased outside the Exchange. U = Not applicable (plan/product is not offered in the commercial, large, small, or non-group market).	Text	char	1	100%	Required
31	ME046	Member PCP National Provider ID	The NPI of the member's primary care physician (PCP).	Integer	char	10	60%	Required
32	ME047	Member PCP Effective Date	PCP effective date with member.	Date	YYYY-MM-DD	10	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
33	ME048	Member PCP Termination Date	Date member terminated PCP association.	Date	YYYY-MM-DD	10	0%	Optional
34	ME049	Member Deductible	Annual maximum member deductible for benefit type represented by member record. 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 from member deductible (ME049). 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	Member's employment status. A = Active I = Involuntary Leave P = Pending R = Retiree S = Student Z = Unemployed U = Unknown	Text	char	1	100%	Required
40	ME062	Marital Status	Subscriber's marital status. S = Single D = Divorced M = Married P = Domestic Partnership N = Never Married	Text	char	1	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			W = Widowed X = Legally Separated U = Unknown					
41	ME063	Benefit Status	Code that defines status of benefits for the member. A = Active C = COBRA R = Retiree U = Unknown	Text	char	1	100%	Required
42	ME065	Retirement Date	Date subscriber retired.put	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 Appendix K – External Sources.	Text	char	4	0%	Optional
45	ME078	Employer Location ZIP Code	Report the 5- or 9-digit ZIP code of the member's employer's location. When submitting the 9-digit ZIP code do not include hyphen. If using 5 digits, *do not* fill last 4 digits with zeros. See Appendix K – External Sources.	Integer	varchar	9	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. Alphanumeric characters only—omit spaces and hyphens.	Text	vvarchar	15	50%	Required
48	ME107	Carrier Specific Unique Member ID	Member's unique ID. Value should be masked prior to submission to the APCD. Masking should be consistent across time so the masked value representing the Member ID does not change. Masking criteria should be determined by submitting entity.	Text	varchar	128	100%	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

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
50	ME110	Subscriber ZIP Code of Residence	Report the 5- or 9-digit ZIP code of the subscriber's residence. When submitting the 9-digit ZIP code do not include hyphen. If using 5 digits, *do not* fill last 4 digits with zeros. See Appendix K – External Sources.	Integer	varchar	9	99%	Required
51	ME112	Pharmacy Deductible	Annual maximum 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 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	The subscriber's unique ID. Value should be masked prior to submission to the APCD. Masking should be consistent across time so the masked value representing the Subscriber ID does not change. Masking criteria should be determined by submitting entity.	Text	varchar	128	100%	Required
54	ME120	Actuarial Value	Actuarial Value represented as a percentage of a grandfathered plan. Use in conjunction with ME122 – Grandfather Status. 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: http://cciio.cms.gov/resources/regulations/index.html	Numeric	±decimal	6,4	100%	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
56	ME122	Grandfather Status	See definition of "grandfathered plans" in HHS rules CFR 147.140.	Text	char	1	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			Y = Yes (if ME030 = IND, SMG) N = No/Not Applicable O = Other T = Transitional (to regain grandfathered status) Required as of January 1, 2014, for small group and non-group (individual) plans sold inside or outside the Exchange.					
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 NULL if unavailable. NPI preferred, else system provider ID.	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's gender. M = Male F = Female U = Unknown	Text	char	1	100%	Required
62	ME153A	Subscriber County	County FIPS Code of subscriber's residence. See Appendix K – External Sources.	Text	varchar	25	50%	Required
63	ME154A	Subscriber Race 1	Primary race of subscriber. See Appendix H – Race.	Text	char	6	90%	Required
64	ME155A	Subscriber Race 2	Secondary race of subscriber. See Appendix H – Race.	Text	char	6	50%	Required
65	ME156A	Subscriber Ethnicity 1	Primary ethnicity of subscriber. See Appendix I – Ethnicity.	Text	varchar	2	90%	Required
66	ME157A	Subscriber Language	Subscriber's self-disclosed verbal language preference based on the ISO 639-3: 2007 code set. See Appendix G – Language.	Text	char	3	50%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
67	ME161A	Consumer Directed Health Plan (CDHP)	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 that the member was initially enrolled in the plan, or the plan's effective date.	Date	YYYY-MM-DD	10	100%	Required
69	ME163A	Date of Disenrollment	End date of enrollment or plan term date for the member in plan. If plan is currently active, populate with 9999-12-31. The value in this field cannot be equal to or less than ME162A.	Date	YYYY-MM-DD	10	75%	Required
70	ME164A	Health Plan	Name of health plan.	Text	varchar	100	100%	Required
71	ME166A	Subscriber Ethnicity 2	Secondary ethnicity of subscriber. See Appendix I - Ethnicity.	Text	varchar	2	50%	Required
72	ME170A	Subscriber NAICS Code	Subscriber's industry description. See Appendix K - External Sources.	Text	varchar	6	0%	Optional
73	ME173A	Member County	County FIPS Code of member's residence. See Appendix K - External Sources.	Text	varchar	25	75%	Required
74	ME992	HIOS ID	A 16-byte identifier (CMS field name INSRNC_PLAN_ID) representing submitting entities within the Health Insurance Oversight System, the federal government's primary data collection vehicle for the health insurance 'Exchanges' Marketplaces. Required for submitting entities with HIOS IDs for the Arkansas Health Insurance Marketplace to replicate the HIOS ID data element for the member file. *Request exception if not applicable.* See Appendix N - HIOS ID Value Component Definitions.	Text	varchar	16	10%	Required
75	ME998	APCD Unique ID	Encrypted identifier representing member's 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 Submitted Data Encryption Requirements.	Text	varchar	100	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
76	ME107A	Carrier Specific Unique Member ID – Alias	Alias Member Unique ID. This field is used when submitting entity internal systems change, resulting in systemwide or sub-systemwide member ID changes. This field should contain the original member ID when this change happens. ME107 would contain the new member ID generated by the new system or sub-system. This field should be populated with the original member ID every time the member record is submitted thereafter.	Text	varchar	128	0%	Optional
77	ME117A	Carrier Specific Unique Subscriber ID – Alias	Alias Subscriber's Unique ID. This field is used when submitting entity internal systems change, resulting in systemwide or sub-systemwide subscriber ID changes. This field should contain the original subscriber ID when this change happens. ME117 would contain the new subscriber ID generated by the new system or sub-system. This field should be populated with the original subscriber ID every time the member record is submitted thereafter.	Text	varchar	128	0%	Optional
78	ME024	Member Hispanic Indicator	Indicator represents member's Hispanic origin. Y = Member is Hispanic/Latino/Spanish N= Member is not Hispanic/Latino/Spanish U = Unknown/not specified. The code value "U" for unknown, should be used ONLY when member answers unknown, or refuses to answer X – data is not available	Text	char	1	100%	Required
79	ME159A	Subscriber Hispanic Indicator	Indicator represents subscriber's Hispanic origin. Y = Subscriber is Hispanic/Latino/Spanish N= Subscriber is not Hispanic/Latino/Spanish U = Unknown/not specified. The code value "U" for unknown, should be used ONLY when subscriber answers unknown, or refuses to answer X – data is not available	Text	char	1	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
80	ME910	Medicaid AID Category	For Arkansas Medicaid claims only. Provide the primary Medicaid State Aid Category code for the member. If not applicable, leave blank	Text	char	2	100% when ME001 = '99MCD1'	Required
81	ME850	Placeholder1	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
82	ME851	Placeholder2	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
83	ME852	Placeholder3	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
84	ME853	Placeholder4	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
85	ME854	Placeholder5	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
86	ME993	System ID	System ID. This field represents the submitting entity internal system from which data is sourced. **The default value is 0**, representing the initial system from which the data is pulled. Place the value 0 on all records initially. If a system changes, increase the value by increments of 1. For example, if a system changes, the value would change from 0 to 1. If it changes again, the value would change from 1 to 2. This ID represents the system at the record level. Some submitting entities combine data from multiple systems into a single submission. If one of these systems changes, the system ID would be incremented on the records from the changed system. The system ID on the remaining records would not change. If the system changes, resulting in member ID and subscriber ID changes, utilize the Alias fields to capture new and previous member and subscriber IDs for continuity.	Integer	unsigned int	1	100%	Required

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Medical Claims 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.
- A Header Header, Header Data, Control Header, Control Data, Detail Data Header, Detail Data (when data is present), Trailer Header, and Trailer Data record must be included, in order, with this file submission. *See example below.*
- The Medical Claim Data control count data layout is found in Control Count Record Layout – Medical Claim Data.
- Use values in the Data Element ID column as column names for the Detail Data Header Record.
- If a value is not present for Date, Integer, or Numeric 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 will be required.
- If a date value is unavailable, leave NULL. Do not insert system default date. If a default date is encountered, the file will fail data submission validation. Dates older than 1910-01-01 will be flagged for further review.

Medical Claim Submission Example (DH and DD are shortened for example)

Category	Record Type	Example
Header	Header Header	HH|HD001|HD002|HD003|HD004|HD005|HD006|HD007|HD008|HD009|HD010
	Header Data	HD|28362||MC|2015-01-01|2015-02-01|1|1|1|8.0.2022|PROD
Control Count	Control Header	CH|CC001|CC002|CC003|CC004|CC005|CC011|CC012|CC013|CC014|CC015
	Control Data	CD|28362|CLM|M|8923|9602|62221|63|34723|926623|3436
Data	Detail Data Header	DH|MC999|MC001|MC002|MC003|MC004|MC005|MC137|MC141
	Detail Data	DD|1|28362|432|CI|36203AB1|1|120922d84|120683S7a
Trailer	Trailer Header	TH|TR001|TR002|TR003|TR004|TR005|TR006|TR007
	Trailer Data	TD|28362||MC|2015-01-01|2015-02-01|2015-03-01|2015-04-01

Reminder: You must include the DH record before the DD rows in the submitted file.

Medical Claims Data Table Layout

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	15	100%	Required
3	MC001	Submitter	- Code representing entity submitting data. The entity could be the carrier administering fully insured plans, third party administrator (TPA) administered plans, or pharmacy benefit manager (PBM) administered plans. - Use the 5 to 6 alphanumeric entity code provided by Arkansas APCD team assigned during registration process (see the File Naming Convention section). - Must match entity code in the file name. - Must match HD001 and TR001.	Text	varchar	6	100%	Required
4	MC002	National Plan ID	Centers for Medicare & 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	MC003	Insurance Type/Product Code	Insurance type or product identification code that indicates the individual's type of insurance coverage. See Appendix A - Insurance Type/Product Code.	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
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 or claim service line. This value can be assigned independently in the claims system or it can be extracted from the claim number.	Integer	int	35	100% if MC706 = 1 or custom approach	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			The dependency for this field may change depending on the version approach selected. These changes will be handled with the exception process. If not applicable to the versioning process, request an exception. See Exhibit C – APCD Claims Versioning.				requiring version number	
9	MC005B	Version Number Date	Value representing the latest version of the claim. Values must be a Julian date (YYDDD) with 2-digit year and 3-digit day (e.g., January 15, 2016 = 16015) The dependency for this field may change depending on the version approach selected. These changes will be handled with the exception process. If not applicable to the versioning process, request an exception. See Exhibit C – APCD Claims Versioning.	Integer	char	5	100% if MC706 = 2	Required
10	MC006	Insured Group or Policy Number	The alphanumeric group or policy number is associated with the entity that has purchased the insurance. For self-funded plans this relates to the employer paying for claims where the carrier acts as TPA. For the majority of enrollment 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 NULL if unavailable. Set as NULL if contract number is the subscriber's social security number	Text	varchar	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 one is 001, the value for person two is 002, etc.). This value does not have to be in the this format (001, 002, etc.) if the claims system numbers members differently.	Integer	int	10	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
16	MC015	Member State or Province	State or province of member's residence. See Appendix K - External Sources.	Text	char	2	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
17	MC016	Member ZIP Code	Report the 5- or 9-digit ZIP code of the member's residence. When submitting the 9-digit ZIP code do not include hyphen. If using 5 digits, *do not* fill last 4 digits with zeros. See Appendix K - External Sources.	Integer	varchar	9	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 MC036 begins with 11, 12 and MC094 = 002	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. Example: 4 p.m. would be reported as 1600.	Integer	char	4	100% if MC036 begins with 11, 12 and MC094 = 002	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 MC036 begins with 11, 12 and MC094 = 002	Required
22	MC022	Discharge Hour	Hour the inpatient was discharged from the hospital. Time is expressed in military time – HHMM. If only the hour is known, code the minutes as 00. Example: 4 p.m. would be reported as 1600.	Integer	char	4	100% if MC036 begins with 11, 12 and MC094 = 002	Required
23	MC023	Final Discharge Status	Final status for the patient discharged from the institution. See Appendix C - Discharge Status.	Integer	char	2	100% if MC094 = 002	Required
24	MC024	Service Provider Number	Submitting entity's assigned or legacy ID identifying the entity or service/rendering provider directly providing the service - submitting facility for institutional claims, physician or healthcare professional for professional claims. This is the identifier used by the submitter for internal identification purposes, and does not routinely change. Must correspond to Provider ID (PV001) in the Provider File. If not applicable, leave NULL.	Text	varchar	30	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
25	MC025	Service Provider EIN/Federal Tax ID Number	Federal taxpayer'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. Alphanumeric characters only — omit spaces and hyphens	Text	varchar	15	0%	Optional
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 NULL. Do not populate with associated servicing organization NPI (MC134).	Integer	char	10	100%	Required
27	MC027	Service Provider Entity Type Qualifier	Flag identifying Service Provider NPI as person or non-person/facility. Use 2 if the provider cannot be identified as an individual provider. Values: 1 = Person 2 = Non-Person entity	Integer	unsigned int	1	90%	Required
28	MC028	Service Provider First Name	Service provider's first name. This field should contain first name only. Middle names or middle initials should be in the Service Provider Middle Name field (MC029).	Text	varchar	25	50%	Required
29	MC029	Service Provider Middle Name	Service provider's middle name.	Text	varchar	25	5%	Required
30	MC030	Service Provider Last Name or Organization Name	Service provider's last name. If not individual, place organization name in this field. When the provider is an individual, this field should contain last name only. Suffixes should be in the Service Provider Suffix field (MC031).	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). **Do not code the clinician's credentials (e.g., MD, LCSW) in this field.** Set to NULL if the provider is a facility or an organization.	Text	varchar	10	5%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
32	MC032	Service Provider Specialty	Code defining provider specialty. Provide lookup tables for every field containing non-standard codes. Not required if CMS Specialty codes are used.	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 Sources.	Text	char	2	90%	Required
35	MC035	Service Provider ZIP Code	Report the 5- or 9-digit ZIP code of the servicing provider's address, preferably the practice location. When submitting the 9-digit ZIP code do not include hyphen. If using 5 digits, *do not* fill last 4 digits with zeros. See Appendix K - External Sources.	Integer	varchar	9	90%	Required
36	MC036	Type of Bill - Institutional	Bill type for institutional claims. Set to NULL for professional claims. See Appendix D - Type of Bill.	Text	char	3	100% if MC094 = 002	Required
37	MC037	Facility Type	This field records the type of facility where the service was performed. See Appendix E - Facility Type/Place.	Integer	unsigned int	2	100%	Required
38	MC038	Coordination of Benefits (COB) 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)	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 institution admission. Decimal point is not coded. See Appendix K - External Sources.	Text	varchar	7	100% if MC094 = 002	Required
41	MC040	Accident Code	This field describes an injury, poisoning, or adverse effect using an ICD-9-CM E-code or ICD-10-CM V, W, X, Y code diagnoses. Decimal point is not coded. Additional E-Codes may be reported	Text	varchar	7	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			in other diagnosis fields MC041–MC053. See Appendix K - External Sources.					
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 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. See Appendix K - External Sources.	Text	varchar	7	50%	Required
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 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 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 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 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 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 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 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 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 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 Sources.	Text	varchar	7	<1%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	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 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. Leading zeros required for values.	Text	char	4	100% if MC094 = 002	Required
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 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

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	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
61	MC058	Principal ICD-9-CM or ICD-10-CM Procedure Code	Principal institutional 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. See Appendix K - External Code Sources.	Text	varchar	7	55% MC094 = 002	Required
62	MC058A	Other ICD-9-CM or ICD-10-CM Procedure Code - 1	First secondary institutional 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	30% if MC094 = 002	Required
63	MC058B	Other ICD-9-CM or ICD-10-CM Procedure Code - 2	Second secondary institutional 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 Sources.	Text	varchar	7	15% if MC094 = 002	Required
64	MC058C	Other ICD-9-CM or ICD-10-CM Procedure Code - 3	Third secondary institutional 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 Sources.	Text	varchar	7	10% if MC094 = 002	Required
65	MC058D	Other ICD-9-CM or ICD-10-CM Procedure Code - 4	Fourth secondary institutional 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 Sources.	Text	varchar	7	5% if MC094 = 002	Required
66	MC058E	Other ICD-9-CM or ICD-10-CM Procedure Code - 5	Fifth secondary institutional 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 Sources.	Text	varchar	7	<1% if MC094 = 002	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
67	MC058EA	Other ICD-9-CM or ICD-10-CM Procedure Code - 6	Sixth secondary institutional 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 Sources.	Text	varchar	7	<1% if MC094 = 002	Required
68	MC058F	Other ICD-9-CM or ICD-10-CM Procedure Code - 7	Seventh secondary institutional 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 Sources.	Text	varchar	7	<1% if MC094 = 002	Required
69	MC058G	Other ICD-9-CM or ICD-10-CM Procedure Code - 8	Eighth secondary institutional 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 Sources.	Text	varchar	7	<1% if MC094 = 002	Required
70	MC058H	Other ICD-9-CM or ICD-10-CM Procedure Code - 9	Ninth secondary institutional 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 Sources.	Text	varchar	7	<1% if MC094 = 002	Required
71	MC058J	Other ICD-9-CM or ICD-10-CM Procedure Code - 10	Tenth secondary institutional 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 Sources.	Text	varchar	7	<1% MC094 = 002	Required
72	MC058K	Other ICD-9-CM or ICD-10-CM Procedure Code - 11	Eleventh secondary institutional 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 Sources.	Text	varchar	7	<1% if MC094 = 002	Required
73	MC058L	Other ICD-9-CM or ICD-10-CM Procedure Code - 12	Twelfth secondary institutional 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 Sources.	Text	varchar	7	<1% if MC094 = 002	Required
74	MC059	Date of Service - From	First date of service for this service line.	Date	YYYY-MM-DD	10	100%	Required
75	MC060	Date of Service - Thru	Last date of service for this service line. **Future dates are acceptable.**	Date	YYYY-MM-DD	10	100%	Required
76	MC061	Quantity	Count of services rendered.	Integer	int	4	100%	Required
77	MC062	Charge Amount	Total charges for the service as reported by the provider to the insurance 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	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			If this field is changed in the versioning process and the dollars must be voided or backed out, value should be represented as a negative.					
78	MC063	Paid Amount	Amount paid by the submitting entity/insurance carrier 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. If this field is changed in the versioning process and the dollars must be voided or backed out, value should be represented as a negative.	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 all lines of the claim with H. Put the payment on the header record and populate the paid amount on each line after the first line $0.00. 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. If no amount withheld, populate with $0.00. 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	99%	Required
81	MC064	Capitation Amount	Fee for service equivalent that would have been paid by the healthcare 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. If record does not meet the dependency, do not populate with $0.00. Leave NULL. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	100% if MC206 = Y	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	99%	Required
83	MC066	Coinsurance Amount	Defines a calculated percentage amount for the claim line service that the individual 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	99%	Required
84	MC067	Deductible Amount	Amount that defines a preset, fixed amount for this claim line service that the individual is responsible to pay. Report $0.00 if no deductible applies to 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	99%	Required
85	MC068	Patient Account/Control Number	Identifying number assigned by hospital/facility.	Text	varchar	20	100%	Required
86	MC069	Discharge Date	Date patient discharged. Required for all inpatient claims.	Date	YYYY-MM-DD	10	100% if MC036 begins with 11, 12 and MC094 = 002	Required
87	MC070	Service Provider Country Code	Country code of the Service Provider. Use 3-digit ISO Country Codes. See Appendix K - External Sources.	integer	unsigned int	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 MC036 begins with 11, 12 and MC094 = 002	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	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 healthcare claims processors shall code using CMS methodology.	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 as part of a medical claim or when a DME device has an NDC code. J codes should be submitted under procedure code (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.	Text	varchar	11	0%	Optional
93	MC076	Billing Provider Number	Submitting entity's assigned or legacy ID identifying the provider responsible for billing the service rendered. This is the identifier used by the submitter for internal identification purposes, and does not routinely change. Must correspond to Provider ID (PV001) in the Provider File. If not applicable, leave NULL.	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. When the provider is an individual, this field should contain last name only. Suffixes should be in the Billing Provider Suffix field (MC213).	Text	varchar	100	100%	Required
96	MC079	Diagnosis Code Pointer - 1	Number indicating order of relevance for Primary Diagnosis code for claims filed using CMS 1500 form. For example, if Primary Diagnosis code is the most relevant diagnosis on the claim line, the value in Diagnosis Code Pointer 1 becomes 1 or A. However, if Other Diagnosis Code 2 is the most relevant and the Primary Diagnosis code becomes secondary, the value in Diagnosis Code Pointer 1 becomes 2 or B.	Text	varchar	4	25%	Required
97	MC080	Diagnosis Code Pointer - 2	Number indicating order of relevant for Other Diagnosis Code 1 for claims filed using CMS 1500 form. For example, if Other Diagnosis code 2 becomes the most relevant diagnosis on the claim line, the value in Diagnosis Code Pointer 2 becomes 1 or A.	Text	varchar	4	10%	Required
98	MC081	Diagnosis Code Pointer - 3	Number indicating order of relevance for Other Diagnosis Code 2 for claims filed using CMS 1500 form. For example, if Other	Text	varchar	4	<1%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			Diagnosis code 2 becomes the most relevant diagnosis on the claim line, the value in Diagnosis Code Pointer 3 becomes 1 or A.					
99	MC082	Diagnosis Code Pointer - 4	Number indicating order of relevance for Other Diagnosis Code 3 for claims using CMS 1500 form. For example, if Other Diagnosis code 3 becomes the most relevant diagnosis on the claim line, the value in Diagnosis Code Pointer 4 becomes 1 or A.	Text	varchar	4	<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. Alphanumeric 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
102	MC092	Covered Days	Covered institutional days. Report the number of covered days the patient incurred during this admission. Report at the claim header level if billing by DRG, episode, or other grouped services. Otherwise report at the claim line level.	Integer	unsigned int	4	100% if MC094 = 002	Required
103	MC093	Non-Covered Days	Non-covered inpatient days. Report the number of non-covered days the patient incurred during this admission. Report at the claim header level if billing by DRG, episode, or other grouped services. Otherwise report at the claim line level.	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 **due** from a secondary carrier. Report the amount that another payer is liable for after submitting payer has processed this 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	10%	Required
106	MC098	Allowed Amount	Maximum amount allowed and that an insurance carrier will pay to a provider 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

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.					
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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	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	Date claim is processed.	Date	YYYY-MM-DD	10	99%	Required
110	MC112	Referring National Provider ID	Referring provider's NPI number.	Integer	char	10	50%	Required
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 09 = Payment Amount Per Episode	Integer	char	2	100%	Required
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	The APR Diagnostic Related Group code severity level. 1 = Minor 2 = Moderate 3 = Major 4 = Extreme	Integer	unsigned int	1	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
114	MC121	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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	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
118	MC131	In Network Indicator	Network rate applied indicator. 1 = Yes, in network 2 = No, out of network	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 Sources.	Text	varchar	7	0%	Optional
121	MC137	Carrier Specific Unique Member ID	Member's unique ID. Value should be masked prior to submission to the APCD. Masking should be consistent across time so the masked value	Text	varchar	128	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			representing the Member ID does not change. Masking criteria should be determined by submitting entity.					
122	MC138	Claim Status	Status of the claim header or claim line. O = Original A = Adjusted – data on claim has been changed* B = Back Out/Reversal – record aligns with existing record that is no longer valid, nullifying the claim line's associated information. Dollars should be represented as negative. An adjustment, amendment, or replacement claim is expected to replace claim. D = Delete/Drop – claim line will be dropped from data. Negative dollar values are preferred. M = Amendment – data on claim has been changed.* R = Replacement – data on claim has been changed.* V = Void – record aligns with existing record that is incorrect and should not be used. Dollars should be represented as negative. F = Final – Status for paid claims (use when versioning process does not require claim status to identify final claim). Use as default. *These values have the same meaning. The values differ to align with submitting entity claims systems in an effort to reduce submitting entity data transformation.	Text	char	1	100%	Required
123	MC139	Original Claim Number	Original Claim Number. Report the Claim Control Number (MC004) that was originally sent in a prior filing to which this line corresponds. When reported, this data cannot equal its own MC004. If this field is not used for versioning, submit an exception to set the required threshold to 0.	Text	varchar	35	10%	Required
124	MC141	Carrier Specific Unique Subscriber ID	Subscriber's unique ID. Value should be masked prior to submission to the APCD. Masking should be consistent across time so the masked value representing the Subscriber ID does not change. Masking criteria should be determined by submitting entity.	Text	varchar	128	100%	Required
125	MC154	Present on Admission Code (POA) Primary	Code indicating the primary diagnosis was present at the time of admission. 1 = Exempt from POA reporting (use if POA reporting is not required by carrier)	Text	char	1	50% if MC094 = 002 and MC041 <> NULL	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			3 = Unknown N = Other Diagnosis was not present at time of institutional admission U = Documentation insufficient to determine if condition was present at time of institutional admission W = Clinically undetermined Y = Diagnosis was present at time of institutional admission					
126	MC155	Present on Admission Code – (POA) - 01	Code indicating the presence of Other Diagnosis - 1 at the time of admission. 1 = Exempt from POA reporting (use if POA reporting is not required by carrier) 3 = Unknown N = Other Diagnosis was not present at time of institutional admission U = Documentation insufficient to determine if condition was present at time of institutional admission W = Clinically undetermined Y = Diagnosis was present at time of institutional admission	Text	char	1	10% if MC094 = 002 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. 1 = Exempt from POA reporting (use if POA reporting is not required by carrier) 3 = Unknown N = Other Diagnosis was not present at time of institutional admission U = Documentation insufficient to determine if condition was present at time of institutional admission W = Clinically undetermined Y = Diagnosis was present at time of institutional admission	Text	char	1	10% if MC094 = 002 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. 1 = Exempt from POA reporting (use if POA reporting is not required by carrier) 3 = Unknown N = Other Diagnosis was not present at time of institutional admission U = Documentation insufficient to determine if condition was present at time of institutional admission W = Clinically undetermined Y = Diagnosis was present at time of institutional admission	Text	char	1	>1% if MC094 = 002 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. 1 = Exempt from POA reporting (use if POA reporting is not required by carrier) 3 = Unknown N = Other Diagnosis was not present at time of institutional admission U = Documentation insufficient to determine if condition was present at time of institutional admission W = Clinically undetermined Y = Diagnosis was present at time of institutional admission	Text	char	1	>1% if MC094 = 002 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. 1 = Exempt from POA reporting (use if POA reporting is not required by carrier) 3 = Unknown N = Other Diagnosis was not present at time of institutional admission U = Documentation insufficient to determine if condition was present at time of institutional admission W = Clinically undetermined Y = Diagnosis was present at time of institutional admission	Text	char	1	>1% if MC094 = 002 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. 1 = Exempt from POA reporting (use if POA reporting is not required by carrier) 3 = Unknown N = Other Diagnosis was not present at time of institutional admission U = Documentation insufficient to determine if condition was present at time of institutional admission W = Clinically undetermined Y = Diagnosis was present at time of institutional admission	Text	char	1	>1% if MC094 = 002 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. 1 = Exempt from POA reporting (use if POA reporting is not required by carrier) 3 = Unknown N = Other Diagnosis was not present at time of institutional admission U = Documentation insufficient to determine if condition was present at time of institutional admission W = Clinically undetermined Y = Diagnosis was present at time of institutional admission	Text	char	1	>1% if MC094 = 002 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. 1 = Exempt from POA reporting (use if POA reporting is not required by carrier) 3 = Unknown N = Other Diagnosis was not present at time of institutional admission U = Documentation insufficient to determine if condition was present at time of institutional admission W = Clinically undetermined Y = Diagnosis was present at time of institutional admission	Text	char	1	>1% if MC094 = 002 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. 1 = Exempt from POA reporting (use if POA reporting is not required by carrier) 3 = Unknown N = Other Diagnosis was not present at time of institutional admission U = Documentation insufficient to determine if condition was present at time of institutional admission W = Clinically undetermined Y = Diagnosis was present at time of institutional admission	Text	char	1	>1% if MC094 = 002 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. 1 = Exempt from POA reporting (use if POA reporting is not required by carrier) 3 = Unknown N = Other Diagnosis was not present at time of institutional admission U = Documentation insufficient to determine if condition was present at time of institutional admission W = Clinically undetermined Y = Diagnosis was present at time of institutional admission	Text	char	1	>1% if MC094 = 002 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. 1 = Exempt from POA reporting (use if POA reporting is not required by carrier) 3 = Unknown N = Other Diagnosis was not present at time of institutional admission U = Documentation insufficient to determine if condition was present at time of institutional admission W = Clinically undetermined Y = Diagnosis was present at time of institutional admission	Text	char	1	>1% if MC094 = 002 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. 1 = Exempt from POA reporting (use if POA reporting is not required by carrier) 3 = Unknown N = Other Diagnosis was not present at time of institutional admission U = Documentation insufficient to determine if condition was present at time of institutional admission W = Clinically undetermined Y = Diagnosis was present at time of institutional admission	Text	char	1	>1% if MC094 = 002 and MC053 <> NULL	Required
138	MC203	Billing Provider First Name	Billing provider first name. Set to NULL if provider is a facility or an organization. This field should contain first name only. Middle names or middle initials should be in the Billing Provider Middle Name field (MC204).	Text	varchar	25	100%	Required
139	MC204	Billing Provider Middle Name	Billing provider middle name. Set to NULL 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	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 Y = Services are paid under a capitated arrangement N = Services are not paid under a capitated arrangement U = Unknown	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	State or province of Billing provider's address. See Appendix K - External Sources.	Text	char	2	90%	Required
157	MC210	Billing Provider ZIP Code	Report the 5- or 9-digit ZIP code of the billing provider's address, preferably the practice location. When submitting the 9-digit ZIP code do not include hyphen. If using 5 digits, *do not* fill last 4 digits with zeros. See Appendix K - External Sources.	Integer	varchar	9	90%	Required
158	MC211	Billing Provider Country Code	Country of the Billing Provider. Use 3-digit ISO Country Codes. See Appendix K - External Sources.	Integer	unsigned int	3	100%	Required
159	MC212	Billing Provider Specialty	Code defining provider specialty. Provide lookup tables for every field containing non-standard codes. Not required if CMS specialty codes are used.	Text	varchar	10	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
160	MC213	Billing Provider Suffix	Billing 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 NULL 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 The value in this field will be used in determining the code set to validate ICD diagnosis and procedure codes (e.g., MC041, MC042, MC058, etc.). The ICD columns will fail validation if the values do match the code set specified by the ICD indicator flag.	Integer	unsigned int	1	100%	Required
163	MC986	Subscriber State	State or province of subscriber's residence. See Appendix K - External Code Sources.	Text	char	2	100%	Required
164	MC987	Subscriber ZIP Code	Report the 5- or 9-digit ZIP code of the subscriber's residence. When submitting the 9-digit ZIP code do not include hyphen. If using 5 digits, *do not* fill last 4 digits with zeros.. See Appendix K - External Code Sources.	Integer	varchar	9	100%	Required
165	MC990	Subscriber Date of Birth	Subscriber's date of birth.	Date	YYYY-MM-DD	10	100%	Required
166	MC992	HIOS ID	The 16-byte identifier (CMS field name INSRNC_PLAN_ID) representing submitting entities 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. See Appendix N - HIOS ID Value Component Definitions.	Text	varchar	16	99%	Required
167	MC991	Subscriber Gender	Gender of the subscriber. M = Male F = Female U = Unknown	Text	char	1	100%	Required
168	MC700	Void Date	Date representing the date the claim or claim line was voided. Used for Versioning process.	Date	YYYY-MM-DD	10	5%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			Void Date must be greater than or equal to MC017, Paid Date. *If this field is not used for versioning, submit an exception to set the required threshold to 0.*					
169	MC701	Source/Processing System Identifier	Code or name identifying claims processing system upon which the version process was executed. *If this field is not used for versioning, submit an exception to set the required threshold to 0.*	Text	varchar	15	10%	Required
170	MC702	Adjustment/ Amendment Date	If MC138 is A, date representing the date the claim or claim line was adjusted. Used for versioning process. If MC138 is M, date representing the date the claim or claim line was amended. Used for versioning process. *If this field is not used for versioning, submit an exception to set the required threshold to 0.*	Date	YYYY-MM-DD	10	100% if MC138 = M or A	Required
171	MC703	Adjudication Date	Date representing the date the claim or claim line was adjudicated. Used for versioning process. *If this field is not used for versioning, submit an exception to set the required threshold to 0.*	Date	YYYY-MM-DD	10	100% if MC138 = A, M, R, B	Required
172	MC130	Procedure Code Type	The value that defines the type of Procedure Code expected in MC055. 1 = CPT or HCPCS Level 1 Code 2 = HCPCS Level II Code 3 = HCPCS Level III Code (State Medicare code) 4 = American Dental Association (ADA) Procedure Code (also referred to as CDT code) 5 = CPT Category II 8 = Unknown (provide explanation describing why the code types are unknown prior to submission) 9 = None of the above	Integer	unsigned int	1	100% if MC055 is not NULL	Required
173	MC083	Diagnosis Code Pointer - 5	Number indicating order of relevance for Other Diagnosis Code 5 for claims filed using CMS 1500 form. For example, if Other Diagnosis Code 4 becomes the most relevant diagnosis on the claim line, the value in Diagnosis Code Pointer 5 becomes 1 or A.	Text	varchar	4	<1%	Required
174	MC084	Diagnosis Code Pointer - 6	Number indicating order of relevance for Other Diagnosis Code 6 for claims using CMS 1500 form. For example, if Other Diagnosis code 5 becomes the most relevant diagnosis on the claim line, the value in Diagnosis Code Pointer 6 becomes 1 or A.	Text	varchar	4	<1%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
175	MC706	Versioning Method	Identifies which of the versioning methods will be used for these data. *If no versioning process is applicable or available, populate with the value 8.* 1 = Versioning Approach 1 – Version Number 2 = Versioning Approach 2 – Version Date 3 = Versioning Approach 3 – Original Claim Number 4 = Versioning Approach 4 – Claim Status and Paid Date 5 = Versioning Approach 5 – Paid Date 6 = Versioning Approach 6 – Complete Replacement 7 = Versioning Approach 7 – Pharmacy 8 = Versioning Approach 8 – Not available Custom versioning processes will be assigned an entity specific Versioning Method number. See Exhibit C – APCD Claims Versioning.	Integer	unsigned int	3	100%	Required
176	MC707	Previous Claim Number	Claim number representing the claim from which the current claim was versioned. This is not the original claim number, although it could be if the claim was only versioned once. This field is required to accommodate custom versioning. If not required, leave NULL and request exception.	Text	varchar	35	35%	Required
177	MC117A	Carrier Specific Unique Member ID – Alias	Alias Member Unique ID This field is used when submitting entity internal systems change, resulting in systemwide or sub-systemwide member ID changes. This field should contain the original member ID as submitted to the Arkansas APCD when this change happens. MC137 would contain the new member ID generated by the new system or sub-system. This field should be populated with the original member ID every time the member record is submitted thereafter.	Text	varchar	128	0%	Optional
178	MC141A	Carrier Specific Unique Subscriber ID – Alias	Alias subscriber's unique ID. This field is used when submitting entity internal systems change, resulting in systemwide or sub-systemwide subscriber ID changes. This field should contain the original subscriber ID as submitted to the Arkansas APCD when this change happens. MC141 would contain the new subscriber ID generated by the new system or sub-system. This field should be populated with	Text	varchar	128	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			the original subscriber ID every time the member record is submitted thereafter.					
179	MC021	Point of Origin Code	This code indicates the source of the referral for an admission or visit. Required except for Bill Type 14X, (the bill type is used for non-patient laboratory specimens and the point of origin would not be known). See Appendix P - Point of Origin Codes	Text	char	1	100% when MC094 = 002 and MC036 does not begin with '14'	Required
180	MC910	Medicaid AID Category	For Arkansas Medicaid claims only. Provide the primary Medicaid Aid Category code for the member. If not applicable, leave empty.	Text	char	2	100% when MC001 = '99MCD1'	Required
181	MC966	Other Insurance Paid Amount	Amount already paid by another carrier. Report the amount that a prior payer has paid for this claim line. Indicates the submitting payer is not the primary payer. Only report "0" if the prior payer paid 0 toward this claim line; or if there is no prior payer. 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
182	MC850	Placeholder1	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
183	MC851	Placeholder2	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
184	MC852	Placeholder3	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
185	MC853	Placeholder4	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
186	MC854	Placeholder5	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
187	MC993	System ID	The system ID.	Integer	unsigned int	1	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			This field represents the submitting entity internal system from which data is sourced. **The default value is 0**, representing the initial system from which the data is pulled. Place the value 0 on all records initially. If a system changes, increase the value by increments of 1. For example, if a system changes, the value would change from 0 to 1. If it changes again, the value would change from 1 to 2. This ID represents the system at the record level. Some submitting entities combine data from multiple systems into a single submission. If one of these systems changes, the system ID would be incremented on the records from the changed system. The system ID on the remaining records would not change. If the system changes resulting in member ID and subscriber ID changes, utilize the Alias fields to capture new and previous member and subscriber IDs for continuity.					

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Pharmacy Claims 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
- A Header Header, Header Data, Control Header, Control Data, Detail Data Header, Detail Data (when data is present), Trailer Header, and Trailer Data record must be included in order with this file submission. *See example below.*
- The Pharmacy Claim Data control count data layout is found in Control Count Record Layout – Pharmacy Claims Data.
- Use values in Data Element ID column as column names for the Detail Data Header Record.
- If a value is not present for Date, Integer or Numeric 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 will be required.
- If a date value is unavailable, leave NULL. Do not insert system default date. If a default date is encountered, the file will fail data submission validation. Dates older than 1910-01-01 will be flagged for further review.

Pharmacy Claim Submission Example (DH and DD are shortened for example)

Category	Record Type	Example
Header	Header Header	HH|HD001|HD002|HD003|HD004|HD005|HD006|HD007|HD008|HD009|HD010
	Header Data	HD|28362||PC|2015-01-01|2015-02-01|1|1|1|8.0.2022|PROD
Control Count	Control Header	CH|CC001|CC002|CC003|CC004|CC005|CC011|CC012|CC013|CC014|CC016|CC017
	Control Data	CD|28362|PHM|M|7833|8578|685111|52|855523|892623|34236|69822
Data	Detail Data Header	DH|PC999|PC001|PC002|PC003|PC004|PC005|PC026|PC107
	Detail Data	DD|1|28362|432|CI|1948206101|1|2840286070482|120683S7a
Trailer	Trailer Header	TH|TR001|TR002|TR003|TR004|TR005|TR006|TR007
	Trailer Data	TD|28362||PC|2015-01-01|2015-02-01|2015-03-01|2015-04-01

Reminder: You must include the DH record before the DD rows in the submitted file.

Pharmacy Data Table Layout

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	15	100%	Required
3	PC001	Submitter	- Code representing entity submitting data. The entity could be the carrier administering fully insured plans, third party administrator (TPA) administered plans, or pharmacy benefit manager (PBM) administered plans. - Use the 5 to 6 alphanumeric entity code provided by Arkansas APCD team assigned during registration process (see File Naming Convention section). - Must match entity code in the file name. - Must match HD001 and TR001	Text	varchar	6	100%	Required
4	PC002	National Plan ID	Centers for Medicare & 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
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 or claim service line. This value can be assigned independently in the claims system or it can be extracted from the claim number. The dependency for this field may change depending on the version approach selected. These changes will be handled with	Integer	int	35	100% if PC706 = 1 or custom approach requiring	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			the exception process. If not applicable to the versioning process, request an exception. See Exhibit C – APCD Claims Versioning.				version number	
9	PC005B	Version Number Date	Value representing the latest version of the claim. Values can be YYMM or Julian date with 2-digit year and 3-digit day (e.g., January 15, 2016 = 16015) The dependency for this field may change depending on the version approach selected. These changes will be handled with the exception process. If not applicable to the versioning process, request an exception. See Exhibit C – APCD Claims Versioning.	Integer	char	5	100% if PC706 = 2	Required
10	PC006	Insured Group Number or Policy Number	The alphanumeric group or policy number is associated with the entity that has purchased the insurance. For self-funded plans this relates to the employer paying for claims where the carrier acts as TPA. 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	Submitting entity's assigned contract number for the subscriber. Set as NULL if unavailable. Set as NULL if contract number is the subscriber's social security number.	Text	varchar	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 one is 001, the value for person two is 002, etc.). This value does not have to be in the this format (001, 002, etc.) if the claims system numbers members differently.	Integer	int	10	99%	Required
13	PC011	Individual Relationship Code	Member's relationship to the subscriber or the insured. See Appendix B - Relationship Code.	Integer	char	2	99%	Required
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 Sources.	Text	char	2	99%	Required
17	PC016	Member ZIP Code	Report the 5- or 9-digit ZIP code of the subscriber's residence. When submitting the 9-digit ZIP code do not include hyphen. If using 5 digits, *do not* fill last 4 digits with zeros. Appendix K - External Sources.	Integer	varchar	9	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	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 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. Alphanumeric 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 services and prescribing providers. See Appendix K - External Sources.	Text	varchar	10	98%	Required
23	PC022	Pharmacy Location City	City of pharmacy location.	Text	varchar	30	98%	Required
24	PC023	Pharmacy Location State	State or province of pharmacy location. See Appendix K - External Sources.	Text	char	2	98%	Required
25	PC024	Pharmacy ZIP Code	Report the 5- or 9-digit ZIP code of the pharmacy's location. When submitting the 9-digit ZIP code do not include hyphen. If using 5 digits, *do not* fill last 4 digits with zeros.. See Appendix K - External Sources.	Integer	varchar	9	98%	Required
26	PC024A	Pharmacy Country Code	ISO Country Code of the pharmacy location. See Appendix K - External 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, 02 = second refill, 03 = third 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

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
31	PC030	Dispense as Written Code	Drug dispense code. 1 = Physician dispensed as written 2 = Member dispensed as written 3 = Pharmacy dispensed 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
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. Decimals and negative values accepted. Decimal point must be included in field, even when value is whole number.	Numeric	±decimal	18,6	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 pharmacy to the insurance 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
37	PC036	Paid Amount	Amount paid by the submitting entity/insurance carrier 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	99%	Required
38	PC037	Ingredient Cost/List Price	Amount defined as the pharmaceutical 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	99%	Required
40	PC040	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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	99%	Required
41	PC041	Coinsurance Amount	Amount that defines a calculated percentage amount for the claim line service that the individual is responsible for paying. 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
42	PC042	Deductible Amount	Amount that defines a preset, fixed amount for this claim line service that the individual is responsible to pay. Report $0.00 if no deductible applies to 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	99%	Required
43	PC043	Prescribing Submitter Provider Number	Submitting entity's assigned or legacy ID identifying the prescriber. This is the identifier used by the submitter for internal identification purposes, and does not routinely change. Must correspond to Provider ID (PV001) in the Provider File. If not applicable, leave NULL.	Text	varchar	30	98%	Required
44	PC044	Prescribing Physician First Name	Prescribing physician's first name.	Text	varchar	25	98%	Required
45	PC045	Prescribing Physician Middle Name	Prescribing physician's middle name.	Text	varchar	25	50%	Required
46	PC046	Prescribing Physician Last Name	Prescribing physician's 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 services 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
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

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
51	PC051	Prescribing Physician Street Address	Prescribing physician's street address, line 1.	Text	varchar	100	50%	Required
52	PC052	Prescribing Physician Street Address 2	Prescribing physician's 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 Sources.	Text	char	2	50%	Required
55	PC055	Prescribing Physician ZIP Code	Report the 5- or 9-digit ZIP code of the prescribing physician's address. When submitting the 9-digit ZIP code do not include hyphen. If using 5 digits, *do not* fill last 4 digits with zeros. See Appendix K - External Sources.	Integer	varchar	9	50%	Required
56	PC057	Mail Order Pharmacy Indicator	Mail Order – 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
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. Alphanumeric 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 phyician's office.	Date	YYYY-MM-DD	10	98%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	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	Pharmaceutical route of administration indicator that defines method of drug administration. 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	Integer	char	2	80%	Required
66	PC075	Drug Unit of Measure	Units of measure for drug dispensed. EA = Each F2 = International Units GM = Grams ML = Milliliters	Text	char	2	0%	Optional
67	PC107	Carrier Specific Unique Member ID	Member's unique ID. Value should be masked prior to submission to the APCD. Masking should be consistent across time so the masked value representing the Member ID does not change. Masking criteria should be determined by submitting entity.	Text	varchar	128	100%	Required
68	PC108	Carrier Specific Unique Subscriber ID	Subscriber's unique ID.	Text	varchar	128	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			Value should be masked prior to submission to the APCD. Masking should be consistent across time so the masked value representing the Subscriber ID does not change. Masking criteria should be determined by submitting entity.					
69	PC110	Claim Status	Status of the claim header or claim line. O = Original A = Adjusted – data on claim has been changed* B = Back Out/Reversal – record aligns with existing record that is no longer valid, nullifying the claim line's associated information. Dollars should be represented as negative; an adjustment, amendment, or replacement claim is expected to replace claim D = Delete/Drop – claim line will be dropped from data; negative dollar values are preferred M = Amendment – data on claim has been changed* R = Replacement – data on claim has been changed* V = Void – record aligns with existing record that is incorrect and should not be used; dollars should be represented as negative F = Final – Status for paid claims (use when versioning process does not require claim status to identify final claim); use as default *These values have the same meaning. The values differ to align with submitting entity claims systems in an effort to reduce submitting entity data transformation.	Text	char	1	100%	Required
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. See Appendix K - External Sources.	Text	char	2	100%	Required
72	PC954	Subscriber ZIP Code	Report the 5- or 9-digit ZIP code of the subscriber's residence. When submitting the 9-digit ZIP code do not include hyphen. If using 5 digits, *do not* fill last 4 digits with zeros. See Appendix K - External Sources.	Integer	varchar	9	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

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	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
78	PC966	Claim Processing Date	Date the claim was processed.	Date	YYYY-MM-DD	10	99%	Required
79	PC700	Void Date	Date representing the date the claim or claim line was voided. Used for versioning process. Void Date must be greater than or equal to PC017, Paid Date. *If this field is not used for versioning, submit an exception to set the required threshold to 0.*	Date	YYYY-MM-DD	10	5%	Required
80	PC701	Source/Processing System Identifier	Code or name identifying claims processing system upon which the version process was executed. *If this field is not used for versioning, submit an exception to set the required threshold to 0.*	Text	varchar	15	10%	Required
81	PC702	Adjustment /Amendment Date	If PC110 is A, Date representing the date the claim or claim line was adjusted. Used for versioning process. If PC110 is M, Date representing the date the claim or claim line was amended. Used for versioning process. *If this field is not used for versioning, submit an exception to set the required threshold to 0.*	Date	YYYY-MM-DD	10	100% if PC110 = M, R or A	Required
82	PC703	Adjudication Date	Date representing the date the claim or claim line was adjudicated. Used for versioning process. *If this field is not used for versioning, submit an exception to set the required threshold to 0.*	Date	YYYY-MM-DD	10	100% if PC110 = A, M, R, B	Required
83	PC704	Original Claim Number	Original Claim Number. Report the Claim Control Number (PC004) that was originally sent in a prior filing to which this line corresponds. When reported, this data cannot equal its own PC004. *If this field is not used for versioning, submit an exception to set the required threshold to 0.*	Text	varchar	35	10% if PC005A > 1	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
84	PC706	Versioning Method	Identifies which versioning method will be used for these data. If no versioning process is applicable or available, populate with the value 8. 1 = Versioning Approach 1 – Version Number 2 = Versioning Approach 2 – Version Date 3 = Versioning Approach 3 – Original Claim Number 4 = Versioning Approach 4 – Claim Status and Paid Date 5 = Versioning Approach 5 – Paid Date 6 = Versioning Approach 6 – Complete Replacement 7 = Versioning Approach 7 - Pharmacy 8 = Versioning Approach 8 – Not available Custom versioning processes will be assigned an entity specific versioning method number. See Exhibit C – APCD Claims Versioning.	Int	unsigned int	3	100%	Required
85	PC707	Previous Claim Number	Claim number representing the claim from which the current claim was versioned. This is not the original claim number, although it could be if the claim was only versioned once. This field is required to accommodate custom versioning. If not required, leave NULL and request exception.	Text	varchar	35	35%	Required
86	PC107A	Carrier Specific Unique Member ID – Alias	Alias member's unique ID. This field is used when submitting entity internal systems change, resulting in systemwide or sub-systemwide member ID changes. This field should contain the original member ID when this change happens. PC107 would contain the new member ID generated by the new system or sub-system. This field should be populated with the original member ID every time the member record is submitted thereafter.	Text	varchar	128	0%	Optional
87	PC108A	Carrier Specific Unique Subscriber ID – Alias	Alias subscriber's unique ID. This field is used when submitting entity internal systems change, resulting in systemwide or sub-systemwide subscriber ID changes. This field should contain the original subscriber ID when this change happens. PC108 would contain the new subscriber ID generated by the new system or sub-system. This field should be populated with the original subscriber ID every time the member record is submitted thereafter.	Text	varchar	128	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
88	PC993	System ID	The system ID. This field represents the submitting entity internal system from which data is sourced. **The default value is 0**, representing the initial system from which the data is pulled. Place the value 0 on all records initially. If a system changes, increment the value by 1. For example, if a system changes, the value would change from 0 to 1. If it changes again, the value would change from 1 to 2. This ID represents the system at the record level. Some submitting entities combine data from multiple systems into a single submission. If one of these systems changes, the system ID would be incremented on the records from the changed system. The system ID on the remaining records would not change. If the system changes resulting in member ID and subscriber ID changes, utilize the Alias fields to capture new and previous member and subscriber IDs for continuity.	Integer	unsigned int	1	100%	Required
89	PC708	Generic Product Identifier (GPI)	The Generic Product Identifier (GPI) hierarchical classification system that identifies drugs from their primary therapeutic use down to the unique interchangeable product regardless of manufacturer or package size.	Text	char	14	85%	Required
90	PC068	Allowed Amount	Maximum amount allowed and that an insurance carrier will pay to a provider for a particular product, 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	100%	Required
91	PC066	Other Insurance Amount Paid	Amount that a prior payer has paid for this claim line. Indicates the submitting entity is the 'secondary payer' to the prior payer. 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
92	PC067	Medicare Paid Amount	Amount Medicare paid toward 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	100%	Required
93	PC112	Medicare Indicator	Indicates Medicare payment applied. 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Text	char	1	100%	Required
94	PC715	Pharmacy U&C Amount	Amount charged to a member if paying cash for the identical prescription drug services on the date dispensed. 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	100%	Required
95	PC065	Coordination of Benefits/TPL Liability Amount	Amount **due** from a secondary carrier. Report the amount that another payer is liable for after submitting payer has processed this 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	10%	Required
96	PC113	Payment Arrangement Type	Value for contracted payment methodology at the claim level. 01 = Capitation 02 = Fee for Service 03 = Percent of Charges	Integer	char	2	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			04 = DRG 05 = Pay for Performance 06 = Global Payment 07 = Other 08 = Bundled Payment 09 = Payment Amount Per Episode					
97	PC910	Medicaid AID Category	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. If not applicable, leave empty.	Text	Char	2	100% when PC001 = '99MCD1'	Required
98	PC038	Postage Amount Claimed	Amount of postage claimed 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	100% if PC057 = '1'	Required
99	PC850	Placeholder1	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
100	PC851	Placeholder2	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
101	PC852	Placeholder3	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
102	PC853	Placeholder4	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
103	PC854	Placeholder5	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
104	PC716	Specialty Code	Indicates that the pharmaceutical dispensed is classified as a specialty drug. Y = Specialty Drug N = Not a Specialty Drug	Text	char	1	100%	Required

Dental Claims 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.
- A Header Header, Header Data, Control Header, Control Data, Detail Data Header, Detail Data (when data is present), Trailer Header, and Trailer Data record must be included in order with this file submission. *See example below.*
- The Dental Claim Data control count data layout is found in Control Count Record Layout – Dental Claim Data.
- Use values in Data Element ID column as column names for the Detail Data Header Record.
- If a value is not present for Date, Integer or Numeric 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 will be required.
- If a date value is unavailable, leave NULL. Do not insert system default date. If a default date is encountered, the file will fail data submission validation. Dates older than 1910-01-01 will be flagged for further review.

Dental Claim Submission Example example (DH and DD are shortened for example)

Category	Record Type	Example
Header	Header Header	HH|HD001|HD002|HD003|HD004|HD005|HD006|HD007|HD008|HD009|HD010
	Header Data	HD|28362||DC|2015-01-01|2015-02-01|1|1|1|8.0.2022|PROD
Control Count	Control Header	CH|CC001|CC002|CC003|CC004|CC005|CC011|CC012|CC013|CC014
	Control Data	CD|28362|DNT|M|1237|858|6511|66|4523|9263
Data	Detail Data Header	DH|DC999|DC001|DC002|DC003|DC004|DC005|DC056|DC057
	Detail Data	DD|1|28362|432|CI|202250|1|302201|302201
Trailer	Trailer Header	TH|TR001|TR002|TR003|TR004|TR005|TR006|TR007
	Trailer Data	TD|28362||DC|2015-01-01|2015-02-01|2015-03-01|2015-04-01

Reminder: You must include the DH record before the DD rows in the submitted file.

Dental Claims Data Table Layout

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	15	100%	Required
3	DC001	Submitter	- Code representing entity submitting data. The entity could be the carrier administering fully insured plans, third party administrator (TPA) administered plans, or pharmacy benefit manager (PBM) administered plans. - Use the 5 to 6 alphanumeric entity code provided by Arkansas APCD team assigned during registration process (see File Naming Convention section). - Must match entity code in the file name. - Must match HD001 and TR001.	Text	varchar	6	100%	Required
4	DC002	National Plan ID	Centers for Medicare & 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	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
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 or claim service line. This value can be assigned independently in the claims system or it can be extracted from the claim number. The dependency for this field may change depending on the version approach selected. These changes will be handled with	Integer	int	35	100% if DC706 = 1 or custom approach requiring	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			the exception process. If not applicable to the versioning process, request an exception. See Exhibit C – APCD Claims Versioning.				version number	
9	DC005B	Version Number Date	Value representing the latest version of the claim. Values must be a Julian date (YYDDD) with 2-digit year and 3-digit day (e.g., January 15, 2016 = 16015) The dependency for this field may change depending on the version approach selected. These changes will be handled with the exception process. If not applicable to the versioning process, request an exception. See Exhibit C – APCD Claims Versioning.	Integer	char	5	100% if DC706 = 2	Required
10	DC006	Insured Group or Policy Number	The alphanumeric group or policy number is associated with the entity that has purchased the insurance. For self-funded plans, this relates to the employer paying for claims where the carrier acts as TPA. 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 NULL if unavailable. Set as NULL if contract number is the subscriber's social security number.	Text	varchar	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 one is 001, the value for person two is 002, etc.). This value does not have to be in the this format (001, 002, etc.) if the claims system numbers members differently.	Integer	int	10	99%	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	Report the 5- or 9-digit ZIP code of the member's residence. When submitting the 9-digit ZIP code do not include hyphen. If using 5 digits, *do not* fill last 4 digits with zeros. See Appendix K - External Sources.	Integer	varchar	9	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

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
18	DC018	Service Provider Number	Submitting entity's assigned or legacy ID identifying for the entity or service/rendering provider directly providing the service. This is the identifier used by the submitter for internal identification purposes, and does not routinely change. Must correspond to Provider ID (PV001) in the Provider File. If not applicable, leave NULL.	Text	varchar	30	98%	Required
19	DC019	Service Provider EIN / Federal Tax ID Number	Federal taxpayer'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. Alphanumeric 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 services and prescribing providers. See Appendix K - External Sources.	Integer	char	10	98%	Required
21	DC021	Service Provider Entity Type Qualifier	Flag identifying Service Provider NPI as person or non-person/facility. Use 2 if the provider cannot be identified as an individual provider. 1 = Person 2 = Non-Person entity	Integer	unsigned int	1	100%	Required
22	DC022	Service Provider First Name	Service Provider first name. Set to NULL 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 NULL 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). **Do not code the clinician's credentials (e.g., MD, LCSW) in this field.** Set to NULL if the provider is a facility or an organization.	Text	varchar	10	10%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	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's 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	Report the 5- or 9-digit ZIP code of the servicing provider's address, preferably the practice location. When submitting the 9-digit ZIP code do not include hyphen. If using 5 digits, *do not* fill last 4 digits with zeros. See Appendix K - External Sources.	Integer	varchar	9	98%	Required
30	DC030	Facility Type - Professional	Type of professional facility where the service was performed. The field should be set to NULL for institutional claims. See Appendix E - Facility Type.	Integer	unsigned int	2	98%	Required
31	DC032	CDT Code	Common Dental Terminology Codes. Use standard CDT codes where codes are prefaced with D. 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	100%	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	100%	Required
36	DC037	Charge Amount	Total charges for the service as reported by the provider to the insurance 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	98%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
37	DC038	Paid Amount	Amount paid by the submitting entity/insurance carrier 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	100%	Required
38	DC039	Copay Amount	Pre-set, fixed dollar amount payable by a member, often on a per-visit/per-service 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	98%	Required
39	DC040	Coinsurance Amount	Amount that defines a calculated percentage amount for the claim line service that the individual is responsible for paying. 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	98%	Required
40	DC041	Deductible Amount	Amount that defines a preset, fixed amount for this claim line service that the individual is responsible for paying. Report $0.00 if no deductible applies to 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	98%	Required
41	DC042	Product Identifier	Submitter-assigned product identifier for type of coverage/product purchased.	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. Alphanumeric 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	Maximum amount allowed and that an insurance carrier will pay to a provider 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	100%	Required
44	DC047	Tooth Number/Letter	Tooth Number or Letter Identification (Universal Numbering System). Note, multiple tooth numbers can be present in the field. All must have leading zeros unless non-numeric value. This field must be comma delimited. Place comma between each value (for example, 010223A should be submitted as 01,02,23,A). See Appendix M – Tooth Identification	Text	varchar	128	90%	Required
45	DC048	Dental Quadrant	Dental Quadrant This field must be comma delimited. Place comma between each value (for example, 1040UL should be submitted as 10,40,UL). See Appendix M – Tooth Identification	Text	varchar	128	90%	Required
46	DC049	Tooth Surface	Tooth Surface Multiple values from list below can be placed in this field. B = Buccal D = Distal F = Facial I = Incisal L = Lignual M = Mesial O = Occlusal This field must be comma delimited. Place comma between each value (for example, BDFI should be submitted as B,D,F,I). See Appendix M - Tooth Identification	Text	varchar	128	90%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
47	DC056	Carrier Specific Unique Member ID	Member's unique ID. Value should be masked prior to submission to the APCD. Masking should be consistent across time so the masked value representing the Member ID does not change. Masking criteria should be determined by submitting entity.	Text	varchar	128	100%	Required
48	DC057	Carrier Specific Unique Subscriber ID	Subscriber's unique ID. Value should be masked prior to submission to the APCD. Masking should be consistent across time so the masked value representing the Subscriber ID does not change. Masking criteria should be determined by submitting entity.	Text	varchar	128	100%	Required
49	DC059	Claim Status	Status of the claim header or claim line. O = Original A = Adjusted – data on claim has been changed.* B = Back Out/Reversal – record aligns with existing record that is no longer valid, nullifying the claim line's associated information. Dollars should be represented as negative. An adjustment, amendment, or replacement claim is expected to replace claim. D = Delete/Drop – claim line will be dropped from data. Negative dollar values are preferred. M = Amendment – data on claim has been changed.* R = Replacement – data on claim has been changed.* V = Void – record aligns with existing record that is incorrect and should not be used. Dollars should be represented as negative. F = Final – Status for paid claims (use when versioning process does not require claim status to identify final claim). Use as default. *These values have the same meaning. The values differ to align with submitting entity claims systems in an effort to reduce submitting entity data transformation.	Text	char	1	100%	Required
50	DC064	Denial Reason	Denial Reason Code Placeholder for future requirements	Text	varchar	5	0%	Optional
51	DC015	Member State or Province	State or province of the member's address. See Appendix K - External Sources.	Text	char	2	98%	Required
52	DC065	Claim Processing Date	Date the claim was processed.	Date	YYYY-MM-DD	10	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
53	DC130	Procedure Code Type	The value that defines the type of procedure code expected in DC032. 1 = CPT or HCPCS Level 1 Code 2 = HCPCS Level II Code 3 = HCPCS Level III Code (State Medicare code) 4 = American Dental Association (ADA) Procedure Code (also referred to as CDT code) 5 = CPT Category II 8 = Unknown (provide explanation describing why the code types are unknown prior to submission) 9 = None of the above	Int	unsigned int	1	100%	Required
54	DC990	Subscriber Date of Birth	Subscriber's date of birth.	Date	YYYY-MM-DD	10	100%	Required
55	DC991	Subscriber Gender	Gender of the subscriber. M = Male F = Female U = Unknown	Text	char	1	100%	Required
56	DC992	Subscriber State or Province	State or province of the subscriber's address. See Appendix K - External Sources.	Text	char	2	98%	Required
57	DC700	Void Date	Date representing the date the claim or claim line was voided. Used for versioning process. Void Date must be greater than or equal to DC017, Paid Date. *If this field is not used for versioning, submit an exception to set the required threshold to 0.*	Date	YYYY-MM-DD	10	5%	Required
58	DC701	Source/Processing System Identifier	Code or name identifying claims processing system upon which the version process was executed. *If this field is not used for versioning, submit an exception to set the required threshold to 0.*	Text	varchar	15	10%	Required
59	DC702	Adjustment/ Amendment Date	If DC059 is A, date representing the date the claim or claim line was adjusted. Used for versioning process. If DC059 is M, date representing the date the claim or claim line was amended. Used for versioning process. *If this field is not used for versioning, submit an exception to set the required threshold to 0.*	Date	YYYY-MM-DD	10	100% if DC059 = M or A	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
60	DC703	Adjudication Date	Date representing the date the claim or claim line was adjudicated. Used for versioning process. *If this field is not used for versioning, submit an exception to set the required threshold to 0.*	Date	YYYY-MM-DD	10	100% if DC059 = A, M, R, B	Required
61	DC704	Original Claim Number	Original Claim Number. Report the Claim Control Number (DC004) that was originally sent in a prior filing to which this line corresponds. When reported, this data cannot equal its own DC004. *If this field is not used for versioning, submit an exception to set the required threshold to 0.*	Text	varchar	35	10% if DC005A > 1	Required
62	DC706	Versioning Method	Identifies which of the versioning methods will be used for these data. If no versioning process is applicable or available, populate with the value 8. 1 = Versioning Approach 1 – Version Number 2 = Versioning Approach 2 – Version Date 3 = Versioning Approach 3 – Original Claim Number 4 = Versioning Approach 4 – Claim Status and Paid Date 5 = Versioning Approach 5 – Paid Date 6 = Versioning Approach 6 – Complete Replacement 7 = Versioning Approach 7 – Pharmacy 8 = Versioning Approach 8 – Not available Custom versioning processes will be assigned an entity specific versioning method number. See Exhibit C – APCD Claims Versioning.	Integer	unsigned int	3	100%	Required
63	DC707	Previous Claim Number	Claim number representing the claim from which the current claim was versioned. This is not the original claim number though it could be if the claim was only versioned once. This field is required to accommodate custom versioning. If not required, leave NULL and request exception.	Text	varchar	35	35%	Required
64	DC058	Subscriber ZIP Code	Report the 5- or 9-digit ZIP code of the subscriber's residence. When submitting the 9-digit ZIP code do not include hyphen. If using 5 digits, *do not* fill last 4 digits with zeros. See Appendix K - External Sources.	Integer	varchar	9	98%	Required
65	DC056A	Carrier Specific Unique Member ID – Alias	Alias member's unique ID. This field is used when submitting entity internal systems change, resulting in systemwide or sub-systemwide member ID changes. This field should contain the original member ID	Text	varchar	128	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			when this change happens. DC056 would contain the new member ID generated by the new system or sub-system. This field should be populated with the original member ID every time the member record is submitted thereafter.					
66	DC057A	Carrier Specific Unique Subscriber ID – Alias	Alias subscriber's unique ID. This field is used when submitting entity internal systems change, resulting in systemwide or sub-systemwide subscriber ID changes. This field should contain the original subscriber ID when this change happens. DC057 would contain the new subscriber ID generated by the new system or sub-system. This field should be populated with the original subscriber ID every time the member record is submitted thereafter.	Text	varchar	128	0%	Optional
67	DC113	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 09 = Payment Amount Per Episode	Integer	char	2	100%	Required
68	DC910	Medicaid AID Category	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. If not applicable, leave empty.	Text	char	2	100% when DC001 = '99MCD1'	Required
69	DC911	Diagnosis Code	This field contains the ICD-9-CM or ICD-10-CM diagnosis code indicating the reason for the service. Decimal point is not coded. See Appendix K - External Sources.	Text	varchar	7	100%	Required
70	DC915A	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 The value in this field will be used in determining the code set to validate ICD diagnosis. The ICD columns will fail validation if the values do match the code set specified by the ICD indicator flag.	Integer	unsigned int	1	100% when DC911 is not NULL	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
71	DC850	Placeholder1	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
72	DC851	Placeholder2	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
73	DC852	Placeholder3	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
74	DC853	Placeholder4	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
75	DC854	Placeholder5	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
76	DC993	System ID	System ID. This field represents the submitting entity internal system from which data is sourced. **The default value is 0**, representing the initial system from which the data is pulled. Place the value 0 on all records initially. If a system changes, increase the value by increments of 1. For example, if a system changes, the value would change from 0 to 1. If it changes again, the value would change from 1 to 2. This ID represents the system at the record level. Some submitting entities combine data from multiple systems into a single submission. If one of these systems changes, the system ID would be incremented on the records from the changed system. The system ID on the remaining records would not change. If the system changes resulting in member ID and subscriber ID changes, utilize the Alias fields to capture new and previous member and subscriber IDs for continuity.	Integer	unsigned int	1	100%	Required

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Provider 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.
- A Header Header, Header Data, Control Header, Control Data, Detail Data Header, Detail Data (when data is present), Trailer Header, and Trailer Data record must be included in order with this file submission. *See example below.*
- The Provider Data control count data layout is found in Control Count Record Layout – Provider Data.
- Use values in Data Element ID column as column names for the Detail Data Header Record.
- If a value is not present for Date, Integer or Numeric 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 will be required.
- If a date value is unavailable, leave NULL. Do not insert system default date. If a default date is encountered, the file will fail data submission validation. Dates older than 1910-01-01 will be flagged for further review.

Provider Data Submission Example example (DH and DD are shortened for example)

Category	Record Type	Example
Header	Header Header	HH|HD001|HD002|HD003|HD004|HD005|HD006|HD007|HD008|HD009|HD010
	Header Data	HD|28362||PV|2015-01-01|2015-02-01|1|1|1|8.0.2022|PROD
Control Count	Control Header	CH|CC001|CC002|CC003|CC013|CC014|CC015|CC018|CC019
	Control Data	CD|28362|PRV|M|258|158|984|68|43
Data	Detail Data Header	DH|PV999|PV114|PV001|PV002|PV003|PV004|PV006
	Detail Data	DD|1|28362|1234894510|1581596872|2|FRED|JONES
Trailer	Trailer Header	TH|TR001|TR002|TR003|TR004|TR005|TR006|TR007
	Trailer Data	TD|28362||PV|2015-01-01|2015-02-01|2015-03-01|2015-04-01

Reminder: You must include the DH record before the DD rows in the submitted file.

Provider File Data Table Layout

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	15	100%	Required
3	PV114	Submitter	- Code representing entity submitting data. The entity could be the carrier administering fully insured plans, third party administrator (TPA) administered plans, or pharmacy benefit manager (PBM) administered plans. - Use the 5 to 6 alphanumeric entity code provided by Arkansas APCD team assigned during registration process (see File Naming Convention section). - Must match entity code in the file name. - Must match HD001 and TR001.	Text	varchar	6	100%	Required
4	PV001	Provider ID	Submitting entity's assigned or legacy ID identifying the provider. This is the identifier used by the submitter for internal identification purposes, and does not routinely change.	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. Alphanumeric characters only — omit spaces and hyphens.	Text	varchar	15	98% if PV003 = 2,3,4,5,6,7, 0	Required
6	PV003	Entity Type	The entity type. Report the value that defines the 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 healthcare services. 1 = Person; physician, clinician, orthodontist, and any individual that is licensed/certified to perform healthcare services. 2 = Facility; hospital, health center, long-term care, rehabilitation and any building that is licensed to transact healthcare services. 3 = Professional Group; collection of licensed/certified healthcare professionals who are practicing healthcare services under the same entity name and Federal Tax Identification Number. 4 = Retail Site; brick-and-mortar licensed/certified place of transaction that is not solely a healthcare entity (i.e., pharmacies, independent laboratories, vision services). 5 = E-Site; internet-based order/logistic system of healthcare 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. 6 = Financial parent; financial governing body that does not perform	Integer	unsigned int	1	98%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			healthcare services itself but directs and finances healthcare service entities, usually through a board of directors. 7 = Transportation; any form of transport that conveys a patient to/from a healthcare provider.					
7	PV004	Provider First Name	Provider's first name. Set to NULL if provider is a facility or an organization. Place facility or organization name in PV057.	Text	varchar	25	100% if PV057 is NULL	Required
8	PV005	Provider Middle Name	Provider's middle name. Set to NULL if provider is a facility or an organization. Place facility or organization name in PV057.	Text	varchar	25	5% if PV057 is NULL	Required
9	PV006	Provider Last Name	Provider's last name. Set to NULL if provider is a facility or an organization. Place facility or organization name in PV057.	Text	varchar	60	100% if PV057 is NULL	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 NULL if the provider is a facility or an organization.	Text	varchar	10	10% if PV057 is NULL	Required
11	PV008	Provider Office Street Address	Provider's office address line 1 for NPI in PV023.	Text	varchar	100	100%	Required
12	PV009	Provider Office Street Address 2	Provider's office address line 2 for NPI in PV023.	Text	varchar	100	25%	Required
13	PV010	Provider Office City	City of provider's physical practice location for NPI in PV023.	Text	varchar	30	100%	Required
14	PV011	Provider Office State	State or province of provider's physical practice location for NPI in PV023. See Appendix K - External Code Sources.	Text	char	2	100%	Required
15	PV012	Provider Office ZIP Code	Report the 5- or 9-digit ZIP code of the physical practice address for NPI in PV023. When submitting the 9-digit ZIP code do not include hyphen. If using 5 digits, *do not* fill last 4 digits with zeros. See Appendix K - External Code Sources.	Integer	varchar	9	100%	Required
16	PV013	Mailing Street Address	Provider mailing address line 1.	Text	varchar	100	100%	Required
17	PV014	Mailing Street Address 2	Provider mailing address line 2.	Text	varchar	100	50%	Required
18	PV015	Mailing City	City of provider's practice mailing address.	Text	varchar	35	25%	Required
19	PV016	Mailing State Code	State or province of provider's practice mailing address. See Appendix K - External Code Sources.	Text	varchar	2	100%	Required
20	PV017	Mailing Country Code	Country code of the provider's/entity's mailing address. Use 3-digit numeric ISO Country Codes. See Appendix K - External Code Sources.	integer	unsigned int	3	100%	Required
21	PV018	Mailing ZIP Code	Report the 5- or 9-digit ZIP code of the physical practice address for NPI in PV023. When submitting the 9-digit ZIP code do not include hyphen. If using 5	Integer	varchar	9	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			digits, *do not* fill last 4 digits with zeros. See Appendix K - External Code Sources.					
22	PV019	Provider Specialty	Primary specialty associated with provider. Use CMS 2-byte provider specialty codes or 10-byte Taxonomy codes. See Appendix K - External Code Sources.	Text	varchar	10	100%	Required
23	PV020	Provider second specialty	Second specialty associated with provider. Use CMS 2-byte provider specialty codes or 10-byte Taxonomy codes. See Appendix K - External Code Sources.	Text	varchar	10	2%	Required
24	PV021	Provider third specialty	Third specialty identified for provider. Use CMS 2-byte provider specialty codes or 10-byte Taxonomy codes. See Appendix K - External Code Sources.	Text	varchar	10	2%	Required
25	PV022	Provider DEA Number	A Drug Enforcement Administration (DEA) number assigned to a healthcare 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 services 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 practitioner identifiable field.	Text	varchar	10	0%	Optional
29	PV026	Taxonomy Code	This field is used to standardize the specialty coding of provider records. See Appendix K - External Code Sources.	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	Placeholder	Leave as empty value.					
32	PV031	Provider Type	Provider type code. Report the value that defines the provider type. See Appendix J – Provider Type 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	50%	Required
35	PV034	Provider Country Code	Country code of the Provider/Entity mailing address. Use 3-digit numeric ISO Country Codes. See Appendix K - External Sources.	Integer	unsigned int	3	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	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's 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's 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
39	PV045	Offers e-Visits	An 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.	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's organization/facility. Set to NULL 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's (PV023) residency program.	Text	varchar	100	0%	Optional
47	PV103	Residency Completion Date	Date provider (PV023) completed residency.	Date	YYYY-MM-DD	10	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

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
51	PV107	Board Certification 1 From	Date when provider was certified in first certification area.	Date	YYYY-MM-DD	10	0%	Optional
52	PV108	Board Certification 1 To	Date when first board certification expired. Leave NULL if current. Leave NULL if active.	Date	YYYY-MM-DD	10	0%	Optional
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 NULL if current. Leave NULL 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
58	PV850	Placeholder1	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
59	PV851	Placeholder2	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
60	PV852	Placeholder3	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
61	PV853	Placeholder4	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
62	PV854	Placeholder5	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
63	PV993	System ID	System ID. This field represents the submitting entity internal system from which data is sourced. **The default value is 0**, representing the initial system from which the data is pulled. Place the value 0 on all records initially. If a system changes, increase the value by increments of 1. For example, if a system changes, the value would change from 0 to 1. If it changes again, the value would change from 1 to 2. This ID represents the system at the record level. Some submitting entities combine data from multiple systems into a single submission. If one of these systems changes, the system ID would be incremented on the records from the changed system. The system ID on the remaining records would not change.	Integer	unsigned int	1	100%	Required

Lookup 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.
- A Header Header, Header Data, Control Header, Control Data, Detail Data Header, Detail Data (when data is present), Trailer Header, and Trailer Data record must be included in order with this file submission. *See example below.*
- The Lookup Data control count data layout is found in Control Count Record Layout – Lookup File Data.
- Use values in Data Element ID column as column names for the Detail Data Header Record.
- Lookup data files are required only if the provider specialty data is not provided by CMS Health Care Provider Taxonomy. Submit data exception if CMS Health Care Provider Taxonomy codes are used and Lookup Data file will not be submitted.

Lookup Data Submission Example example (DH and DD are shortened for example)

Category	Record Type	Example
Header	Header Header	HH|HD001|HD002|HD003|HD004|HD005|HD006|HD007|HD008|HD009|HD010
	Header Data	HD|28362||LU|2015-01-01|2015-02-01|1|1|1|8.0.2022|PROD
Control Count	Control Header	CH|CC001|CC002|CC003|CC020
	Control Data	CD|28362|LU|M|87
Data	Detail Data Header	DH|LU001|LU002|LU003|LU004|LU005
	Detail Data	DD|PED|PEDIATRICS||MC032|28362 DD|PED|PEDIATRICS|FAMILY PRACTICE MEDICINE|MC212|28362 DD|GEN|GENERAL FAMILY PRACTICE||MC032|28362 DD|GER|GERIATRICS||MC212|28362
Trailer	Trailer Header	TH|TR001|TR002|TR003|TR004|TR005|TR006|TR007
	Trailer Data	TD|28362||LU|2015-01-01|2015-02-01|2015-03-01|2015-04-01

Reminder: You must include the DH record before the DD rows in the submitted file.

Lookup Data Table Layout

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
1	DH	Record Prefix	Record Prefix Place the value DD in the Lookup Data detail record.	Text	char	2	100%	Required
2	LU001	Lookup Value	Alpha, alphanumeric, or numeric value representing the value description.	Text	varchar	20	100%	Required
3	LU002	Lookup Value Description	Description of lookup value.	Text	varchar	128	100%	Required
4	LU003	Additional Information	Use as necessary to supplement the lookup value description.	Text	varchar	128	0%	Optional
5	LU004	Data Element ID	Data Element ID associated with lookup value: MC212 or MC032	Text	varchar	6	100%	Required
6	LU005	Submitter	- Code representing entity submitting data. The entity could be the carrier administering fully insured plans, third party administrator (TPA) administered plans, or pharmacy benefit manager (PBM) administered plans. - Use the 5 to 6 alphanumeric entity code provided by Arkansas APCD team assigned during registration process (see File Naming Convention section). - Must match entity code in the file name. - Must match HD001 and TR001.	Text	varchar	6	100%	Required

Supplemental Payment 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.
- A Header Header, Header Data, Control Header, Control Data, Detail Data Header, Detail Data (when data is present), Trailer Header, and Trailer Data record must be included in order with this file submission. *See example below.*
- Use values in Data Element ID column as column names for the Detail Data Header Record.

Supplemental Payment Data Submission Example example (DH and DD are shortened for example)

Category	Record Type	Example
Header	Header Header	HH|HD001|HD002|HD003|HD004|HD005|HD006|HD007|HD008|HD009|HD010
	Header Data	HD|28362||SP|2015-01-01|2015-02-01|1|1|1|8.0.2022|PROD
Control Count	Control Header	CH|CC001|CC002|CC003|(remaining fields to be determined)
	Control Data	CD|MCD991|SP|M|(remaining fields to be determined)
Data	Detail Data Header	DH|SP001|(remaining fields to be determined)
	Detail Data	DD|MCD991|(remaining fields to be determined) DD|MCD991|(remaining fields to be determined)
Trailer	Trailer Header	TH|TR001|TR002|(remaining fields to be determined)
	Trailer Data	TD| MCD991|SP|2015-01-01|2015-02-01|2015-03-01|2015-04-01

Reminder: You must include the DH record before the DD rows in the submitted file.

Supplemental Payment Data Table Layout

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
1	DH	Record Prefix	Record Prefix Place the value DD in the Lookup Data detail record.	Text	char	2	100%	Required
2	SP001	Submitter	- Code representing entity submitting data. The entity could be the carrier administering fully insured plans, third party administrator (TPA) administered plans, or pharmacy benefit manager (PBM) administered plans. - Use the 5 to 6 alphanumeric entity code provided by Arkansas APCD team assigned during registration process (see File Naming Convention section). - Must match entity code in the file name. - Must match HD001 and TR001.	Text	varchar	6	100%	Required
Remaining data elements dependent upon source field availability.								

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Pharmacy Benefit Manager Claims Data

File Guidelines

All fields shall be coded with the values specified in the Enrollment data file. See also Data Categories for Submission – Pharmacy Benefit Manager Claims Data for submission requirements.

- All fields must be included in the data submission
- A Header Header, Header Data, Control Header, Control Data, Detail Data Header, Detail Data (when data is present), Trailer Header, and Trailer Data record must be included in order with this file submission. *See example below.*
- The Pharmacy Benefit Manager Claim Data control count data layout is found in Control Count Record Layout – Pharmacy Benefit Manager Claims Data.
- Use values in Data Element ID column as column names for the Detail Data Header Record.
- If a value is not present for Date, Integer or Numeric 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 will be required.
- If a date value is unavailable, leave NULL. Do not insert system default date. If a default date is encountered, the file will fail data submission validation. Dates older than 1910-01-01 will be flagged for further review.

Pharmacy Claim Submission Example (DH and DD are shortened for example)

Category	Record Type	Example
Header	Header Header	HH|HD001|HD002|HD003|HD004|HD005|HD006|HD007|HD008|HD009|HD010
	Header Data	HD|28362||PB|2015-01-01|2015-02-01|1|1|1|8.0.2022|PROD
Control Count	Control Header	CH|CC001|CC002|CC003|CC004|CC005|CC011|CC012|CC013|CC014|CC016|CC017
	Control Data	CD|28362|PBM|M|7833|8578|685111|52|855523|892623|34236|69822
Data	Detail Data Header	DH|PB999|PB001|PB002|PB003|PB004|PB005|PB026|PB107
	Detail Data	DD|1|28362|432|CI|1948206101|1|2840286070482|120683S7a
Trailer	Trailer Header	TH|TR001|TR002|TR003|TR004|TR005|TR006|TR007
	Trailer Data	TD|28362||PB|2015-01-01|2015-02-01|2015-03-01|2015-04-01

Reminder: You must include the DH record before the DD rows in the submitted file.

Pharmacy Benefits Manager Data Table Layout

Note: The field inclusion criteria in the Required column applies only if PBM data is being submitted.

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	PB999	Unique Row ID	Each row must contain a unique ID or row number.	Integer	unsigned int	15	100%	Required
3	PB001	Submitter	- Code representing entity submitting data. The entity could be the carrier administering fully insured plans, third party administrator (TPA) administered plans, or pharmacy benefit manager (PBM) administered plans. - Use the 5 to 6 alphanumeric entity code provided by Arkansas APCD team assigned during registration process (see File Naming Convention section). - Must match entity code in the file name. - Must match HD001 and TR001	Text	varchar	6	100%	Required
4	PB002	National Plan ID	Centers for Medicare & 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	PB003	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
6	PB004	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	PB005	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

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
8	PB005A	Version Number	Final version number of the claim or claim service line. This value can be assigned independently in the claims system or it can be extracted from the claim number. The dependency for this field may change contingent upon the version approach selected. These changes will be handled with the exception process. If not applicable to the versioning process, request an exception. See Exhibit C – APCD Claims Versioning.	Integer	int	35	100% if PB706 = 1 or custom approach requiring version number	Required
9	PB005B	Version Number Date	Value representing the latest version of the claim. Values must be a Julian date (YYDDD) with 2-digit year and 3-digit day (e.g., January 15, 2016 = 16015) The dependency for this field may change depending on the version approach selected. These changes will be handled with the exception process. If not applicable to the versioning process, request an exception. See Exhibit C – APCD Claims Versioning.	Integer	char	5	100% if PB706 = 2	Required
10	PB006	Insured Group Number or Policy Number	The alphanumeric group or policy number is associated with the entity that has purchased the insurance. For self-funded plans this relates to the employer paying for claims where the carrier acts as TPA. For the majority of enrollment and claims data the group relates to the employer.	Text	varchar	30	99%	Required
11	PB008	Plan Specific Contract Number	Submitting entity's assigned contract number for the subscriber. Set as NULL if unavailable. Set as NULL if contract number is the subscriber's social security number.	Text	varchar	20	50%	Required
12	PB009	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 one is 001, the value for person two is 002, etc.). This value does not have to be in the this format (001, 002, etc.) if the claims system numbers members differently.	Integer	int	10	99%	Required
13	PB011	Individual Relationship Code	Member's relationship to the subscriber or the insured. See Appendix B - Relationship Code.	Integer	char	2	99%	Required
14	PB012	Member Gender	Gender of the member. M = Male F = Female U = Unknown	Text	char	1	99%	Required
15	PB013	Member Date of Birth	Member's date of birth.	Date	YYYY-MM-DD	10	99%	Required
16	PB015	Member State or Province	State or province of member's residence. See Appendix K - External Sources.	Text	char	2	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
17	PB016	Member ZIP Code	Report the 5- or 9-digit ZIP code of the member's residence. When submitting the 9-digit ZIP code do not include hyphen. If using 5 digits, *do not* fill last 4 digits with zeros. See Appendix K - External Sources.	Integer	varchar	9	99%	Required
18	PB017	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	PB018	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 Sources.	Text	varchar	30	99%	Required
20	PB019	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. Alphanumeric characters only — omit spaces and hyphens.	Text	varchar	15	20%	Required
21	PB020	Pharmacy Name	Name of pharmacy.	Text	varchar	100	90%	Required
22	PB021	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 Sources.	Text	varchar	10	98%	Required
23	PB022	Pharmacy Location City	City of pharmacy location.	Text	varchar	30	98%	Required
24	PB023	Pharmacy Location State	State or province of pharmacy location. See Appendix K - External Sources.	Text	char	2	98%	Required
25	PB024	Pharmacy ZIP Code	Report the 5- or 9-digit ZIP code of the pharmacy's location. When submitting the 9-digit ZIP code do not include hyphen. If using 5 digits, *do not* fill last 4 digits with zeros. See Appendix K - External Sources.	Integer	varchar	9	98%	Required
26	PB024A	Pharmacy Country Code	ISO Country Code of the pharmacy location. See Appendix K - External Sources.	Integer	unsigned int	3	90%	Required
27	PB026	Drug Code	National Drug Code (NDC)	Text	char	11	98%	Required
28	PB027	Drug Name	Name of the drug as supplied.	Text	varchar	80	95%	Required
29	PB028	Fill Number	Prescription Status Indicator. For example, 00 = new prescription, 01 = first refill, 02 = second refill, 03 = third refill, etc.	Integer	char	2	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
30	PB029	Generic Drug Indicator	Generic drug indicator. 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Integer	unsigned int	1	100%	Required
31	PB030	Dispense as Written Code	Drug dispense code. 1 = Physician dispensed as written 2 = Member dispensed as written 3 = Pharmacy dispensed 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	PB031	Compound Drug Indicator	Compound drug indicator. 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Integer	unsigned int	1	100%	Required
33	PB032	Date Prescription Filled	Date the pharmacy filled and dispensed prescription to the patient.	Date	YYYY-MM-DD	10	99%	Required
34	PB033	Quantity Dispensed	Number of metric units dispensed. Decimals and negative values accepted. Decimal point must be included in field, even when value is whole number.	Numeric	±decimal	18,6	99%	Required
35	PB034	Days Supply	Number of days the prescription will last if taken as prescribed.	Integer	unsigned int	4	99%	Required
36	PB035	Charge Amount	Total charges for the service as reported by the pharmacy benefits manager to the insurance 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
37	PB036	Paid Amount	Amount paid by the submitting entity/insurance carrier 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	99%	Required
38	PB037	Ingredient Cost/List Price	Amount defined as the pharmaceutical 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	99%	Required
39	PB039	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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	99%	Required
40	PB040	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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	99%	Required
41	PB041	Coinsurance Amount	Amount that defines a calculated percentage amount for the claim line service that the individual 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
42	PB042	Deductible Amount	Amount that defines a preset, fixed amount for this claim line service that the individual is responsible to pay. Report $0.00 if no deductible applies to 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	99%	Required
43	PB043	Prescribing Submitter Provider Number	Submitting entity's assigned or legacy ID identifying the prescriber. This is the identifier used by the submitter for internal identification purposes, and does not routinely change. Must correspond to Provider ID (PV001) in the Provider File. If not applicable, leave NULL.	Text	varchar	30	98%	Required
44	PB044	Prescribing Physician First Name	Prescribing physician's first name.	Text	varchar	25	98%	Required
45	PB045	Prescribing Physician Middle Name	Prescribing physician's middle name.	Text	varchar	25	50%	Required
46	PB046	Prescribing Physician Last Name	Prescribing physician's last name.	Text	varchar	60	98%	Required
47	PB047	Prescribing Physician DEA Number	Prescribing Drug Enforcement Administration (DEA) number for provider.	Text	char	9	80%	Required
48	PB048	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	PB049	Prescribing Physician Plan Number	Submitting entity-assigned Provider Plan ID.	Text	varchar	30	98%	Required
50	PB050	Prescribing Physician License Number	State license number for the provider identified in PB043. 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

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
51	PB051	Prescribing Physician Street Address	Prescribing physician's street address, line 1.	Text	varchar	100	50%	Required
52	PB052	Prescribing Physician Street Address 2	Prescribing physician's street address, line 2.	Text	varchar	100	5%	Required
53	PB053	Prescribing Physician City	City of the prescribing physician's address.	Text	varchar	30	50%	Required
54	PB054	Prescribing Physician State	State or province of the prescribing physician's address. See Appendix K - External Sources.	Text	char	2	50%	Required
55	PB055	Prescribing Physician ZIP Code	Report the 5- or 9-digit ZIP code of the pharmacy's prescribing physician's address. When submitting the 9-digit ZIP code do not include hyphen. If using 5 digits, *do not* fill last 4 digits with zeros. See Appendix K - External Sources.	Integer	varchar	9	50%	Required
56	PB057	Mail Order Pharmacy Indicator	Mail Order – indicator. 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Integer	unsigned int	1	100%	Required
57	PB058	Script number	Unique prescription number.	Text	varchar	20	100%	Required
58	PB059	Member PCP ID	Member's PCP provider NPI number.	Integer	char	10	0%	Optional
59	PB060	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
60	PB062	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. Alphanumeric characters only — omit spaces and hyphens.	Text	varchar	15	50%	Required
61	PB064	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

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
62	PB069	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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	98%	Required
63	PB070	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	PB073	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	PB074	Route of Administration	Pharmaceutical route of administration indicator that defines method of drug administration. 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	Integer	char	2	80%	Required
66	PB075	Drug Unit of Measure	Units of measure for drug dispensed. EA = Each F2 = International Units GM = Grams ML = Milliliters	Text	char	2	0%	Optional
67	PB107	Carrier Specific Unique Member ID	Member's unique ID. Value should be masked prior to submission to the APCD. Masking should be consistent across time so the masked value representing the Member ID does not change. Masking criteria should be determined by submitting entity. Value should correspond to the Member ID associated with the carrier so that the PBM claims can be linked to the carrier's pharmacy claims.	Text	varchar	128	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
68	PB108	Carrier Specific Unique Subscriber ID	Subscriber's unique ID. Value should be masked prior to submission to the APCD. Masking should be consistent across time so the masked value representing the Subscriber ID does not change. Masking criteria should be determined by submitting entity. Value should correspond to the Subscriber ID associated with the carrier so that the PBM claims can be linked to the carrier's pharmacy claims.	Text	varchar	128	100%	Required
69	PB110	Claim Status	Status of the claim header or claim line. O = Original A = Adjusted – data on claim has been changed* B = Back Out/Reversal – record aligns with existing record that is no longer valid, nullifying the claim line's associated information. Dollars should be represented as negative; an adjustment, amendment, or replacement claim is expected to replace claim D = Delete/Drop – claim line will be dropped from data; negative dollar values are preferred M = Amendment – data on claim has been changed* R = Replacement – data on claim has been changed* V = Void – record aligns with existing record that is incorrect and should not be used; dollars should be represented as negative F = Final – Status for paid claims (use when versioning process does not require claim status to identify final claim); use as default *These values have the same meaning. The values differ to align with submitting entity claims systems in an effort to reduce submitting entity data transformation.	Text	char	1	100%	Required
70	PB124	Denial Reason	Denial reason code. Placeholder for future requirements	Text	char	5	0%	Optional
71	PB953	Subscriber State	State or province of subscriber's residence. See Appendix K - External Sources.	Text	char	2	100%	Required
72	PB954	Subscriber ZIP Code	Report the 5- or 9-digit ZIP code of the subscriber's residence. When submitting the 9-digit ZIP code do not include hyphen. If using 5 digits, *do not* fill last 4 digits with zeros. See Appendix K - External Sources.	Integer	varchar	9	100%	Required
73	PB955	Subscriber Date of Birth	Subscriber's date of birth.	Date	YYYY-MM-DD	10	50%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
74	PB956	Subscriber Gender	Gender of the subscriber. M = Male F = Female U = Unknown	Text	char	1	50%	Required
75	PB963	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	PB964	Drug Strength	Drug strength (e.g., 500MG, 0.5%, etc.).	Text	varchar	20	0%	Optional
77	PB965	USC Code	USC Code (Universal System of Classification).	Text	varchar	5	0%	Optional
78	PB966	Claim Processing Date	Date the claim was processed.	Date	YYYY-MM-DD	10	99%	Required
79	PB700	Void Date	Date representing the date the claim or claim line was voided. Used for versioning process. Void Date must be greater than or equal to PB017, Paid Date. *If this field is not used for versioning, submit an exception to set the required threshold to 0.*	Date	YYYY-MM-DD	10	5%	Required
80	PB701	Source/Processing System Identifier	Code or name identifying claims processing system upon which the version process was executed. *If this field is not used for versioning, submit an exception to set the required threshold to 0.*	Text	varchar	15	10%	Required
81	PB702	Adjustment /Amendment Date	If PB110 is A, Date representing the date the claim or claim line was adjusted. Used for versioning process. If PB110 is M, Date representing the date the claim or claim line was amended. Used for versioning process. *If this field is not used for versioning, submit an exception to set the required threshold to 0.*	Date	YYYY-MM-DD	10	100% if PB110 = M or A	Required
82	PB703	Adjudication Date	Date representing the date the claim or claim line was adjudicated. Used for versioning process. *If this field is not used for versioning, submit an exception to set the required threshold to 0.*	Date	YYYY-MM-DD	10	100% if PB110 = A, M, R, B	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
83	PB704	Original Claim Number	Original Claim Number. Report the Claim Control Number (PB004) that was originally sent in a prior filing to which this line corresponds. When reported, this data cannot equal its own PB004. *If this field is not used for versioning, submit an exception to set the required threshold to 0.*	Text	varchar	35	10% if PB005A > 1	Required
84	PB706	Versioning Method	Identifies which versioning method will be used for these data. If no versioning process is applicable or available, populate with the value 8. 1 = Versioning Approach 1 – Version Number 2 = Versioning Approach 2 – Version Date 3 = Versioning Approach 3 – Original Claim Number 4 = Versioning Approach 4 – Claim Status and Paid Date 5 = Versioning Approach 5 – Paid Date 6 = Versioning Approach 6 – Complete Replacement 7 = Versioning Approach 7 - Pharmacy 8 = Versioning Approach 8 – Not available Custom versioning processes will be assigned an entity specific versioning method number. See Exhibit C – APCD Claims Versioning.	Int	unsigned int	3	100%	Required
85	PB707	Previous Claim Number	Claim number representing the claim from which the current claim was versioned. This is not the original claim number, although it could be if the claim was only versioned once. This field is required to accommodate custom versioning. If not required, leave NULL and request exception.	Text	varchar	35	35%	Required
86	PB107A	Carrier Specific Unique Member ID – Alias	Alias member's unique ID. This field is used when submitting entity internal systems change, resulting in system wide or sub-system wide member ID changes. This field should contain the original member ID when this change happens. PB107 would contain the new member ID generated by the new system or sub-system. This field should be populated with the original member ID every time the member record is submitted thereafter.	Text	varchar	128	0%	Optional
87	PB108A	Carrier Specific Unique Subscriber ID – Alias	Alias subscriber's unique ID. This field is used when submitting entity internal systems change, resulting in system wide or sub-system wide subscriber ID changes. This field should contain the original subscriber ID when this change happens. PB108 would contain the new subscriber ID generated by	Text	varchar	128	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			the new system or sub-system. This field should be populated with the original subscriber ID every time the member record is submitted thereafter.					
88	PB993	System ID	The system ID. This field represents the submitting entity internal system from which data is sourced. **The default value is 0**, representing the initial system from which the data is pulled. Place the value 0 on all records initially. If a system changes, increment the value by 1. For example, if a system changes, the value would change from 0 to 1. If it changes again, the value would change from 1 to 2. This ID represents the system at the record level. Some submitting entities combine data from multiple systems into a single submission. If one of these systems changes, the system ID would be incremented on the records from the changed system. The system ID on the remaining records would not change. If the system changes resulting in member ID and subscriber ID changes, utilize the Alias fields to capture new and previous member and subscriber IDs for continuity.	Integer	unsigned int	1	100%	Required
89	PB708	Generic Product Identifier (GPI)	The Generic Product Identifier (GPI) hierarchical classification system that identifies drugs from their primary therapeutic use down to the unique interchangeable product regardless of manufacturer or package size.	Text	char	14	85%	Required
90	PB068	Allowed Amount	Maximum amount allowed and that an insurance carrier will pay to a provider for a particular product, 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	100%	Required
91	PB709	AWC Unit Price	Average wholesale cost. A benchmark used for pricing and reimbursement of prescription drugs for both government and private payers. 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
			If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.					
92	PB710	MAC	Maximum Allowable Cost. Refers to a payer or PBM-generated list of products that includes the upper limit or maximum amount that a plan will pay for generic drugs and brand name drugs that have generic versions available ("multi-source brands"). 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	100%	Required
93	PB071	State Sales Tax	Amount of applicable sales tax 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	100%	Required
94	PB038	Postage Amount Claimed	Amount of postage claimed 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	100%	Required
95	PB711	Member Self-Pay	Amount the member has paid beyond the copay structure. For example, this amount would be the amount paid for the Gap on Medicare Part D or difference between generic and brand (not otherwise listed in co-pay or co-insurance fields). 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
96	PB066	Other Insurance Amount Paid	Amount that a prior payer has paid for this claim line. Indicates the submitting entity is the 'secondary payer' to the prior payer. 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	100%	Required
97	PB067	Medicare Paid Amount	Amount Medicare paid toward 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	100%	Required
98	PB112	Medicare Indicator	Indicates Medicare payment applied. 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Text	char	1	100%	Required
99	PB114	Pregnancy Indicator	Indicates member was pregnant when prescription was prescribed. 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Text	char	1	100%	Required
100	PB712	Pharmacy Provider Payment Amount	Amount paid to pharmacy by the PBM for the 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	100%	Required
101	PB713	Pharmacy Provider Payment Amount - Ingredient Cost	Cost of ingredients as part of the Pharmacy Provider Payment Amount that the PBM paid to the pharmacy for the 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	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.					
102	PB714	Pharmacy Provider Payment Amount - Dispensing Fee	Cost for dispensing prescription as part of the Pharmacy Provider Payment Amount that the PBM paid to the pharmacy for the 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	100%	Required
103	PB715	Pharmacy U&C Amount	Amount charged to a member if paying cash for the identical prescription drug services on the date dispensed. 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	100%	Required
104	PB065	Coordination of Benefits/TPL Liability Amount	Amount **due** from a secondary carrier. Report the amount that another payer is liable for after submitting payer has processed this 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. If this field is changed in the versioning process and the dollars must be voided or backed out, the value should be represented as a negative.	Numeric	±decimal	10,2	10%	Required
105	PB113	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 09 = Payment Amount Per Episode	Integer	char	2	100%	Required
106	PB910	Medicaid AID Category	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. If not applicable, leave blank.	Text	Char	2	100% when PB001 = '99MCD1'	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
107	PB850	Placeholder1	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
108	PB851	Placeholder2	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
109	PB852	Placeholder3	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
110	PB853	Placeholder4	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
111	PB854	Placeholder5	Reserved field for use with subsequent Arkansas Data Submission Guide changes.	Text	Varchar	1	0%	Required
112	PB716	Specialty Code	Indicates that the pharmaceutical dispensed is classified as a specialty drug. Y = Specialty Drug N = Not a Specialty Drug	Text	char	1	100%	Required

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EXHIBIT B – ENCRYPTION PROTOCOLS

Data Submission Encryption Protocols

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
    1. "Encrypt" with the recipient's RSA key
    2. "Sign" with the sender's DSA 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 ".gpg.sig"
- Zip the "encrypted + signed" and "detached-signature" files into one archive
  - Name the .zip archive as follows:
    ARAPCD_[EntityCode]_[Test or Prod]_[SubmissionDate]_
    [CoveragePeriodDate]_[FileNo]_[FileCount]_[EntityAbbreviation].dat.zip
    (e.g., "ARAPCD_12345_PROD_20151015_201509_01_02_CLM.dat.zip")
  - Resulting zipped archive file extension should be ".zip"

Encryption Software Recommendations

The APCD Technical Support team recommends that submitters use the following software options for file encryption if they have not already established an encryption process with the Arkansas APCD. These recommendation describe GPG encryption protocols that can be accomplished at no cost to the submitter.

The APCD Technical Support team will work with submitting entities if PGP encryption protocols are the only option.

GPG Encryption Software Tools

- 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

GPG Command Line Examples

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

- Definition:
    - "recipient" parameter is the ARAPCD Public RSA Key
    - "local-user" parameter is the SE's DSA KeyID
    - "passphrase" is the SE's passphrase
    - "file name" is the file name format described above
- Examples:
    - GPG --recipient ***[ARAPCD Public RSA Key]*** --local-user ***[SE DSA Key]*** --sign --yes --passphrase ***[SE's DSA Key passphrase]*** --always-trust --output "[***file name]***.dat.gpg" --encrypt "***file name***.dat"
    - gpg --local-user ***[SE DSA Key]*** --yes --passphrase ***[SE's DSA Key pass phrase]*** --output " ***[file name]***.dat.gpg.sig" --detach-sign "***[file name]***.dat.gpg"
    - 7z a --tzip "***[file name]***.dat.zip" "***[file name]***.dat.gpg"
    - 7z a --tzip "***[file name]***.dat.zip" "***[file name]***.dat.gpg.sig"

EXHIBIT C – APCD CLAIMS VERSIONING

Arkansas APCD claims versioning is used to build the most recent "version" of a claim that most accurately represents the diagnoses, procedures, dollars paid, service dates, and other related information for the claim. It is not an attempt to replicate submitting entity versioning, adjustment, or adjudication processes but to provide accurate information for analysis and reporting. Versioned claims will be used to calculate aggregation fields such as Total Claim Amounts for the Arkansas APCD.

The Arkansas APCD identified nine claims versioning approaches that generally fit most requirements. Submitting entities can choose from these approaches for data submission.

Versioning Approach Selection

1. If selecting a versioning approach described herein:
    a. Submitting entities participating in the initial Arkansas APCD build (those having registered in 2015) should identify the versioning approach they will utilize prior to December 31, 2016, in preparation for the data submission as defined in Rule 100 due on March 31, 2017.
        i. Submit an email to the Arkansas APCD Technical Support team with the subject line, "[Entity ID] Versioning Approach." The body of the email should name the versioning approach from the selection in this section. For example, submitting entity name and/or entity ID selects versioning approach 1 for medical and dental claims.
        ii. The APCD Technical Support team will reach out for confirmation, will address outstanding questions, and will establish a testing process.
        iii. Populate MC706, PC706, and DC706 with the appropriate values to identify the versioning approach.
    b. New submitting entities (those registering after 2015) should identify the versioning approach they will utilize prior to test file data submission. Refer to the Submission Schedule for file submission instructions.
        i. Submit an email to the Arkansas APCD Technical Support team with the subject line, "[Entity ID] Versioning Approach." The body of the email should name the versioning approach from the selection in this section. For example, submitting entity name and/or entity ID selects versioning approach 1 for medical and dental claims.
        ii. The APCD Technical support team will reach out for confirmation, will address outstanding questions, and will establish a testing process.
        iii. Populate MC706, PC706, and DC706 with the appropriate value to identify the versioning approach.

2. If the submitting entity's versioning approach is not defined here, it can be accommodated but will be considered custom. The Arkansas APCD team will work with submitting entities as needed to establish the appropriate versioning process.

Assumptions

- Claim Status (MC138, PC110, DC059) will provide the primary direction for claim versioning priorities.
- Amounts must be represented as negative values for voided claims, back out claims, or reversed claims and must be associated with a previous claim.

- When fields specified in any of the included approaches cannot determine the final version, other fields may be used to fulfill versioning logic.
- Even with standard approaches defined, the Arkansas APCD Technical Support team will work with submitting entities to understand how data element IDs should be handled.
- As the new "versions" of each claim are added to the Arkansas APCD data warehouse as transactions, the Arkansas APCD data transformation processes will aggregate them to create the final version of a claim for reporting and analysis.
- Member/enrollment data versioning is different than claims versioning. Member/enrollment versioning is described in Data Categories for Submission – Enrollment Data.
- Versioning fields specified in this DSG that are not required by the selected versioning approach should be left NULL. Submit an exception for each field that is not used.

Validation Process for Versioning Approaches

Refer to the Data Integrity Audit section.

Claims Versioning Approaches

Approach 1: Version Numbers

Use Version Number to identify the latest version of a claim or claim line. Version Number can be an alphanumeric value up to 20 bytes in length. It must represent the incremented version of the claim. While a Version Number that is specific to a submitting entity can be accommodated, the preferred format is a 2-digit number beginning with 00 that is incremented as claim versions are generated.

Claim lines with higher Version Numbers will incrementally replace those with lower Version Numbers. If multiple versioned claims are received in a data submission period, the claim line with the highest Version Number will be considered the final claim for that period.

When claims are received with a Version Number greater than 00, the following steps occur:

- Payer Claim Control Number (MC004, PC004, DC004) and Line Number (MC005, PC005, DC005) are matched to existing data.
- Version Number (MC005A, PC005A, DC005A) is compared to existing data to identify order of version (multiple versions of a claim can be received in a submission period).

Populate fields MC706, PC706, and DC706 with value 1 to indicate that Version Numbers will be used as the versioning approach.

See Versioning Example 1.

Approach 2: Version Date

Use Version Date to identify the latest version of a claim or claim line. The value in Version Date represents either the year and month or the Julian date of the latest version of the claim.

Claim lines with higher Version Dates will incrementally replace those with lower Version Dates. If multiple versioned claims are received in a data submission period, the claim line with the latest Version Dates will be considered the final claim for that period.

When claims are received with Version Dates (and Version Number is not present), the following steps occur:

- Payer Claim Control Number (MC004, PC004, DC004) and Line Counter (MC005, PC005, DC005) are matched to existing data.
- Version Date (MC005B, PC005B, DC005B) is compared to existing data to identify order of version (multiple versions of a claim can be received in a submission period).

Populate fields MC706, PC706, and DC706 with value 2 to indicate that Version Date will be used as the versioning approach.

See Versioning Example 2.

Approach 3: Original Claim Number

When Version Number and/or Version Date cannot be used to identify versions, Original Claim Number can be used to identify a change. Changed claims are sent with a new Payer Claim Control Number (MC004, PC004, DC004). The Payer Claim Control Number from the original claim will be in the Original Claim Number field (MC139, PC704, DC704) of the changed claim. Original Claim Number (MC139, PC704, DC704) cannot contain the same value as Payer Claim Control Number (MC004, PC004, DC004).

When claims are received with Original Claim Number and no other versioning information, the following steps occur:

- Original Claim Number (MC139, PC704, DC704) on the newly submitted claim is matched to the Payer Claim Control Number (MC004, PC004, DC004) on existing claims.
- Paid Dates (MC017, PC017, DC017) are compared to existing data to identify order of version (multiple versions of a claim can be received in a submission period).

Populate fields MC706, PC706, and DC706 with value 3 to indicate that Original Claim Number will be used as the versioning approach.

See Versioning Example 3.

Approach 4: Claim Status and Paid Date

When Version Number, Version Date, and/or Original Claim Number cannot be used to identify versions, Claim Status and Paid Date can be used to identify a change. The following steps occur:

- Payer Claim Control Number (MC004, PC004, DC004) and Line Counter (MC005, PC005, DC005) are matched to existing data.
- Claim Status (MC138, PC110, DC059) is used to identify the type of version and the action to be taken.
- Paid Dates (MC017, PC017, DC017) are compared to existing data to identify order of version (multiple versions of a claim can be received in a submission period).

Populate fields MC706, PC706, and DC706 with value 4 to indicate that Claim Status and Paid Date will be used as the versioning approach.

See Versioning Example 4.

Approach 5: Paid Date

When Paid Date is the only variable available to identify versions, the following steps occur:

- Payer Claim Control Number (MC004, PC004, DC004) and Line Counter (MC005, PC005, DC005) are matched to existing data.
- Paid Dates (MC017, PC017, DC017) are compared to existing data to identify order of version (multiple versions of a claim can be received in a submission period).

Populate fields MC706, PC706, and DC706 with value 5 to indicate that Paid Date alone will be used as the versioning approach.

See Versioning Example 5.

Approach 6: Complete File Replacement

When versioning requirements are too complex to replicate effectively, a complete file replacement (or refresh) is recommended. A complete file replacement requires that the most recent version of all claims included in the historical file submission and the subsequent file submissions be submitted along with new claims.

Version number should be incremented on claims that are versioned. Use sequential version numbers beginning with 0 for original, 1 for the first versions, 2 for the second version, etc. It is understood that claims can be versioned multiple times during a submission period and that the version numbers between data submissions may not increment by 1. For example, an existing claim could be version 0. This claim could change twice during the submission period so the claim received during the next submission could be version 2.

Upon receipt of replacement data feeds, claim numbers and claim lines will be compared to existing data to ensure that all data is present as part of the load process. Once counts are verified, the Arkansas APCD data load processes will drop all existing claims based on the submitting entity ID and load the replacement and new data.

Populate fields MC706, PC706, and DC706 with value 6 to indicate that a Complete File Replacement will negate the use of versioning.

Approach 7 – Pharmacy Claims

Variables used to identify new versions of a pharmacy claim.

- PC004 – Payer Claim Control Number
- PC005 – Line Counter
- PC018 – Pharmacy Number
- PC058 – Script Number
- PC032 – Date Prescription Filled
- PC028 – Fill Number
- PC017 – Paid Date
- PC107 – Carrier Specific Unique Member ID
- PC110 – Claim Status

To identify a pharmacy claim version, the following steps occur:

- PC107 - Carrier Specific Unique Member ID, PC018 – Pharmacy Number, PC032 – Date Prescription Filled, PC058 – Script Number, and PC028 – Fill Number are grouped
- PC004 - Payer Claim Control Number, PC005 – Line Counter, PC028 – Fill Number, PC017 – Paid Date, and PC110 – Claim Status are evaluated for differences to find the last transaction and identify the final version of the claim.

Populate fields MC706, PC706, and DC706 with value 7 to indicate that a Pharmacy Claims approach will be used for versioning.

See Versioning Example 6.

Approach 8 – No Versioning Available

The Arkansas APCD recognizes that some legacy processing systems do not have claims versioning. If this is not available, populate fields MC706, PC706, and DC706 with value 8 to indicate that there is no versioning option available.

Custom Versioning Approach

The Arkansas APCD recognizes that some claims processing system versioning process cannot be accommodated by the approaches available. The Arkansas APCD team will work with submitters requiring custom versioning approaches, assigning them a versioning process number indicating that a custom approach is required.

Voids

Voided claims are identified by the presence of Claim Status (MC138, PC110, DC059) = V or the presence of a Void Date (MC700, PC700, DC700). All dollar fields should be negative.

When a void record is received, the following steps occur:

- Payer Claim Control Number (MC004, PC004, DC004) and Line Counter (MC005, PC005, DC005) are matched to existing data
- Claim Status (MC138, PC110, DC059) is evaluated for the presence of value V.
- Void Date (MC700, PC700, DC700) is evaluated to ensure presence of valid date.
- Total claim amount aggregations will be reduced by the amount on the void record.

See Versioning Example 7.

Versioning Examples

The following examples illustrate basic versioning concepts to be applied for each versioning approach. These concepts can be enhanced with other data elements as required by submitting entities.

Example 1: With Version Numbers

#	Payer Claim Control Number	Line Counter	Version Number	Paid Date	Claim Status	Amount*	Description
1	**789**	1	00	2014-07-15	O	$10	Original submission
2	**789**	2	00	2014-07-15	O	$20	Original submission
3	**789**	3	00	2014-07-15	O	$30	Original submission
4						*$60*	*Total claim amount calculated for APCD*
5	**789**	1	01	2014-07-15	B	-$10	Back Out/Reversal Claim Line with updated data
6						*$50*	*Total claim amount calculated for APCD*
7	**789**	2	01	2014-07-15	A, R, or M	$5	Adjusted/Amended/Replacement Claim Line with updated data
8	**789**	1	02	2014-07-15	A, R, or M	$15	Adjusted/Amended/Replacement Claim Line with updated data
9						*$50*	*Total claim amount calculated for APCD (Lines 3 + 7 + 8)*

*The amount column represents any dollar field on the claim.

Match Criteria	Versioning Process
Match on Payer Claim Control Number and Line Counter Other Data Element IDs Used: Claim Status	Evaluate Version Number and Claim Status. Keep as final the record with the highest Version Number per each unique Payer Claim Control Number and Line Counter. For this example, the final lines for this claim are 3, 7, and 8. Note, if versioned claim line represents a back out, void, or drop, the dollar values should be negative.

Example 2: No Version Numbers With Version Date Indicators Only

#	Payer Claim Control Number	Line Counter	Version Date	Paid Date	Claim Status	Amount*	Description
1	**321**	1	16015	2014-07-15	Unavailable	$10	Original submission
2	**321**	2	16015	2014-07-15	Unavailable	$20	Original submission
3	**321**	3	16015	2014-07-15	Unavailable	$30	Original submission
4						*$60*	*Total claim amount calculated for APCD*
5	**321**	1	16036	2014-09-30	Unavailable	-$10	Back Out/Reversal Claim Line with updated data
6	**321**	1	16036	2014-09-30	Unavailable	$20	Adjusted/Amended/Replacement Claim Line with updated data
7						*$70*	*Total claim amount calculated for APCD* *((Lines 1 + 2 + 3) - Line 5 + Line 6)*

*The amount column represents any dollar field on the claim.

Match Criteria	Versioning Process
Match on Payer Claim Control Number and Line Counter (If Claim Status was available, the methodology in Example 1 would be followed)	Evaluate Version Date. When Version Date is later than the original Version Date, add as versioned claim and incorporate Amount into Total Claim amount calculated for APCD. Apply in chronological order based on Version Date. For multiple versions on the same day, add all positive values and then subtract negative values. Note: If versioned claim line represents a back out, void, or drop, the dollar values should be negative.

Example 3: Original Claim Number

#	Payer Claim Control Number	Line Counter	Original Claim Number	Paid Date	Claim Status	Amount*	Description
1	**321**	1		2014-07-15	O	$10	Original submission
2	**321**	2		2014-07-15	O	$20	Original submission
3	**321**	3		2014-07-15	O	$30	Original submission
4						*$60*	*Total claim amount calculated for APCD*
5	**456**	1	321	2014-09-30	O	-$20	Back Out/Reversal Claim Line with updated data
7						*$30*	*Total claim amount calculated for APCD* *((Lines 1 + 2 + 3) - Line 5)*

* The amount column represents any dollar field on the claim.

Match Criteria	Versioning Process
Match on Payer Claim Control Number and Original Claim Number	Evaluate other data fields. When record with Original Claim Number matches the Payer Claim Control Number on a new record, evaluate key fields on the record including but not limited to Paid Date and Amount Fields. Identify differences and aggregate based on changes. Note: If versioned claim line represents a back out, void, or drop, the dollar values should be negative.

Example 4: No Version Numbers With Claim Status and Paid Date Indicators

#	Payer Claim Control Number	Line Counter	Paid Date	Claim Status	Amount*	Description
1	**123**	1	2014-07-15	O	$10	Original submission
2	**123**	2	2014-07-15	O	$20	Original submission
3	**123**	3	2014-07-15	O	$30	Original submission
4					*$60*	*Total claim amount calculated for APCD*
5	**123**	2	2014-09-30	B	-$20	Back Out/Reversal Claim Line with updated data
6	**123**	3	2014-09-30	A, M, R	$10	Adjusted/Amended/Replacement Claim Line with updated data
7					*$20*	*Total claim amount calculated for APCD (Lines 1 + 6)*

*The amount column represents any dollar field on the claim.

Match Criteria	Versioning Process
Match on Payer Claim Control Number	Evaluate Line Counter, Claims Status and Paid Date. Keep as final the record with the latest paid date per each unique Payer Claim Control Number and Line Counter. For this example, the final lines for this claim are 1 and 6. Lines 2 and 5 are not included because their claim status indicated O and B, cancelling each other out. Note: If versioned claim line represents a back out, void, or drop, the dollar values should be negative.

Example 5: No Version Numbers Using Paid Date Indicators Only

#	Payer Claim Control Number	Line Counter	Paid Date	Claim Status	Amount*	Description
1	**456**	1	2014-07-15	Unavailable	$10	Original submission
2	**456**	2	2014-07-15	Unavailable	$20	Original submission
3	**456**	3	2014-07-15	Unavailable	$30	Original submission
4					*$60*	*Total claim amount calculated for APCD*
5	**456**	1	2014-09-30	Unavailable	-$10	Back Out/Reversal Claim Line with updated data
6	**456**	1	2014-09-30	Unavailable	$20	Adjusted/Amended/Replacement Claim Line with updated data
7					*$70*	*Total Claim Amount calculated for APCD* *(Lines 1 + 2 + 3 + 5 + 6)*

*The amount column represents any dollar field on the claim.

Match Criteria	Versioning Process
Match on Payer Claim Control Number	Keep as final the record with the latest paid date per each unique Payer Claim Control Number. For this example, the final lines for this claim are 1, 2, 3, 5, and 6. Because claim status is missing to govern order of operations, all claim lines will be added, regardless of status. Note: If versioned claim line represents a back out, void, or drop, the dollar values should be negative.

Example 6: Pharmacy Example with No Version Numbers or Version Dates

#	Payer Claim Control Number	Line Counter	Carrier Specific Unique Member ID	PharmacyNumber	Fill Date	Script Number	Fill Number	Claim Status	Amount*	Description
1	**567**	1	120	100	2014-07-15	72	00	O	$10	Original submission
2	**1589**	1	120	100	2014-07-15	72	00	A	$20	New version of Claim 567
3									*$20*	*Total claim amount calculated for APCD* *(Line 2 replaces Line 1)*
4	**2235**	1	120	100	2014-08-15	72	01	O	$20	Original submission
5									*$20*	*Total claim amount calculated for APCD* *(Line 4 only)*
6	**789**	1	120	225	2015-08-30	175	00	O	$30	Original submission
7	**1864**	1	120	225	2015-08-30	175	00	B	-$30	New version of Claim 789
8									$0	*Total claim amount calculated for APCD* *(Line 6 - Line 7)*

*The amount column represents any dollar field on the claim.

Match Criteria	Versioning Process
Match on Carrier Specific Unique Member ID, Pharmacy Number, Fill Date, Script Number, and Fill Number	Evaluate match fields. When records are grouped by these fields, and the claim status is different, the original claim has been adjusted or amended. When Claims Status equals A, M, R, claim line with the incrementally higher Payer Claim Control Number will be the versioned and final claim. The Amount* will be used as the Total Claim amount calculated for APCD. When Claims Status equals B, claim line with the incrementally higher Payer Claim Control Number will be backed out. The Amount will be reversed from the Total Claim amount calculated for APCD.

Example 7: Voids

#	Payer Claim Control Number	Line Counter	Version Number	Paid Date	Claim Status	Void Date	Amount*	Description
1	**749**	1	00	2014-07-15	O		$10	Original submission
2	**749**	2	00	2014-07-15	O		$20	Original submission
3	**749**	3	00	2014-07-15	O		$30	Original submission
4							*$60*	*Total claim amount calculated for APCD*
5	**749**	1	01	2014-07-15	V	2014-09-30	-$20	Voided claim
6							*$40*	*Total claim amount calculated for APCD* *((Lines 1 + 2 + 3) - Line 5)*

*The amount column represents any dollar field on the claim.

Match Criteria	Versioning Process
Match on Payer Claim Control Number and Line Counter	Evaluate Claim Status and Void Date. When Claim Status is V and/or Void Date is populated, the Amount will be reversed from the Total Claim Amount calculated for APCD.

APPENDICES

Appendix A: Insurance Type Product Codes

Insurance type product codes represent a custom set of values developed to support Arkansas health insurance plans.

Value	Description
AW	Arkansas Workers' Compensation Commission Coverage
CAP	Capitated Plan
CI	Commercial Insurance Company
DNT	Dental
EBD	State Employee Benefits Division
EP	Exclusive Provider Organization
HM	Health Maintenance Organization (HMO)
HN	Health Maintenance Organization (HMO) Medicare Risk/Medicare Part C
HS	Special Low Income Medicare Beneficiary
IN	Indemnity
MCR	Medicare
MA	Medicare Part A
MB	Medicare Part B
MCD	Medicaid
MCO	Managed Care Organization
MD	Medicare Part D
MDV	Medicare Advantage
MH	Medigap Part A
MHO	Medicare Advantage HMO
MI	Medigap Part B
MMC	Arkansas Medicaid Managed Care
MPO	Medicare Advantage Preferred Provider Organization (PPO)
PBM	Pharmacy Benefits Manager
PR	Preferred Provider Organization (PPO)
PS	Point of Service (POS)
RPO	Risk-Based Provider Organizations
SP	Supplemental Policy

Appendix B: Relationship Codes

Relationship codes listed here are based on CMS HIPAA Individual Relationship codes: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R9MSP.pdf.

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
99	Unknown

Appendix C: Discharge Status

This appendix should not be considered the definitive list of discharge status values. Values may be available that are not included in this list. If submitting entities have values that are not present in this list they should contact the Arkansas APCD Technical Support team.

Value	Description
00	Unknown value
01	Discharged to home/self care (routine charge)
02	Discharged/transferred to other short-term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care (for hospitals with an approved swing bed arrangement, use Code 61 – swing bed; for reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04 – ICF)
04	Discharged/transferred to intermediate care facility (ICF)
05	Discharged/transferred to another type of institution for inpatient care (including distinct parts) NOTE: Effective January 2005, psychiatric hospital or psychiatric distinct part unit of a hospital will no longer be identified by this code. New code is “65.”
06	Discharged/transferred to home 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 drug therapy provider (discontinued effective 10/1/05)
09	Admitted as an inpatient to this hospital (effective 3/1/91) NOTE: In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient.
10	Discharged state assigned
11	Discharged state assigned
12	Discharged state assigned
13	Discharged state assigned
14	Discharged state assigned
15	Discharged state assigned
16	Discharged state assigned
17	Discharged state assigned
18	Discharged state assigned
19	Discharged state assigned
20	Expired (did not recover – Christian Science patient)
21	Discharged/transferred to court/law e nforcement
22	Died state assigned
23	Died state assigned
24	Died state assigned
25	Died state assigned
26	Died state assigned
27	Died state assigned
28	Died state assigned
29	Died state assigned
30	Still patient
31	Admitted (first interim bill)
32	Still patient state assigned
33	Still patient state assigned
34	Still patient state assigned
35	Still patient state assigned

Value	Description
36	Still patient state assigned
37	Still patient state assigned
38	Still patient state assigned
39	Still patient state assigned
40	Expired at home (hospice claims only)
41	Expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice (hospice claims only)
42	Expired – place unknown (Hospice claims only)
43	Discharged/transferred to a federal hospital (effective 10/1/03)
44	National assignment
45	National assignment
46	National assignment
47	National assignment
48	National assignment
49	National assignment
50	Hospice – home (effective 10/1996)
51	Hospice – medical facility (effective 10/1996)
52	National assignment
53	National assignment
54	National assignment
55	National assignment
56	National assignment
57	National assignment
58	National assignment
59	National assignment
60	National assignment
61	Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (effective 9/2001)
62	Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital (effective 1/2002)
63	Discharged/transferred to a long-term care hospital (effective 1/2002)
64	Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare (effective 10/2002)
65	Discharged/Transferred to a psychiatric hospital or a psychiatric-distinct unit of a hospital (effective 1/2005) NOTE: These types of hospitals were pulled from patient/discharge status code “05” and given their own code.
66	Discharged/transferred to a Critical Access Hospital (CAH) (effective 1/1/06)
67	National assignment
68	National assignment
69	Discharged/transferred to a designated disaster alternative care site (effective 10/2013)
70	Discharged/transferred to another type of health care institution not defined elsewhere in code list
71	Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (effective 9/2001) (discontinued effective 10/1/05)
72	Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (effective 9/2001) (discontinued effective 10/1/05)
73	National assignment
74	National assignment
75	National assignment
76	National assignment
77	National assignment
78	National assignment
79	National assignment

Value	Description
80	National assignment
81	Discharged to home or self-care with a planned acute care hospital readmission (effective 10/2013)
82	Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission (effective 10/2013)
83	Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission (effective 10/2013)
84	Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission (effective 10/2013)
85	Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission (effective 10/2013)
86	Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission (effective 10/2013)
87	Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission (effective 10/2013)
88	Discharged/transferred to a federal healthcare facility with a planned acute care hospital inpatient readmission (effective 10/2013)
89	Discharged/transferred to a hospital-based Medicare-approved swing bed with a planned acute care hospital inpatient readmission (effective 10/2013)
90	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation-distinct units of a hospital with a planned acute care hospital inpatient readmission (effective 10/2013)
91	Discharged/transferred to a Medicare-certified long-term care hospital (LTCH) with a planned acute care hospital inpatient readmission (effective 10/2103)
92	Discharged/transferred to nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission (effective 10/2013)
93	Discharged/transferred to a psychiatric hospital/distinct part unit of a hospital with a planned acute care hospital inpatient readmission (effective 10/2013)
94	Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission (effective 10/2013)
95	Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission (effective 10/2013)
96	National assignment
97	National assignment
98	National assignment
99	National assignment

Appendix D: Type of Bill

Type of Bill tables were pulled in compiled format from: http://docplayer.net/1732911-Bill-types-page-1-of-8-updated-9-13.html

This appendix section should not be considered the definitive list of type of bill values. Values may be available that are not included in this list. If submitting entities have values that are not present in this list they should contact the Arkansas APCD Technical Support team.

INPATIENT HOSPITAL	
VALUE	**DESCRIPTION**
110	NO PAYMENT CLAIM
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
13X	OTHER NON-SIGNIFICANT PROCEDURES PERFORMED IN HOSPITAL OUTPATIENT SETTINGS

OUTPATIENT DIAGNOSTIC (NON TREATMENT PLAN)	
VALUE	**DESCRIPTION**
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

HOSPITAL SWING BEDS	
VALUE	**DESCRIPTION**
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

SKILLED NURSING	
VALUE	**DESCRIPTION**
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

SKILLED NURSING (MEDICARE PART B ONLY)	
VALUE	**DESCRIPTION**
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

SKILLED NURSING OUTPATIENT	
VALUE	**DESCRIPTION**
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

HOME HEALTH INPATIENT (NOT UNDER A PLAN OF TREATMENT) – DESCRIPTION CHANGE	
VALUE	**DESCRIPTION**
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

COORDINATED HOME CARE (MEDICARE A TREATMENT PLAN INCLUDING DME) – DISCONTINUED AS OF OCTOBER 1, 2013	
VALUE	**DESCRIPTION**
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

HOME HEALTH SERVICES (NOT UNDER A PLAN OF TREATMENT) – DESCRIPTION CHANGE	
VALUE	**DESCRIPTION**
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

RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTION – HOSPITAL INPATIENT	
VALUE	**DESCRIPTION**
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
777	ADJUSTMENT OR REPLACEMENT OF PRIOR CLAIM

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
83X	SIGNIFICANT SURGICAL PROCEDURES PERFORMED IN HOSPITAL OUTPATIENT SETTINGS

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**
860	RESERVED FOR NATIONAL USE – NON-PAYMENT/ZERO CLAIM
861	RESERVED FOR NATIONAL USE – ADMIT THROUGH DISCHARGE
862	RESERVED FOR NATIONAL USE – INTERIM, FIRST CLAIM

863	RESERVED FOR NATIONAL USE – INTERIM, CONTINUING CLAIM
864	RESERVED FOR NATIONAL USE – INTERIM, LAST CLAIM
865	RESERVED FOR NATIONAL USE – LATE CHARGE(S) ONLY CLAIM
867	RESERVED FOR NATIONAL USE – REPLACEMENT OF PRIOR CLAIM
868	RESERVED FOR NATIONAL USE – VOID/CANCEL OF PRIOR CLAIM
869	RESERVED FOR NATIONAL USE – RESERVED FOR NATIONAL ASSIGNMENT

SPECIALTY FACILITY – RESERVED FOR NATIONAL USE	
VALUE	**DESCRIPTION**
860, 870, 880	RESERVED FOR NATIONAL USE – NON-PAYMENT/ZERO CLAIM
871, 881	RESERVED FOR NATIONAL USE – ADMIT THROUGH DISCHARGE
872, 882	RESERVED FOR NATIONAL USE – INTERIM, FIRST CLAIM
873, 883	RESERVED FOR NATIONAL USE – INTERIM, CONTINUING CLAIM
874,884	RESERVED FOR NATIONAL USE – INTERIM, LAST CLAIM
875, 885	RESERVED FOR NATIONAL USE – LATE CHARGE(S) ONLY CLAIM
877, 887	RESERVED FOR NATIONAL USE – REPLACEMENT OF PRIOR CLAIM
878, 888	RESERVED FOR NATIONAL USE – VOID/CANCEL OF PRIOR CLAIM
879, 889	RESERVED FOR NATIONAL USE – RESERVED FOR NATIONAL ASSIGNMENT

SPECIALTY FACILITY – OTHER – RECLASSIFIED TO OUTPATIENT ONLY	
VALUE	**DESCRIPTION**
890	OTHER – NON-PAYMENT/ZERO CLAIM
891	OTHER – ADMIT THROUGH DISCHARGE
892	OTHER – INTERIM, FIRST CLAIM
893	OTHER – INTERIM, CONTINUING CLAIM
894	OTHER – INTERIM, LAST CLAIM
895	OTHER – LATE CHARGE(S) ONLY CLAIM
897	OTHER – REPLACEMENT OF PRIOR CLAIM
898	OTHER – VOID/CANCEL OF PRIOR CLAIM
899	OTHER – RESERVED FOR NATIONAL ASSIGNMENT

To determine all other types of bills, use the following:

1st Digit = Type of facility.
2nd Digit = Bill classification (three different categories) facilities excluding clinics and special facilities clinics only. Special facilities only.
3rd 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/Place of Service

Facility Type / Place of Service codes should be used on professional claims to specify the entity where service(s) are rendered. They are sourced from CMS Medicare coding tables.

This appendix should not be considered the definitive list of facility type values. Values may be available that are not included in this list. If submitting entities have values that are not present in this list they should contact the Arkansas APCD Technical Support team.

Value	Name	Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Telehealth	The location where health services and health related services are provided or received, through a telecommunication system. (Effective January 1, 2017)
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency, individual, or family shelters).
05	Indian Health Service – Free Standing Facility	A facility or location, owned and operated by the Indian Health Service, that provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization (effective January 1, 2003).
06	Indian Health Service – Provider Based Facility	A facility or location, owned and operated by the Indian Health Service, that provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 – Free Standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, that provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization (effective January 1, 2003).
08	Tribal 638 – Provider Based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, that provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison/Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either federal, state, or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
10	Unassigned	N/A
11	Office	Location — other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF) — where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

Value	Name	Description
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home *	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place to place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short-term accommodation such as a hotel, camp ground, hostel, cruise ship, or resort where the patient receives care, and that is not identified by any other POS code.
17	Walk-in Retail Health Clinic	A walk-in health clinic — other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code — that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services. (This code is available for use immediately with a final effective date of May 1, 2010.)
18	Place of Employment – Worksite	A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides ongoing or episodic occupational medical, therapeutic or rehabilitative services to the individual. (This code is available for use effective January 1, 2013, but no later than May 1, 2013).
19	Off Campus – Outpatient Hospital	A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization (effective January 1, 2016).
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, that primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under the supervision of, physicians to patients admitted for a variety of medical conditions.
22	On Campus – Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization (description change effective January 1, 2016).
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

Value	Name	Description
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services, but that does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility that primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility that provides room, board, and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance – Land	A land vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis by, or under the supervision of, a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full-time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's

Value	Name	Description
		mental health services area who have been discharged from inpatient treatment at a mental health facility; 24-hour-a-day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/ Individuals with Intellectual Disabilities	A facility that primarily provides health-related care and services above the level of custodial care to individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility that provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-Residential Substance Abuse Treatment Facility	A location that provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58-59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, that provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	Public Health Clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility that is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A

Value	Name	Description
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other place of service not identified above.
00	Unknown	Facility type is not known.

Appendix F: Procedure Modifier Codes

Utilize the latest Alphanumeric 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.html

This appendix should not be considered the definitive list of modifier code values. Values may be available that are not included in this list. If submitting entities have values that are not present in this list they should contact the Arkansas APCD Technical Support team.

The following table lists only 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

ISO 639-3:2007 codes will be used to represent languages for Arkansas APCD language codes. They can be found at these links.

https://www.iso.org/standard/39534.html

https://iso639-3.sil.org/code_tables/639/data

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Appendix H: Race

Race values are sourced from the Centers for Disease Control and Prevention (CDC) Public Health Information Network (PHIN) Vocabulary. PHIN Vocabulary Standards is a key component in supporting the development and deployment of standards-based public health information systems.
https://www.cdc.gov/nchs/data/dvs/Race_Ethnicity_CodeSet.pdf

This appendix should not be considered the definitive list of race code values. Values may be available that are not included in this list. If submitting entities have values that are not present in this list they should contact the Arkansas APCD Technical Support team.

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

Value	Description
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
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

Value	Description
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
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

Value	Description
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
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

Value	Description
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
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

Value	Description
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
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

Value	Description
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
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

Value	Description
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
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	Israeili
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

Value	Description
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
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

Value	Description
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
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

Value	Description
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	Metlakatla
1072-8	Mexican American Indian
1358-1	Miami
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

Value	Description
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
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

Value	Description
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
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

Value	Description
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
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

Value	Description
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
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

Value	Description
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
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

Value	Description
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
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	Suqpigaq
1536-2	Suquamish
1651-9	Susanville
1245-0	Susquehanock
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

Value	Description
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
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

Value	Description
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
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

Value	Description
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
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 Management Information System required ethnicity codes.

This appendix should not be considered the definitive list of ethnicity code values. Values may be available that are not included in this list. If submitting entities have values that are not present in this list they should contact the Arkansas APCD Technical Support team.

State Codes Effective October 2010

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

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Appendix J: Provider Type Codes

This appendix should not be considered the definitive list of provider type code values. Values may be available that are not included in this list. If submitting entities have values that are not present in this list they should contact the Arkansas APCD Technical Support team.

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
50	Physician Group
60	Nurse
70	Clinician
80	Technician
90	Pharmacy/Site or Mail Order
99	Other Individual or Group

Appendix K: External Code Sources

The reference files assigned to these links are not inclusive. Arkansas APCD data validation tables utilize these data however, because they are not always complete, the Arkansas APCD team will work with submitting entities to identify and fill gaps between APCD reference tables and data submitted in data.

Lookup	Link
State Codes, ZIP Codes, county codes, and Other Geographic Associations	https://www.usps.com/ https://www.census.gov/geo/reference/codes/cou.html
Provider Names Associated with National Provider Identifier (NPI) Number	https://nppes.cms.hhs.gov/NPPES/
Health Care Provider Taxonomy Specialty Codes	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf Dental codes: http://www.ada.org/~/media/ADA/Member%20Center/FIles/topics_npi_taxonomy.ashx
Definitions of ICD-9 and ICD-10 Diagnosis Codes	ICD Diagnosis codes: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html
Definitions of ICD-9 and ICD-10 Procedure Codes	ICD9 Procedure codes: https://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp ICD10 Procedure Codes: https://www.hcup-us.ahrq.gov/toolssoftware/ccs10/ccs10.jsp
Definitions of HCPCS, CPTs and Modifier Codes	CPT codes: https://www.hcup-us.ahrq.gov/toolssoftware/ccs_svcsproc/ccssvcproc.jsp HCPC codes: https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/index.html
Dental Procedure and Identifier Codes	http://www.icd9data.com/HCPCS/2010/D/
Standard Professional Billing Elements	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
Claim Adjustment Reason Codes	http://www.wpc-edi.com/reference/
ISO Country Codes	http://unstats.un.org/unsd/methods/m49/m49alpha.htm Note: This link is the no-cost best resource for ISO 3 numeric country codes.
National Council for Prescription Drug Programs (NCPDP)	http://www.ncpdp.org
National Association of Boards of Pharmacy (NABP)	http://www.nabp.net
North American Industry Classification System	http://www.census.gov/eos/www/naics/
Standard Industrial Classification (SIC) System	https://www.osha.gov/pls/imis/sic_manual.html
Dental Provider Specialty Codes, Tooth Surface, Tooth Number, and Dental Quadrant Definitions	http://www.ada.org/~/media/ADA/Member%20Center/Files/ada_dental_claim_form_completion_instructions_2012.ashx
Atypical Provider Taxonomy Codes	https://www.nucc.org/index.php

Appendix L: Plan and Group Definitions

This appendix section shuld not be considered the definitive list of plan and group definitions values. Values may be available that are not included in this list. If submitting entities have values that are not present in this list they should contact the Arkansas APCD Technical Support team.

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 small employer.	A.C.A. 23-86-303.35

Plan/Group	Definition	Source
Third-Party Administrator (TPA)	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: (1) An employer, for its employees or for the employees of a subsidiary or affiliated corporation of the employer; (2) A union, for its members; (3) An insurer or health maintenance organization licensed to do business in this state; (4) A creditor, for its debtors, regarding insurance covering a debt between them; (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; (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 (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.	A.C.A. 23-92-201
Self-Funded Plans (SLF)	A self-insurance arrangement whereby an employer provides health or disability benefits to employees with its own funds. 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.	Administrative Services Only (ASO)

Appendix M: Tooth Identification

The following tables provide valid value requirements for Tooth Number, Dental Quadrant, and Tooth Surface fields. This information was sourced from Appendix K – External Code Sources, Dental Provider Specialty Codes, Tooth Surface, Tooth Number, and Dental Quadrant Definitions.

Tooth Number or Letter Identification

The Tooth Numbering System tables support DC047 – Tooth Number or Letter Identification.

Permanent Tooth Numbering System	
01 = 3rd Molar (wisdom tooth) – Upper Right	17 = 3rd Molar (wisdom tooth) – Lower Left
02 = 2nd Molar (12-year molar) – Upper Right	18 = 2nd Molar (12-year molar) – Lower Left
03 = 1st Molar (6-year molar) – Upper Right	19 = 1st Molar (6-year molar) – Lower Left
04 = 2nd Bicuspid (2nd premolar) – Upper Right	20 = 2nd Bicuspid (2nd premolar) – Lower Left
05 = 1st Bicuspid (1st premolar) – Upper Right	21 = 1st Bicuspid (1st premolar) – Lower Left
06 = Cuspid (canine/eye tooth) – Upper Right	22 = Cuspid (canine/eye tooth) – Lower Left
07 = Lateral incisor – Upper Right	23 = Lateral incisor – Lower Left
08 = Central incisor – Upper Right	24 = Central incisor – Lower Left
09 = Central incisor – Upper Left	25 = Central incisor – Lower Right
10 = Lateral incisor – Upper Left	26 = Lateral incisor – Lower Right
11 = Cuspid (canine/eye tooth) – Upper Left	27 = Cuspid (canine/eye tooth) – Lower Right
12 = 1st Bicuspid (1st premolar) – Upper Left	28 = 1st Bicuspid (1st premolar) – Lower Right
13 = 2nd Bicuspid (2nd premolar) – Upper Left	29 = 2nd Bicuspid (2nd premolar) – Lower Right
14 = 1st Molar (6-year molar) – Upper Left	30 = 1st Molar (6-year molar) – Lower Right
15 = 2nd Molar (12-year molar) – Upper Left	31 = 2nd Molar (12-year molar) – Lower Right
16 = 3rd Molar (wisdom tooth) – Upper Left	32 = 3rd Molar (wisdom tooth) – Lower Right

Primary Tooth Numbering System	
A = 2nd Molar – Upper Right	K = 2nd Molar – Lower Left
B = 1st Molar – Upper Right	L = 1st Molar – Lower Left
C = Cuspid – Upper Right	M = Cuspid – Lower Left
D = Lateral Incisor – Upper Right	N = Lateral Incisor – Lower Left
E = Central Incisor – Upper Right	O = Central Incisor – Lower Left
F = Central Incisor – Upper Left	P = Central Incisor – Lower Right
G = Lateral Incisor – Upper Left	Q = Lateral Incisor – Lower Right
H = Cuspid – Upper Left	R = Cuspid – Lower Right
I = 1st Molar – Upper Left	S = 1st Molar – Lower Right
J = 2nd Molar – Upper Left	T = 2nd Molar – Lower Right

Universal Tooth Numbering System by Quadrant

Permenant Dentition															
Upper Right								Upper Left							
01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Lower Right								Lower Left							

Primary Dentition															
Upper Right								Upper Left							
			A	B	C	D	E	F	G	H	I	J			
			T	S	R	Q	P	O	N	M	L	K			
Lower Right								Lower Left							

Dental Quadrants

The Dental Quadrant table supports DC048 – Dental Quadrants.

Value	Definition
00	Entire Oral Cavity
01	Maxillary Arch
02	Mandibular Arch
10	Upper Right Quadrant
20	Upper Left Quadrant
30	Lower Left Quadrant
40	Lower Right Quadrant
LA	Lower Anterior
UR	Upper Right Quadrant
UL	Upper Left Quadrant
LR	Lower Right Quadrant
LL	Lower Left Quadrant
BR	Bottom Right Quadrant
TR	Top Right Quadrant
TL	Top Left Quadrant
BL	Bottom Left Quadrant

Tooth Surface

The Tooth Surface table supports DC049 – Tooth Surface.

Value	Definition
B	Buccal
D	Distal
F	Facial (or labial)
I	Incisal
L	Lingual
M	Mesial
O	Occlusal

`

Appendix N: HIOS ID Value Component Definitions

The following bullets provide valid value component requirements requirements for ME992 and MC992. The 16-byte value (CMS field name INSRNC_PLAN_ID) is comprised of several components, each with a specific meaning. All components should be provided in the field.

This information was sourced from: http://edgy.guru/docs/cms/DDC_Slides_090815_v4_5CR_090815.pdf

HIOS_ID or INSRNC_PLAN_ID

- A 16-digit field that serves as a unique plan identifier for a plan and a given variant
- Structured as follows: [HIOS ID][State][Product Iteration][Plan Iteration][Variant]
    - [HIOS ID] = 5-digit HIOS ID
    - [STATE] = 2-digit state code, such as CA, TX, AL, etc. (does include District of Columbia as DC)
    - [Product Iteration] = 3-digit number to indicate a unique product designation
    - [Plan Iteration] = 4-digit number to indicate a unique plan designation
    - [Variant] = 2-digit number to indicate cost-sharing variant and on/off Exchange
        - 00 = Plan sold off the Exchange [Maximum Out of Pocket (MOOP) values not required for these plans]
        - 01-06 = Plan sold on the Exchange in a given CSR variant
        - 31-36 = On-Exchange Medicaid expansion plans (Arkansas and Iowa only)
- The 14-digit version of this ID is often referred to as the “Standard Component ID” or SCID

Appendix O: Data Integrity Audit File Configuration

The following examples illustrate the configuration of the ARAPCD Data Integrity Audit (DIA) files sent to and received from submitting entities to resolve issues identified in claims.

NOTE: *These are examples that illustrate semi-fictitious scenarios. It is possible that the scenarios provided do not represent specific submitting entity system processing. Also, the following versioning examples may not represent the versioning approach utilized by all submitting entities. The examples should be used to conceptually understand the Data Integrity Audit file and how it might be used.*

The Arkansas APCD team will work with each submitting entity receiving a Data Integrity Audit file to understand what issues are being seen and the data expected for resolution. It should be noted that, depending on the issue identified, return data may not be required.

When claims are encountered in the Arkansas APCD update process that do not conform to contextual checks (including, but not limited to, versioning issues, data contextual issues, etc. — e.g., duplicate data, out-of-range dollar amounts), they are flagged as invalid for exclusion from analyses or other data uses until issues are resolved. The DIA review process provides the submitting entity the opportunity to address issues and resubmit corrected claims data as necessary.

The Arkansas APCD will deliver DIA files in the required file format outlined in the Arkansas APCD Data Submission Guide (DSG) in the Data Integrity Audit File section. DIA files will be delivered to the submitting entity with Header Header, Header Detail, Control Count Header, Control Count Detail, Data Header, Data Detail, Trailer Header, and Trailer Detail records.

DIA files should be returned to the Arkansas APCD from the submitting entity in the required file format outlined in the Arkansas APCD DSG.

DIA files will be created for each file type when issues occur. In other words, separate DIA files will be created for medical claims, pharmacy claims, and dental claims. The DIA file, containing all lines for each claim identified as having an issue, will be sent back to the submitting entity for review. If the issue resolution requires any or all of the claims or claim lines to be corrected and resubmitted, the Arkansas APCD team will request a full record resubmission for affected claims, inclusive of all claim lines (not the entire file).

Example 1: ARAPCD Medical Claims DIA File for SE Review

This example illustrates versioning issues and shows the DIA file created by the Arkansas APCD and delivered to submitting entities for review. Other issues can also result in the creation of a DIA file. **NOTE: Only partial data records are represented in these examples. *All fields in the DSG for the file type shall be resubmitted by the submitting entity in the DIA file for the Arkansas APCD.***

- Header Detail records — PeriodBeginDate (HD004) will always contain the beginning date of the Arkansas APCD data: "2013-01-01". This date will never change. The PeriodEndingDate (HD005) reflects the end date of the last submission period.
- Trailer Detail records — PeriodBeginDate (TR004) aligns with HD004 and will always contain the beginning date of the Arkansas APCD data: "2013-01-01". The PeriodEndingDate (TR005) always aligns with HD005 and reflects the end date of the last submission period. TrailerProcessingDate (TR006) and PostingDate (TR007) reflect the dates the DIA file was created and posted by the Arkansas APCD for submitting entity retrieval.
- Control Count records are based on Arkansas APCD DSG requirements for each file type.
- Example medical claim descriptions:
    - Duplicate Claim Line Number — Claim 36203AB1 contains two claim lines and claim status = "O" and claim line number = "2".
    - Inconsistent Member ID Value — Claim 52362AJ6 has two different carrier specific unique member IDs (MC137).
    - Duplicate Claim Line Number — Claim 73906xi contains two claim lines and claim status = "O" and claim line number = "1" but with different procedure codes.
    - Suspect Versioning Chain — Claim 934712Q contains two claim lines and claim line number = "1" but one has claim status = "O" and the second has claim status = "B". The third claim line contains claim line number = "1" and claim status = "B".
- Example medical claim DIA file for example claims described above:

```
HH|HD001|HD002|HD003|HD004|HD005|HD006|HD007|HD008|HD009|HD010

HD|28362||MC|2013-01-01|2018-03-31|12|1|1|8.0.2022|PRODDIA
```

```
CH|CC001|CC002|CC003|CC004|CC005|CC011|CC013|CC014|CC015

CD|28362|CLM|M|5|5|4|5|5|5
```

```
DH|MC999|MC001|MC002|MC003|MC004|MC005|MC055|MC059|MC060|MC063|MC137|MC141|MC138|PeriodBeginDate|PeriodEndingDate|DIA_IssueDes
cription|DIA_ReportDate

DD|1|28362||CI|36203AB1|1|99201|2017-01-16|2017-01-16|25|120922d84|120683S7a|O|2017-01-01|2017-03-31||2018-04-01
DD|2|28362||CI|36203AB1|2|99241|2017-01-16|2017-01-16|50|120922d84|120683S7a|O|2017-01-01|2017-03-31|Duplicate Claim Line
Number|2018-04-01

DD|3|28362||CI|36203AB1|3|0001U|2017-01-16|2017-01-16|60|120922d84|120683S7a|O|2017-01-01|2017-03-31||2018-04-01
DD|4|28362||CI|36203AB1|2|99241|2017-01-16|2017-01-16|50|120922d84|120683S7a|O|2017-01-01|2017-03-31|Duplicate Claim Line
Number|2018-04-01
```

```
DD|5|28362||CI|52362AJ6|1|99201|2017-05-2|2017-05-2|100|1344521a|1344521a|O|2017-04-01|2017-06-30|Inconsistent Member ID
Value|2018-04-01
DD|6|28362||CI|52362AJ6|2|0006U|2017-05-2|2017-05-2|150|x71263w|x71263w|O|2017-04-01|2017-06-30|Inconsistent Member ID
Value|2018-04-01
DD|7|28362||CI|52362AJ6|3|80150|2017-05-2|2017-05-2|300|1344521a|1344521a|O|2017-04-01|2017-06-30|Inconsistent Member ID
Value|2018-04-01
```

```
DD|8|28362||CI|73906xi|1|99201|2017-05-30|2017-05-31|125|426624K|50263wL|O||2017-04-01|2017-06-30|Duplicate Claim Line
Number|2018-04-01
DD|9|28362||CI|73906xi|1|10021|2017-05-30|2017-05-31|125|426624K|50263wL|O||2017-04-01|2017-06-30|Duplicate Claim Line
Number|2018-04-01
DD|10|28362||CI|934712Q|1|99201|2017-05-30|2017-05-31|125|426624K|50263wL|O|2017-01-01|2017-03-31|Suspect Versioning
Chain|2018-04-01
DD|11|28362||CI|934712Q|1|99201|2017-05-30|2017-05-31|125|426624K|50263wL|B|2017-01-01|2017-03-31|Suspect Versioning
Chain|2018-04-01
DD|12|28362||CI|934712Q|1|99201|2017-05-30|2017-05-31|125|426624K|50263wL|B|2017-01-01|2017-03-31|Suspect Versioning
Chain|2018-04-01

TH|TR001|TR002|TR003|TR004|TR005|TR006|TR007
TD|28362||MC|2013-01-01|2018-03-31|2018-04-01|2018-04-01
```

Example 2: Return DIA File with Corrected Data

This example shows what the file returned from the submitting entity would include and illustrates the versioning issues in Example 1. **NOTE: Only partial data records are represented in these examples.** ***All fields in the DSG for the file type shall be resubmitted by the submitting entity in the DIA file for the Arkansas APCD.***

- Header Detail records — PeriodBeginDate (HD004) will always contain the beginning date of the Arkansas APCD data: “2013-01-01”. This date will never change. The PeriodEndingDate (HD005) reflects the end date of the last submission period.
- Trailer Detail records — PeriodBeginDate (TR004) aligns with HD004 and will always contain the beginning date of the Arkansas APCD data: “2013-01-01”. The PeriodEndingDate (TR005) always aligns with HD005 and reflects the end date of the last submission period. TrailerProcessingDate (TR006) and PostingDate (TR007) reflect the dates the DIA file was created and posted by the submitting entity for Arkansas APCD retrieval.
- Control count records are based on Arkansas APCD DSG requirements for each file type.
- Example medical claim descriptions:
    - Claim 36203AB1 — A record was provided for claim line 2 and claim status = “R”. This record will replace the two records with claim line 2.
    - Claim 52362AJ6 — A record was provided for claim line 2 and claim status = “B”. This record will cancel out the matching record with claim status = “O”. Also a new claim line was included.
    - Claim 73906xi — Two records were returned with corrected claim line numbers. These will replace the original records in the Arkansas APCD.
    - Claim 934712Q — This claim could not be corrected. No records were returned to the Arkansas APCD. This claim is flagged as problematic in the Arkansas APCD and will not be included in data requests or analyses.

- Example medical claim DIA file for example claims described above:

```
HH|HD001|HD002|HD003|HD004|HD005|HD006|HD007|HD008|HD009|HD010
HD|28362||MC|2013-01-01|2018-03-31|12|1|1|8.0.2022|PRODDIA
CH|CC001|CC002|CC003|CC004|CC005|CC011|CC013|CC014|CC015
CD|28362|CLM|M|5|5|4|5|5|5
DH|MC999|MC001|MC002|MC003|MC004|MC005|MC055|MC059|MC060|MC063|MC137|MC141|MC138|PeriodBeginDate|PeriodEndingDate
DD|1|28362||CI|36203AB1|1|99201|2017-01-16|2017-01-16|25|120922d84|120683S7a|O|2017-01-01|2017-03-31
DD|3|28362||CI|36203AB1|3|0001U|2017-01-16|2017-01-16|60|120922d84|120683S7a|O|2017-01-01|2017-03-31
DD|4|28362||CI|36203AB1|2|99241|2017-01-16|2017-01-16|50|120922d84|120683S7a|R|2017-01-01|2017-03-31
DD|5|28362||CI|52362AJ6|1|99201|2017-05-2|2017-05-2|100|1344521a|1344521a|O|2017-04-01|2017-06-30
DD|6|28362||CI|52362AJ6|2|0006U|2017-05-2|2017-05-2|150|x71263w|x71263w|B|2017-04-01|2017-06-30
DD|7|28362||CI|52362AJ6|3|80150|2017-05-2|2017-05-2|300|1344521a|1344521a|O|2017-04-01|2017-06-30
DD|7|28362||CI|52362AJ6|4|80305|2017-05-2|2017-05-2|500|1344521a|1344521a|O|2017-04-01|2017-06-30
DD|8|28362||CI|73906xi|1|99201|2017-05-30|2017-05-31|125|426624K|50263wL|O||2017-04-01|2017-06-30
DD|9|28362||CI|73906xi|2|10021|2017-05-30|2017-05-31|125|426624K|50263wL|R||2017-04-01|2017-06-30
TH|TR001|TR002|TR003|TR004|TR005|TR006|TR007
TD|28362||MC|2013-01-01|2018-03-31|2018-06-01|2018-06-01
```

Example 3: ARAPCD Pharmacy Claims DIA File for SE Review

This example illustrates versioning issues and shows the pharmacy claims DIA file created by the Arkansas APCD and delivered to submitting entities for review. Other issues can also result in the creation of a DIA file. **NOTE: Only partial data records are represented in these examples. *All fields in the DSG for the file type shall be returned to the submitting entity in the DIA file for review.***

- Header Detail records — PeriodBeginDate (HD004) will always contain the beginning date of the Arkansas APCD data: “2013-01-01”. This date will never change. The PeriodEndingDate (HD005) reflects the end date of the last submission period.
- Trailer Detail records — PeriodBeginDate (TR004) aligns with HD004 and will always contain the beginning date of the Arkansas APCD data: “2013-01-01”. The PeriodEndingDate (TR005) always aligns with HD005 and reflects the end date of the last submission period. TrailerProcessingDate (TR006) and Posting Date (TR007) reflect the dates the DIA file was created and posted by the Arkansas APCD for submitting entity retrieval.
- Control count records are based on Arkansas APCD DSG requirements for each file type.
- Example Pharmacy claim descriptions:

- Suspect Versioning Chain — Claim 617252 contains two claim lines and claim status = "O" with differing drug names. The correct record cannot be determined with the selected versioning approach. The PeriodBeginDate and PeriodEndingDate (not used in versioning) indicate that the records came in different submissions.
- Suspect Versioning Chain — Claim 7262-1 has one original record (PC110 = O) and two back out records (PC110 = B).
- Range Issue — Claim A62D0 paid amount field (PC017) contains a value that is out of range.
- Contextual Issue – Claim 731Z123 does not contain a drug name (PC027), yet it contains a fill number (PC028).

- Example Pharmacy claim DIA file for example claims described above:

```
HH|HD001|HD002|HD003|HD004|HD005|HD006|HD007|HD008|HD009|HD010
HD|28362||PC|2013-01-01|2018-06-30|6|1|1|8.0.2022|PRODDIA
CH|CC001|CC002|CC003|CC004|CC005|CC011|CC012|CC013|CC014|CC016|CC017
CD|28362|PHM|Q|3|3|3|1|||3|1
DH|PC999|PC001|PC002|PC003|PC004|PC005|PC017|PC027|PC028|PC032|PC036|PC058|PC110|
PeriodBeginDate|PeriodEndingDate|DIA_IssueDescription|DIA_ReportDate
DD|1|28362||CI|617252|1|2014-08-16|OMEPRAZOLE CAP 20MG|1|2014-08-16|11.86|112|O|2014-07-01|2014-09-30|Suspect Versioning
Chain |2018-04-01
DD|2|28362||CI|617252|1|2014-08-16|OMEPRAZOLE CAP 10MG|1|2014-08-16|11.86|112|O|2014-10-01|2014-12-31|Suspect Versioning
Chain|2018-04-01
DD|3|28362||CI|7262-1|1|2016-11-03|CILOSTAZOL|1|2016-11-03|29.72|1525|O|2017-01-01|2017-03-31|Suspect Versioning Chain|2018-
04-01
DD|4|28362||CI|7262-1|1|2016-11-03|CILOSTAZOL|1|2016-11-03|-29.72|1525|B|2017-01-01|2017-03-31|Suspect Versioning Chain|2018-
04-01
DD|5|28362||CI|7262-1|1|2016-11-03|CILOSTAZOL|1|2016-11-03|-5.00|1525|B|2017-01-01|2017-03-31|Suspect Versioning Chain|2018-
04-01
DD|3|28362||CI|A62D0|1|2016-09-15|CLARINEX-D 12 HOUR TABLET|1|2016-11-03|250632.80|809XAB-1|O|2017-01-01|2017-03-31|Range
Issue|2018-04-01
DD|3|28362||CI|731Z123|1|2016-09-15||3|2016-11-03|10.80|684431|O|2017-01-01|2017-03-31|Contextual Issue|2018-04-01
TH|TR001|TR002|TR003|TR004|TR005|TR006|TR007
TD|28362||PC|2013-01-01|2018-06-30|2018-04-01|2018-04-01
```

Example 4: Return DIA File with Corrected Data

This example illustrates the versioning issues in Example 3 and shows what the file returned from the submitting entity would include. **NOTE: Only partial data records are represented in these examples.** ***All fields in the DSG for the file type shall be resubmitted by the submitting entity in the DIA file for the Arkansas APCD.***

- Header Detail records — PeriodBeginDate (HD004) will always contain the beginning date of the Arkansas APCD data: "2013-01-01". This date will never change. The PeriodEndingDate (HD005) reflects the end date of the last submission period.
- Trailer Detail records — PeriodBeginDate (TR004) aligns with HD004 and will always contain the beginning date of the Arkansas APCD data: "2013-01-01". The PeriodEndingDate (TR005) always aligns with HD005 and reflects the end date of the last submission period.

TrailerProcessingDate (TR006) and PostingDate (TR007) reflect the dates the DIA file was created and posted by the submitting entity for Arkansas APCD retrieval.

- Control Ccount records are based on Arkansas APCD DSG requirements for each file type.
- Example pharmacy claim descriptions:
    - Claim 617252 — A replacement record was provided. The Arkansas APCD will flag the existing records and replace with this record.
    - Claim 7262-1 — This claim could not be corrected. No records were returned to the Arkansas APCD. This claim is flagged as problematic in the Arkansas APCD and will not be included in data requests or analyses.
    - Claim A62D0 — This claim was sent in error. A back out record was sent to ensure it was flagged correctly in the Arkansas APCD versioning process.
    - Claim 731Z123 — This claim was incomplete. A replacement record was sent to ensure it was flagged correctly in the Arkansas APCD versioning process.
- Example Pharmacy claim DIA file for example claims described above:

```
HH|HD001|HD002|HD003|HD004|HD005|HD006|HD007|HD008|HD009|HD010
HD|28362||PC|2013-01-01|2018-06-30|5|1|1|8.0.2022|PRODDIA

CH|CC001|CC002|CC003|CC004|CC005|CC011|CC012|CC013|CC014|CC016|CC017
CD|28362|PHM|Q|2|2|2|2|||2|1

DH|PC999|PC001|PC002|PC003|PC004|PC005|PC017|PC027|PC028|PC032|PC036|PC058|PC110|PeriodBeginDate|PeriodEndingDate
DD|1|28362||CI|617252|1|2014-08-16|OMEPRAZOLE CAP 10MG|1|2014-08-16|10.73|112|R|2014-07-01|2014-09-30

DD|3|28362||CI|A62D0|1|2016-09-15| CLARINEX-D 12 HOUR TABLET|1|2016-11-03|250632.80|809XAB-1|O|2017-01-01|2017-03-31
DD|3|28362||CI|A62D0|1|2016-09-15| CLARINEX-D 12 HOUR TABLET|1|2016-11-03|-250632.80|809XAB-1|B|2017-01-01|2017-03-31

DD|3|28362||CI|731Z123|1|2016-09-15|LISINOPRIL|1|2016-11-03|6.00|684431|R|2017-01-01|2017-03-31

TH|TR001|TR002|TR003|TR004|TR005|TR006|TR007
TD|28362||PC|2013-01-01|2018-06-30|2018-11-01|2018-11-01
```

Appendix P: Point of Origin Codes

Point of Origin (MC021) codes represent the source of the referral for an admission or visit.

Code	Point of Origin	Inpatient/Outpatient
1	Non-Health Care Facility Point of Origin (Physician Referral) **Usage note:** Includes patients coming from home, a physician's office, or workplace.	**Inpatient**: Patient was admitted to this facility upon an order of a physician. **Outpatient**: Patient presents to this facility with an order from a physician for services or seeks scheduled services for which an order is not required (e.g., mammography). Includes non-emergent self-referrals.
2	Clinic or Physician's Office	**Inpatient**: Patient was admitted to this facility. **Outpatient**: Patient presented to this facility for outpatient services.
4	Transfer from a Hospital (different facility) **Usage note:** Excludes transfers from Hospital Inpatient in Same Facility (See Code D)	**Inpatient**: Patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient or an outpatient. **Outpatient**: Patient was referred to this facility for outpatient or referenced diagnostic services by a physician of a different acute care facility. * For transfers from hospital inpatient in the same facility, see code D.
5	Transfer from a SNF, ICF, ALF, or NR	**Inpatient**: Patient was admitted to this facility as a transfer from a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), Assisted Living Facility (ALF) or Nursing Facility (NF) where he or she was a resident. **Outpatient**: Patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the SNF, ICF, ALF or NF where he or she was a resident.
6	Transfer from another Health Care Facility	**Inpatient**: Patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list. **Outpatient**: Patient was referred to this facility for services by (a physician of) another health care facility not defined elsewhere in this code list where he or she was an inpatient or outpatient.
8	Court/Law Enforcement	**Inpatient**: Patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement

Code	Point of Origin	Inpatient/Outpatient
	Usage note: Includes transfers from incarceration facilities	agency representative. **Outpatient**: Patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services.
9	Information Not Available	**Inpatient**: Patient reason for admission is not known. Not defined elsewhere. **Outpatient**: Where the patient came from is unknown. Not defined elsewhere.
A - C	Reserved	
D	Transfer from One Distinct Unit of the Hospital to Another Distinct Unit of the Same Hospital **Usage note**: Results in a Separate Claim to Payer	**Inpatients**: Patient was admitted to this facility as a transfer from hospital inpatient within this hospital resulting in a separate claim to the payer. **Outpatients**: Patient received outpatient services in this facility as a transfer from within this hospital resulting in a separate claim to the payer. For purposes of this code, "distinct unit" is defined as a unique unit or level of care at the hospital requiring the issuance of a separate claim to the payer. Examples could include observation service, psychiatric units, rehabilitation units, a unit in a critical access hospital, or a swing bed located in an acute hospital.
E	Transfer from Ambulatory Surgery Center (ASC)	**Inpatient**: Patient was admitted to this facility as a transfer from an ASC. **Outpatient**: Patient came for outpatient or reference diagnostic services from an ASC.
F	Transfer from Hospice Facility	**Inpatient**: Patient admitted as a transfer from a hospice facility. Patient is under a hospice plan of care or enrolled in a hospice program. **Outpatient**: Patient came for outpatient or reference diagnostic services from a hospice. Patient is under a hospice plan of care or enrolled in a hospice program.
G-Z	Reserved	