ARKANSAS APCD
DATA SUBMISSION GUIDE

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ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.

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Revision History

Version	Change Mgmt. #	Date	Owner	Description
0.1.2014	0	7/22/2014	Sheila Dodson	Initial rough draft. Note comments in document containing questions to be addressed before final version is complete.
1.0.2014	1	9/8/2014	Rachel Phillips Kenley Money	Put in APCD format. Incorporated edits.
2.0.2014	2	11/12/2014	Brady Rice	Incorporated recommendations from Linda Green, Freedman Health
2.1.2014	3	11/12/2014	Brady Rice	Added Column ID so that sort order will group similar/related elements.
2.1.2014	4	12/3/2014	Kenley Money	Added new Pharmacy variable, PC900_2, Spend Down amount for Medicaid.
2.1.2014	5	12/17/2014	Kenley Money	Update email processing and messaging requirements, pages 15, 16, 17
1.0.2015	6	1/21/2015	Kenley Money	Add subscriber address, city, state, zip and spend down for Medical Claims
1.1.2015	7	2/16/2015	Kenley Money	Update Provider file requirements to match table mapping. Deleted redundant fields including Medicaid ID, Provider Category, Provider Plan ID, Delegated Provider Record Flag.

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.

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GLOSSARY OF TERMS

For purposes of this specification, the following terms are outlined below:

Term	Definition
ACHI	Arkansas Center for Health Improvement
AGZ	Air-gapped zone. Physically isolated servers on a closed network with no connectivity to the internet or external networks
AID	Arkansas Insurance Department
APCD	Arkansas all-payer claims database
CPT codes	Current procedural technology codes
DC	Dental claims – insurance record type
DLZ	Data landing zone
DSG	Data Submission Guide
DUA	Data use agreement
ETL	Extract, transform, load
FAQs	Frequently asked questions
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
HIRRD	Health Insurance Rate Review Division of the Arkansas Insurance Department
MC	Medical claims – insurance record type
MCD	Medicaid data source
MCR	Medicare data source
ME	Member eligibility – insurance record type
NPI	National provider identifier
PC	Pharmacy claim – insurance record type
PHI	Protected health information
PV	Provider records – insurance record type
SFTP	Secure Shell (SSH) File Transfer Protocol
TPA	Third-party administrator
UAMS	University of Arkansas for Medical Sciences

For purposes of this specification, the following health care claim forms are defined below:

Term	Definition
837I	The standard claim format used by providers to transmit institutional health care claims electronically.
837P	The standard claim format used by providers to transmit encounter, not institutional, health care claims electronically.
CMS-1450	Used for Medicare fee for service contractors. See also UB-04.
HCFA 1500	The Form CMS-1500, previously called an HCFA 1500 Form, is used in the health care industry for Medicare claims.
UB04	The standard, uniform bill (UB) in paper format for institutional healthcare providers used by hospitals, nursing homes, hospice, home health agencies, and other institutional providers throughout the U.S.

OVERVIEW

Access to timely, accurate, and relevant data is essential in improving quality, mitigating costs, and promoting transparency and efficiency in the health care delivery system. The Arkansas Center for Health Improvement (ACHI) will host a comprehensive all-payer claims database that houses member data, medical claims, pharmacy claims, dental claims, and provider data. The primary purpose of the Arkansas All-Payer Claims Database (APCD) is to establish a database for insurance rate review, and to increase transparency in health care pricing. The APCD Data Submission Guide (DSG) establishes file requirements from which data submitters can develop data files for voluntary or mandatory data submission.

Changes to the DSG are implemented and published annually. Data submitters will be notified at least three months prior to the implementation of DSG revisions to ensure limited disruption to file delivery and processing.

Data Requirements

Data submitters are asked to provide the following data categories if available:

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

Layouts, data element definitions, and other relevant information for the data categories are included in Exhibit A – Data Elements. Each data element description includes the data element definition, required values, value definitions, format, date type, coverage expectation and flag describing the data element as optional or required upon submission.

Data submitters are to provide data in the layouts defined in the DSG. Data exception requests must be submitted to the APCD Technical Support team and agreed upon in writing. No data will be provided to the APCD without a fully-executed data use agreement (DUA) in place. Standard health insurance claim form data is required from all carriers submitting data. Additional fields are to be provided by the data submitter unless a data exception is provided.

The dataset formats contained within Exhibit A were created by ACHI based on a compilation of APCD layouts from several APCD states and the APCD Council. ACHI reviewed the APCD formats from these states and selected the variables that (1) conform to the standard APCD layout provided by the APCD Council; and (2) include the data elements required for health system analytics and consumer data reporting for Arkansas.

Each layout data element is represented by a Data Element Identifier comprised of the two-character data category abbreviation—ME, MC, PC, DC, and PV—and a three-character value (e.g., 001, 025, etc.). Data elements are referred to by the Data Element ID throughout the DSG (e.g., ME001, MC001, etc.). This naming convention aligns with standards defined by the United States Health Information Knowledgebase, http://ushik.org/mdr/portals.

Documentation Requirements

Data submitters are to provide the following documentation supporting their standard data extract files for the DSG.

Data Dictionary. The dictionary will map internal system data elements to the DSG defined data elements.

Extract Specifications. The documentation should include a detailed description of how the data extracts are created and how the requirements of this DSG are accomplished, including specifications on the data being excluded and the parameters that define that excluded data.

Claims Processing Information. The documentation should include an overview of how the carrier processes claims. This information will enable the APCD development team to better understand the origin of the data to inform integration with other submitters' data.

APCD Technical Support

Questions or concerns may be directed to the APCD Technical Support team. See below for the hours of operation and contact information. Also see the Frequently Asked Questions section that follows.

Technical support is available to all data submitters and data users, and issues are logged and tracked upon notification. The APCD Technical Support Team will provide regular feedback during the resolution process.

Hours of Operation:

8:00 am to 4:30 pm Central time, Monday through Friday

Contact Information:

Phone: (501) 526-2244
Fax: (501) 526-2252
Website: http://www.arkansasapcd.net

FREQUENTLY ASKED QUESTIONS

1. **Question:** How often are files submitted to the Arkansas APCD?

   Answer: ACHI requires submission of files no more frequently than monthly and no less frequently than quarterly to capture the attributes necessary for matching to the various Claims files coming in on the same schedule.

2. **Question:** Fields on ME appear to be similar to those collected on the MC, PC, and DC files. Can you clarify?

   Answer: Many of the elements in the files use similar semantics and a few are exact duplicates. APCD team requires these fields on the claims files to allow the data to be joined across tables.

3. **Question:** What might cause a member to have more than one eligibility record per month?

   Answer: A member can or will have more than one eligibility record when they are enrolled in more than one product, have secondary coverage, have a break in eligibility, or have multiple active primary care provider (PCP) assignments within a reporting period. Accurate enrollment data is needed to calculate member months by product and by provider.

4. **Question:** If claims are processed by a third-party administrator (TPA), who is responsible for submitting the data and how should the data be submitted?

   Answer: In instances where more than one entity administers a health plan, the health care carrier and TPAs are responsible for submitting data. The carrier is responsible for ensuring that member identifiers are consistent between the carrier's files and the TPA's files when the carrier holds the risk for the TPA's services.

5. **Question**: If the data submitter is not a risk holder many elements do not apply. Should this be handled using an exception request?

   Answer: 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. By identifying the type of business in ME134 APCD ID Code, the Arkansas APCD will be able to exclude some data submission requirements by mutual agreement.

6. **Question**: Are denied claims captured in the Arkansas APCD?

   Answer: Yes. Wholly denied claims will be included at this time. Denied claims will be identified in the claim status variable. Denied claims can be used in future analyses for quality measures.

7. **Question:** Are claims that are paid under a "global payment" or "capitated payment" (thus, zero paid) reported in the Arkansas APCD?

   Answer: Yes. Any medical claim that is considered "paid" by the carrier 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 data submitter.

8. **Question:** What types of claims are to be included?

   Answer: The MC file is used to report both institutional and professional claims. The unique elements that apply to each are included; however, only those elements that apply to the claim type should be submitted. *Example*: Diagnostic pointer is a professional claim element and would not be a required element on an institutional claim record. See MC094 in Exhibit A: Medical Claims Data, for claim type ID. The Arkansas APCD has adopted the most widely used specification at this time. It is important to note that adhering to claim rules for each specific type will provide cleaner analysis.

9. **Question:** Is Arkansas APCD data encrypted/masked?

   Answer: All Arkansas APCD data is encrypted upon submission. Some APCD data elements are masked if the data submitter requires it and as specified in the DUA; Masking is not recommended. See the Encryption Requirements section within the DSG for more information.

10. **Question:** Can Arkansas APCD files be linked to one another?

    Answer: Yes, Arkansas APCD files can be linked using identifiers assigned in APCD update processes.

11. **Question:** If I have questions about Arkansas APCD data, who should I contact?

    Answer: Questions concerning Arkansas APCD data should be sent to the APCD Technical Support team. APCD Technical Support information is listed in the Overview section of the DSG.

12. **Question:** How will claims be versioned?

    Answer: Claim versioning will be based on claim version numbers (MC005A, PC005A, DC005A). Adjusted claims submitted should be identified using the version number, incremented by one for each adjustment.

DATA CATEGORIES FOR SUBMISSION

This section provides data submission requirements for each data category. Data submissions should be developed to meet the requirements herein.

Member Eligibility Data

Required Submission

Data submitters must provide a data set that contains information on:

- all members (regardless of residence) covered by subscribers holding certificates of coverage for insurers with Arkansas situs
- all Arkansas residents with coverage by the carrier, if the carrier does not have Arkansas situs

File Content

- Files must include variables specified in Exhibit A – Data Elements: Member/Eligibility Data
- Member eligibility files must be formatted to provide one record per member per month
- Each member identifier (ID) must be unique to an individual and must be consistent with the unique ID in the medical claims or pharmacy data
- Each row must contain the information representing a unique eligible member at the product level that a carrier or TPA maintains to process member claims

File Delivery

- Initial build – provide member data from 2011 through 2014
- Ongoing – provide extracts each month or per update period (depending on DUA requirements). Extracts will contain the previous period's data (e.g., a monthly extract received in April 2015 will contain March 2015 data). The first extract should be received in January 2015, and contain November 2014 through December 2014 data

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
- Data elements not available should be waived using the data exception process.
- Member and patient identifiers are to be used in the same manner
- If dual coverage exists, send coverage of eligible members where payer insurance is primary, secondary, or tertiary (ME028)

Medical Claims Data

Required Submission

Data submitters shall provide the following data:

- Paid and denied claims for institutional and professional health care services rendered during update period
- Adjusted claims processed during update period. An adjustment is defined as any change to any field within a claim line previously submitted. Multiple adjustments for a single claim line can be submitted during an update. MC005A should be incremented to reflect the version of the claim line

File Content

- The file must include variables specified in Exhibit A – Data Elements: Medical Claims Data
- Data submitters must provide one row per claim line. If there are multiple services performed and billed on a claim, each of those services will be uniquely identified and reported on a separate line with the claim number linking the lines together
- Files should include claims and adjustments for services rendered during prior reporting periods and paid in the current reporting period.
- Member identifiers must be consistent across member, medical claims and pharmacy claims files.
- Files should contain all claims adjudicated during the observation period for all covered services provided to eligible members, regardless of provider site of service.
- Test files must contain actual data, not dummy data.
- Files should include all non-pharmacy, non-dental claims submitted for services provided to covered members, including behavioral health, therapies, DME, rehab, etc.

File Delivery

- Initial build – provide paid, denied and adjusted member claims data from January 2011 through October 2014. The APCD team will work with data submitters to develop the most effective data submission process. Data feed options are available as described below
  - Option I: Test data feed as initial submission; then all data paid and denied to date from January 2011 through October 2014 for initial build final submission
  - Option II: Test data feed as initial submission; then historic paid and denied data from January 2011 through December 2013 for second submission; and finally, year-to-date paid and denied data from January 2014 through October 2014 for initial build final submission
- Ongoing – provide extracts each month or per update period (depending on DUA requirements). Extracts will contain the previous period's paid, denied, and adjustment data (e.g., a monthly extract received in April 2015 will contain March 2015 data). The first extract should be received in January 2015, and contain November 2014 through December 2014 data

Other Information

- Multiple submitter-assigned identifiers are required for matching to member eligibility and pharmacy claims data. Some examples of these elements include MC003, MC006, MC137, and MC141
- The specific medical data reported in the majority of the medical claims file data correspond to elements found on the UB04, HCFA 1500, HIPAA 837I and 837P datasets. If related claims data exist that

are not in these formats, the data submitter should work with APCD Technical Support team to customize the data submission

- 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, member IDs and paid dates will appear on each line of a claim. Aggregation will recognize these as representing the same claim and not multiple claims
- ICD-9/ICD-10 diagnosis and procedure codes are required to accurately report risk factors related to the episode of care. CPT/HCPCS codes are also required
- Denied claims can be provided as adjusted claim records

Medical Claim Provider Information

- The medical claim data elements required to identify providers and link to the provider file (Provider ID - PV002) for provider analysis are as follows:
    - MC024 – Servicing provider National Provider Identification (NPI)
    - MC076 – Billing provider NPI
    - MC112 – Referring provider NPI
    - MC125 – Attending provider NPI
    - MC134 – Rendering provider NPI
    - MC135 – Provider location
- Servicing provider data (MC024-MC035)
    - APCD team collects entity-level rendering provider information at the lowest level achievable by the data submitter
    - If the submitter only knows the billing entity, and the billing entity is not a service-rendering provider, then the billing provider data (MC076 – MC078) is not appropriate. In this case, the data submitter will need to submit an exception request through APCD Technical Support for the specific service provider elements
    - If the submitter has the data for a main service-rendering site but not the specific satellite information for where the service was rendered, then the main service site is acceptable for the service provider elements
    - A physician's office is also appropriate, but not the physician's data. The physician or other person providing the service is expected in MC134
    - Pharmacy names and addresses appearing on prescription drug claims should not be included in this file.
- Plan rendering provider (MC134) provider location (MC135) data
    - These elements should precisely describe who performed the services for the patient and where the services were rendered
    - If the carrier does not know who actually performed the service or specific site where the service was performed, the submitter will need to request an exception for one or both of these elements. It is not appropriate to include facility or billing information in MC134
- In the event that the health plan carrier contracts with another service entity that manages claims for Arkansas residents, the health plan carrier shall be responsible for ensuring that complete and

accurate files are submitted to the APCD by the subcontractor. The health plan carrier shall ensure that member identification information in the subcontractor's file is consistent with the member identification information on 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

Pharmacy Claims Data

Required Submission

Data submitters shall provide the following data:

- Paid pharmacy claims for prescriptions that were dispensed to members
- Adjusted claims processed during update period. An adjustment is defined as any change to any field within a claim line previously submitted. Multiple adjustments for a single claim line can be submitted during an update. PC005A should be incremented to reflect the version of the claim line

File Content

- The file must include variables specified in Exhibit A – Data Elements: Pharmacy Claims Data
- Data submitters must provide one row per claim line
- Member identifiers must be consistent across member, medical claims and pharmacy claims files.
- Files should contain all claims adjudicated during the observation period for covered pharmacy services provided to members regardless of pharmacy location and including mail order prescriptions.

File Delivery

- Initial build – provide paid, denied, and adjusted pharmacy claims data from January 2011 through October 2014. The APCD team will work with data submitters to develop the most effective data submission process. Data feed options are available as described below
  - Option I: Test data feed as initial submission; then all data paid and denied to date from January 2011 through October 2014 for initial build final submission
  - Option II: Test data feed as initial submission; then historic paid and denied data from January 2011 through December 2013 for second submission; and finally, year-to-date paid and denied data from January 2014 through October 2014 for initial build final submission
- Ongoing – provide extracts each month or per update period (depending on DUA requirements). Extracts will contain the previous period's paid, denied and adjustment data (e.g., a monthly extract received in April 2015 will contain March 2015 data). The first extract should be received in January 2015, and contain November 2014 through December 2014 data

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 process
- Member and patient IDs are to be used in the same manner
- In the event that the health plan carrier contracts with a pharmacy benefits manager or other service entity that manages claims for Arkansas residents, the health plan carrier shall be responsible for ensuring that complete and accurate files are submitted to the Arkansas APCD by the subcontractor. The health plan carrier 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 arrangement
- Denied claims can be provided as adjusted claim records

Dental Claims Data

Required Submission

Data submitters shall provide the following data:

- Paid and denied dental claims and encounters for all individuals utilizing Arkansas dental services
- Adjusted claims processed during update period. An adjustment is defined as any change to any field within a claim line previously submitted. Multiple adjustments for a single claim line can be submitted during an update. DC005A should be incremented to reflect the version of the claim line

File Content

- The file must include variables specified in Exhibit A – Data Elements: Dental Claims Data
- Data submitters must provide one row per claim line. If there are multiple services performed and billed on a claim, each of those services will be uniquely identified and reported on a line

File Delivery

- Initial build – provide paid, denied, and adjusted dental claims data from January 2011 through October 2014. The APCD team will work with data submitters to develop the most effective data submission process. Data feed options are available as described below
  - Option I: Test data feed as initial submission; then all data paid and denied to date from January 2011 through October 2014 for initial build final submission
  - Option II: Test data feed as initial submission; then historic paid and denied data from January 2011 through December 2013 for second submission; and finally, year-to-date paid and denied data from January 2014 through October 2014 for initial build final submission
- Ongoing – provide extracts each month or per update period (depending on DUA requirements). Extracts will contain the previous period's paid, denied, and adjustment data (e.g., a monthly extract received in April 2015 will contain March 2015 data). The first extract should be received in January 2015, and contain November 2014 through December 2014 data

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
- Claims that were paid and reported in one period and voided by either the provider or the carrier in a subsequent period should be reported in the subsequent file
- In the event that the health plan contracts with a service entity that manages claims for Arkansas residents, the health plan shall be responsible for ensuring that complete and accurate files are submitted to the APCD by the subcontractor. The health plan shall ensure that the member identification information on the subcontractor's file(s) is consistent with the member identification information on the health plan's ME, MC, 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
- Denied claims can be provided as adjusted claim records

Provider Data

Required Submission

- Data submitters must provide a data set that contains information on every Arkansas provider for whom claims were adjudicated, regardless of whether they are on the claims file for the time period. Additionally, information for out-of-state providers who are on the claims file for the period of the corresponding claims submission should be included
- A provider is any individual or entity
  - providing services to patients
  - submitting claims for services on behalf of a servicing provider
  - providing business services or contracting arrangements for a servicing provider or pharmacy
- A unique provider is an instance of a provider with a particular affiliation at a particular location during a pre-defined timeframe
- Both in and out of network providers—active and non-active—should be included
- Provider specialties are unique to each carrier. Carriers must submit provider specialty definitions

File Content

- The file must include variables specified in Exhibit A – Data Elements: Provider Data
- One record submitted for each provider for each unique physical address

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

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

File Delivery

- Initial build – provide all provider data from January 2011 through October 2014
- Ongoing – provide complete replacement files each update period beginning January 2015. The first replacement extract should be received in January 2015 and contain November 2014 through December 2014

Other Information

- In the event a specific provider delivered and was reimbursed for services rendered from two different physical locations, the provider data file shall contain two separate records for that same provider ID. The respective records should reflect each of those physical locations
- One record shall be provided for each unique physical location for a provider

DATA SUBMISSION REQUIREMENTS

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

File Submission Information

After the execution of the DUA, the APCD team will set up a carrier-specific SFTP site for data submission. SFTP site information will be delivered to the data submitter prior to agreed-upon data delivery date. The APCD team will work with the data submitter to test data transfer and, after successful testing is complete, will request the full data submission.

Submission Methods

Data submitters will submit files to the Arkansas APCD using one of the following methods:

- SFTP: SSH File Transfer Protocol (also known as Secure FTP and SFTP) is a computing network protocol for accessing and managing files on remote file systems. SFTP also allows file transfers between hosts. Unlike a standard File Transfer Protocol (FTP), SFTP encrypts commands and data, preventing passwords and sensitive information from being transmitted in the clear over a network.[a]
- Web upload: This method allows the transfer and receipt of files and messages from the APCD website without the installation of additional software. This method requires Internet access, a username and password
- Other media: Delivery of data to the APCD team via encrypted hard drive, thumb drive, or carrier specific secure transmission channel

Submission Components

Each data submission should be zipped and posted to the carrier-specific UAMS SFTP site. The zipped submission should include the following files that meet the encryption requirements outlined in the Encryption Requirements section of the DSG:

- Encrypted data file
- Encrypted signature file

Detached-signed Signature File Components

The “detached-signed” file acts a means to verify that the sender of the just-arrived encrypted/signed file was the expected sender and, via the checksum, that the encrypted/signed file has both arrived in full and was uncorrupted upon its arrival. Component requirements and naming convention are outlined in the section, Encryption Requirements.

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[a] Indiana University (2014). *What is SFTP, and how do I use an SFTP client to transfer files?* Indiana University Knowledge Base: https://kb.iu.edu/d/akqg

Submission Process and Communication

Data submitters having executed a DUA with ACHI will work with the APCD team to understand data submission requirements and exchange public and private keys.

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

Figure 1: APCD Data Submission Process

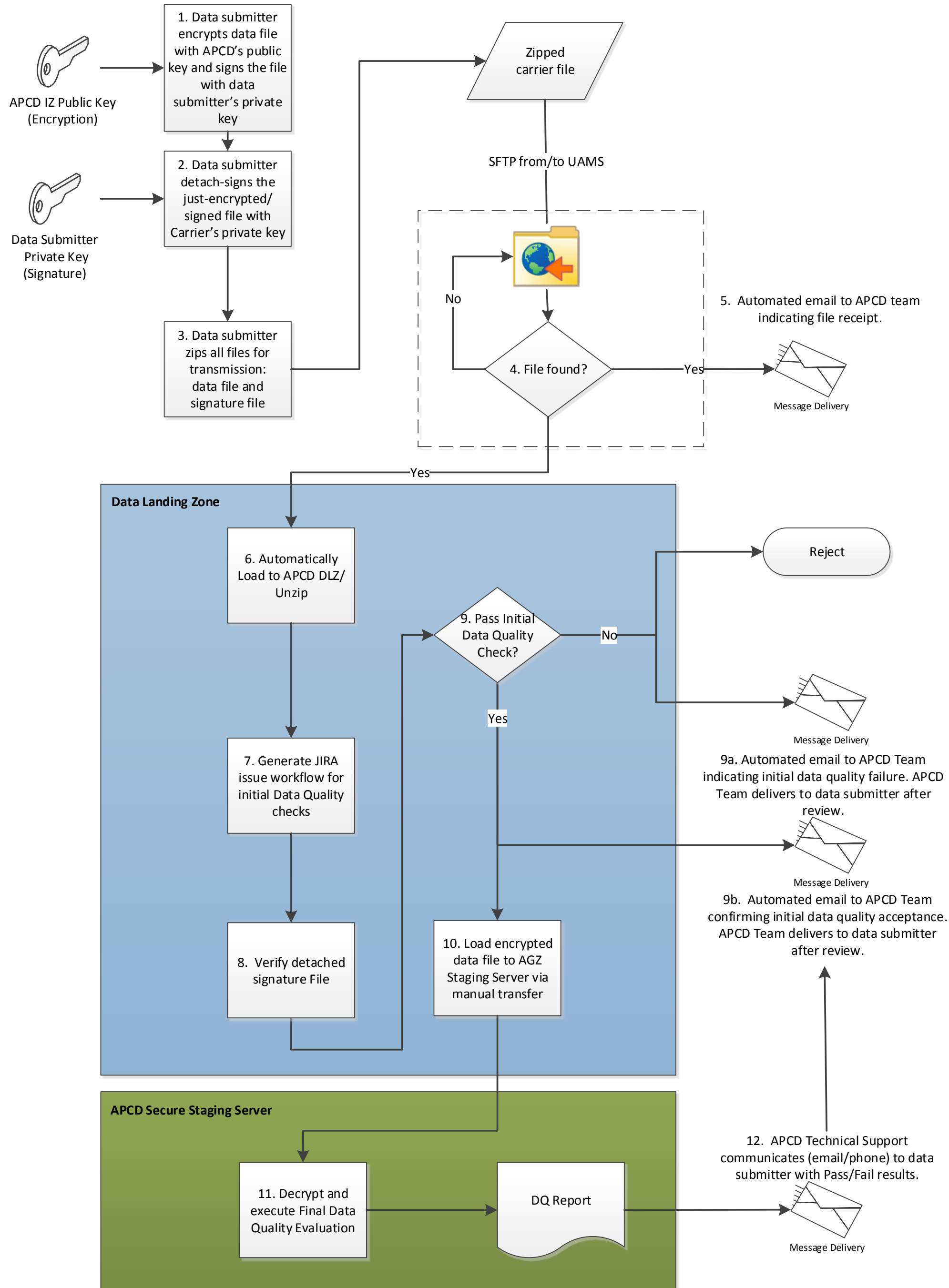

Table 1: Data Submission Process Step Descriptions

Process Task	Description
1. Data submitter encrypts data file with APCD's public key and signs the file with data submitter's private key	Data submitters having executed a data use agreement (DUA) with the APCD will work with the APCD team to understand data submission requirements and exchange public and private keys The data submitter will encrypt required data using the APCD public key
2. Data submitter detach-signs the signed file with data submitter's private key	The data submitter will also pull a detached signature file and encrypt it using their private key
3. Data submitter zips both files for transmission	Data submitter "zips" both the encrypted/signed file (.gpg) and the detach-signed file (.sig) in one ZIP archive file
4. File Found?	APCD processes scan SFTP site for dropped files
5. Email confirming receipt	Automated email is sent to the APCD team confirming data receipt
6. Automatically Load to APCD DLZ/Unzip	Zipped data file automatically transferred to the APCD DLZ and unzipped into two files: • Detached signature file • Encrypted data file
7. Generate JIRA issue workflow for initial data quality checks	Upon receipt on the DLZ, a JIRA workflow will be generated to unzip the file and trigger initial data quality checks The files will NOT be decrypted. The checks will evaluate the data based on the signature file specifications
8. Verify detached signature file	Verify detached signature file • Mime-type • Signature verification • Checksum matches
9. Pass initial data quality check? Messaging a. Automated email to the APCD team indicating initial data quality failure. APCD team delivers email to data submitter after review	If the Mime-type is correct, signature verification is correct and checksum matches the file passes. If not, the file does not pass and file is deleted from APCD DLZ
	If the file passes, an automated email is sent to the

b. Automated email to the APCD team indicating initial data quality acceptance. APCD team delivers email to data submitter after review	APCD team confirming initial quality check acceptance. Message for files passing initial data quality checks: “The file identified within this email was successfully received on the secure APCD data landing zone. This file passed checksum and mime type data quality checks and will move to the secure APCD data infrastructure for final data quality checking. This file will be deleted from the secure data landing zone within 5 days of receipt. Please contact APCD Technical Support at 501-526-2244 if you have any questions.” If the file does not pass, an automated email is sent the APCD team confirming initial quality check failure. If the file fails, the APCD technical support team will contact the carrier directly to determine next steps. Message for files not passing initial data quality checks: “The file identified within this email was successfully received on the secure APCD data landing zone. This file did not pass the following data quality checks: [qualifying error source: enter checksum, mime type and/or signature verification] data quality checks and was deleted from the APCD data landing zone. APCD Technical Support team will contact you for issue resolution. They can be reached at 501-526-2244 if you have any questions.”
Steps 1 through 9 are automated.	
10. Load encrypted data file, to AGZ Staging Server via manual transfer	Load encrypted data to APCD Staging Platform in air-gapped zone (AGZ). Use secure manual transfer process
11. Decrypt and execute final Data Quality Evaluation	Decrypt the data file. Execute final data quality evaluation
12. Data Quality Result Communication	APCD Technical Support communicates (email/phone) to data submitter with Pass/Fail results and data quality reports

Encryption Requirements

Submitted data must be encrypted to protect personal health information. All data files submitted must be encrypted at the file level at minimum before being sent to the APCD. Field level encryption may be required based on protocols outlined in the DUA development detailing file delivery permissions.

All data files submitted to the Arkansas APCD are to 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.

All data submissions should be secured for transfer using Exhibit B: Encryption Protocols for encryption requirements. These protocols are presented at the file encryption level. Field level encryption protocols will be developed as needed.

Public and Private Keys

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

- APCD public key
- APCD private key (APCD internal use only)
- Data submitter public key
- Data submitter private key (carrier internal use only)

File Submission

ACHI will provide the APCD public key to data submitters to encrypt the data file. Each data submitter will provide its public key to decrypt the signature file.

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

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

Report Delivery

ACHI will provide final data quality reports to data submitters after data evaluation is complete. These reports can contain PHI and will be encrypted before delivery to data submitters. ACHI 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 carrier public key and signed with APCD private key
- APCD detached-signed signature file (using the APCD private key) of the encrypted/signed file just created in the above bullet

Final Data Evaluation and Data Exceptions

Final Data Evaluation

Final data evaluation occurs when submitted files pass the first quality check in the DLZ and are moved to the APCD Staging platform. At this point, a final data quality evaluation is executed, producing data element level quality reporting detailing values present, data coverage and format of each data element.

Data files missing required data elements may be rejected unless exceptions have been put in place. Additionally, other data elements will be validated against established ranges and/or data element relationships, e.g. all claim lines should have a valid paid date and paid amount, during the data quality evaluation and may require manual intervention to ensure the data is correct.

Files passing final evaluation will be moved to the APCD production platform for transformation and database build. The final data evaluation quality reports will be encrypted and placed on the carrier-specific UAMS SFTP site for retrieval and review.

Files not passing will be held in the staging area until APCD Technical support contacts the data submitter to resolve the issues identified. If no resolution can be found, the file will be deleted from the staging area while the data submitter resends the data.

Data Exception Process

As data submitters are onboarded into the APCD, the APCD Development team will work with each to develop data extracts that achieve validation and quality specifications. If requested data elements are not available, data submitters can apply for data exceptions addressing data variances that cannot be corrected due to systematic issues that require substantial effort to address.

Data Exception Request Form

If a data exception is required, the data submitter will work with the APCD team to build a data exception request (See Exhibit C: Data Exception Request Form). The data exception request should include the following information:

Request Review

The ACHI APCD Development team will work with data submitter to understand the impact of the exceptions and identify APCD processing changes needed. After the final exception list is mutually agreed upon in writing, the APCD Development team will adjust the data intake process to accommodate the missing data.

Post-APCD Build Data Requests

Data exceptions can be requested at any time. Exceptions required after the initial data on boarding should be submitted through APCD Technical Support. Data submitters should submit the Data Exception Request Form with desired exceptions. APCD Technical Support will initiate the review process with the data submitter and APCD Development team.

File Format

File Formatting Requirements

All files submitted to the APCD should ensure the following formatting requirements:

- All files submitted must be in the layout and data element ID order illustrated in [Exhibit A – Data Elements]
- All files submitted to the Arkansas APCD will be formatted as standard text files
- All text files must comply with the following standards:
  - Files must always contain one line item per row. No single line item of data may contain carriage return or line feed characters
  - All rows must be delimited by the carriage return + line-feed character combination
  - All data elements are variable data element length, delimited using a pipe ("|"). It is imperative that no pipes ("|") appear in the data itself. If data contains pipes, either remove them or discuss using an alternate delimiter character
  - Text 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
  - Unless otherwise stipulated, first, middle, and last names should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed; do not report spaces
  - Text data elements are never padded with leading or trailing spaces or tabs

Header and Trailer Records

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

Each data file will have the following record types. The record type will be indicated in the first column of every row.

- HH: Header's Header (first row of file)
- HD: Header's Data (second row of file)
- DH: Detail Header (third row of file)
- DD: Detail Data (fourth row and beyond until the second-to-last row of file)
- TH: Trailer's Header (second-to-last row of file)
- TD: Trailer's Data (last row of file)

File Naming Convention

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

ARAPCD_PayerID_[Test or Prod]_EntityAbreviation_SubmissionDate_CoveragePeriodDate.txt

- **PayerID** – This is the payer ID assigned to each submitter
  - AM = Ambetter
  - BC = Arkansas Blue Cross and Blue Shield
  - EBD = Employee Benefits Division
  - DD = Delta Dental
  - MCD = Medicaid
  - MCR = Medicare
  - QC = QualChoice of Arkansas
- **[Test or Prod]** – *Test* is for test data files; *Prod* is for production data files.
- **EntityAbbreviation** – Abbreviation representing file type.
  - DC = Dental Claims
  - MC = Medical Claims
  - ME = Member Eligibility
  - PC = Pharmacy Claims
  - PV = Provider Data
- **SubmissionDate** – Date the file was produced. This date should be in the YYYY-MM-DD format.
- **CoveragePeriodDate** – Represents coverage month transmission. This date should be in the *YYYYMM* format, e.g., CoveragePeriodDate = 201510 (October 2015). The date should represent the end month of data date range, e.g., for data pulled between 7/15/2015 and 9/14/2015, the CoveragePeriodDate = 201509.

EXHIBIT A – DATA ELEMENTS

File Guideline and Layout Legend

Layout Column	Column Definition
ID	Table row id representing required variable order
Data Element ID	Number of the element by file type
Data Element	Provides identification of basic data required
Description	Data element definition and associated values with definition
Type	**Date** – Identifies value as date **Integer** – Identifies value as whole number **Numeric** – Identifies values containing digits from 0 to 9 and, optionally, a sign and a decimal point **Text** – Identifies values as having variable length alpha numeric characters
Format	**char** – A fixed length element of characters. Values cannot be longer than the specified length column. This can be any type of data but is governed by the type listed for the element, such as Text versus Numeric **varchar** – A variable length field of characters. Values cannot be longer than the specified length column. This can be any type of data but is governed by the type listed for the element, such as Text versus Numeric **int** – A fixed width field containing numeric values. Values cannot be longer than the specified length column. Records with numeric value formats cannot contain decimal points or leading zeroes *The plus/minus symbol (±) in front on any of the formats above indicate that a negative can be submitted in the element under specific condition*
Length	Maximum value width of the data element
Threshold	Provides the minimum coverage percentage that the Arkansas APCD is expecting in volume of data for the data element
Required	Indicates if variable is required for initial APCD build. Not indicated in Header or Trailer record layout. All data elements are required for Header and Trailer record

Header and Trailer Records

Every submitted data file should have its associated header and trailer records.

Header Record Layout

Data Element ID	Data Element	Description	Type	Format	Length	Threshold
HD001	Record Type	Record Identifier HH = Header record column names (first row of file) HD = Header record data (second row of file)	Text	char	2	100%
HD002	Payer	Payer submitting payments AM = Ambetter BC = Arkansas Blue Cross and Blue Shield QC = QualChoice of Arkansas	Text	varchar	3	100%
HD003	National Plan ID	Header 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 Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans	Integer	varchar	10	100%
HD004	Type of File	MC = Institutional & Professional Claims PC = Pharmacy Claims ME = Eligibility/Member Data DC = Dental Claims PV = Medical/Dental Provider	Text	varchar	2	100%
HD005	Period Beginning Date	First date covered in submission period. Must match TR005	Date	YYYY-MM-DD	10	100%
HD006	Period Ending Date	Last date covered in submission period. Must match TR006	Date	YYYY-MM-DD	10	100%
HD007	Record Count	Total number of records in the submission, excluding the header records, trailer records and data file column name row (i.e., all rows with Record Type = DD). If the number of records within the submission do not equal the number reported in this field, the submission will fail	Integer	varchar	10	100%
HD008	Comments	Submitter may use to document this submission by assigning a filename, system source, etc.	Text	varchar	80	100%
HD009	APCD Version Number	Submission Guide Version	Text	varchar	3	100%

Trailer Record Layout

Data Element ID	Data Element	Description	Type	Format	Length	Threshold
TR001	Record Type	Record Identifier TH = Trailer record column names (second to last row of file) TD = Trailer record data (last row of file)	Text	varchar	2	100%
TR002	Payer Code	Payer submitting payments AM = Ambetter BC = Arkansas Blue Cross and Blue Shield QC = QualChoice of Arkansas	Text	varchar	3	100%
TR003	National Plan ID	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 Centers for Medicare and Medicaid Services (CMS) for Plans or Sub-plans	Integer	varchar	10	100%
TR004	Type of File	MC = Institutional & Professional Claims PC = Pharmacy Claims ME = Eligibility/Member Data DC = Dental Claims PV = Medical/Dental Provider	Text	varchar	2	100%
TR005	Period Beginning Date	First date covered in submission period. Must match HD005	Date	YYYY-MM-DD	10	100%
TR006	Period Ending Date	Last date covered in submission period. Must match HD006	Date	YYYY-MM-DD	10	100%
TR007	Date Processed	Date that the file was created by the submitter	Date	YYYY-MM-DD	10	100%
TR006	Posting Date	This field contains the date the file was posted by the carrier to the SFTP site	Date	YYYY-MM-DD	10	100%

Member/Eligibility Data

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
1	ME000	Record Type	Record type identifier DH = Data record column names (third row of data file) DD = Data detail (fourth row and beyond of file until trailer records)	Text	char	2	100%	Required
2	ME001	Payer	Code representing payer submitting payments AM = Ambetter BC = Arkansas Blue Cross and Blue Shield EBD = Employee Benefits Division DD = Delta Dental MCD = Medicaid MCR = Medicare QC = QualChoice of Arkansas	Text	varchar	3	100%	Required
3	ME003	Insurance Type/Product Code	Insurance type or product identification code that indicates the type of insurance coverage the individual has. Code all but MC and XX as 2 characters; MC and XX must include a valid sub-code See Appendix A - Insurance Type/Product Code	Text	varchar	6	99%	Required
4	ME009	Plan Specific Contract Number	Contract number for the subscriber	Text	varchar	20	99%	Required
5	ME128	Benefit Plan Contract ID	Unique ID associated with a Benefit Plan which is defined as a health insurance contract between an issuer and a subscriber that covers a set of health care services and the financial terms of such coverage - including cost sharing and limitations of amounts of services	Text	varchar	30	100%	Required
6	ME164-A	Health Plan Description	Free Text name of Health Plan	Text	varchar	30	100%	Required
7	ME063	Benefit Status	Code that defines status of benefits for the subscriber A = Active C = COBRA P = Pending S = Surviving Insured T = TEFRA U = Unknown	Text	char	1	100%	Required
8	ME129	Benefit Plan Contract	Date the member is enrolled in the benefit plan	Date	YYYY-MM-DD	10	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
		Enrollment Start Date						
9	ME130	Benefit Plan Contract Enrollment End Date	Date the member's enrollment ends with the benefit plan	Date	YYYY-MM-DD	10	100%	Required
10	ME006	Insured Group or Policy Number	The group or policy number is associated with the entity that has purchased the insurance. For self-insured individuals this relates to the purchaser. For the majority of eligibility and claims data the group relates to the employer	Text	varchar	30	99%	Required
11	ME032	Group Name	Name of the group under which the member is covered.	Text	varchar	128	99% (when ME030 = SML)	Required
12	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 plus N where N equals the number of other covered dependents ESP = Employee and Spouse FAM = Family IND = Individual SPC = Spouse and Children SPO = Spouse Only	Text	char	3	99%	Required
13	ME040	Product ID Number	Submitter-assigned product identifier. This element is used to understand Product and Eligibility attributes of the member/ subscriber as applied to this record	Text	varchar	30	99%	Required
14	ME117	Carrier Specific Unique Subscriber ID	Subscriber's Unique ID per carrier	Text	varchar	50	100%	Required
15	ME008	Subscriber Social Security Number	Subscriber's social security number	Text	varchar	9	99%	Required
16	ME102	Subscriber First Name	Subscriber first name	Text	varchar	25	99%	Required
17	ME103	Subscriber Middle Name	Subscriber's middle name	Text	varchar	25	0%	Optional
18	ME101	Subscriber Last Name	Subscriber last name	Text	varchar	60	99%	Required
19	ME058	Subscriber Street Address	Subscriber street address line 1	Text	varchar	100	99%	Required
20	ME174-A	Subscriber Street Address 2	Subscriber street address line 2	Text	varchar	100	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
21	ME108	Subscriber City	City of Subscriber's residence	Text	varchar	30	99%	Required
22	ME109	Subscriber State or Province	State or province of the Subscriber's residence See Appendix O - External Sources	Text	varchar	2	99%	Required
23	ME110	Subscriber Zip Code of Residence	Five digit USPS ZIP Code of Subscriber's residence See Appendix O - External Sources	Text	varchar	5	99%	Required
24	ME153-A	Subscriber County	County Name of Subscriber's residence	Text	varchar	25	50%	Required
25	ME150-A	Subscriber Date of Birth	Subscriber's date of birth	Date	YYYY-MM-DD	10	90%	Required
26	ME151-A	Subscriber Gender	Subscriber gender M = Male F = Female U = Unknown	Text	char	1	100%	Required
27	ME154-A	Subscriber Race 1	Primary race of Subscriber See Appendix H - Race	Text	char	6	0%	Optional
28	ME155-A	Subscriber Race 2	Secondary race of Subscriber See Appendix H - Race	Text	char	6	0%	Optional
29	ME156-A	Subscriber Ethnicity 1	Primary ethnicity of Subscriber See Appendix I - Ethnicity	Text	varchar	6	0%	Optional
30	ME166-A	Subscriber Ethnicity 2	Secondary ethnicity of Subscriber See Appendix I - Ethnicity	Text	varchar	6	0%	Optional
31	ME157-A	Subscriber Language	Subscriber's self-disclosed verbal language preference See Appendix G - Language	Text	char	2	0%	Optional
32	ME012	Individual Relationship Code	Member's relationship to the subscriber or the insured See Appendix B - Relationship Code	Text	char	2		Required
33	ME107	Carrier Specific Unique Member ID	Member's Unique ID per carrier	Text	varchar	50	100%	Required
34	ME011	Member Social Security Number	Member's social security number	Text	varchar	9	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
35	ME105	Member First Name	Member first name	Text	varchar	25	100%	Required
36	ME106	Member Middle Name	Member middle name	Text	varchar	25	40%	Required
37	ME104	Member Last Name	Member last name	Text	varchar	60	100%	Required
38	ME043	Member Street Address	Member street address line 1	Text	varchar	100	100%	Required
39	ME044	Member Street Address 2	Member street address line 2	Text	varchar	100	0%	Optional
40	ME015	Member City Name	City of member’s residence	Text	varchar	30	100%	Required
41	ME016	Member State or Province	State or province of member’s residence See Appendix O - External Sources	Text	varchar	2	100%	Required
42	ME017	Member ZIP Code	Five digit USPS ZIP Code of the member’s residence See Appendix O - External Sources	Text	varchar	5	99%	Required
43	ME173-A	Member County	County of Member's residence Code or name	Text	varchar	2	75%	Required
44	ME014	Member Date of Birth	Member's data of birth	Date	YYYY-MM-DD	10	100%	Required
45	ME013	Member Gender	Gender of the member M = Male F = Female U = Unknown	Text	char	1	100%	Required
46	ME021	Member Race 1	Member's self-disclosed primary race See Appendix H – Race	Text	char	6	0%	Optional
47	ME022	Member Race 2	Member's self-disclosed Secondary race See Appendix H – Race	Text	char	6	0%	Optional
48	ME025	Member Ethnicity 1	Member's Primary Ethnicity See Appendix I - Ethnicity	Text	varchar	6	0%	Optional
49	ME026	Member Ethnicity 2	Member's Secondary ethnicity See Appendix I - Ethnicity	Text	varchar	6	0%	Optional
50	ME033	Member language preference	Member's self-disclosed verbal language preference See Appendix G - Language	Text	char	3	0%	Optional
51	ME059	Disability Indicator	Member's disability status 1 = Yes 2 = No	Numeric	int	1	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			3 = Unknown 4 = Other 5 = Not Applicable					
52	ME057	Date of Death	Member's date of death	Date	YYYY-MM-DD	10	0%	Optional
53	ME062	Marital Status	Marital status code for members over 18 years of age C = Common Law Married D = Divorced M = Married P = Domestic Partnership S = Never Married-So for a child you would expect this value? W = Widowed X = Legally Separated U = Unknown Else Null	Text	char	1	98%	Required
54	ME060	Employment Status	Employment status of member A = Active I = Involuntary Leave O = Orphan P = Pending R = Retiree Z = Unemployed U = Unknown	Text	char	1	100%	Required
55	ME083	Employer EIN	Member's Employer Identification Number (EIN)	Text	varchar	9	50%	Required
56	ME159-A	Employer Federal Tax ID Number	Employer Federal Tax ID number	Text	varchar	9	75%	Required
57	ME082	Employer Name	Member's employer name	Text	varchar	60	99%	Required
58	ME078	Employer Zip Code	Five digit USPS ZIP Code of the Employer’s address See Appendix O - External Sources	Text	varchar	5	50%	Required
59	ME049	Member Deductible	Annual maximum out of pocket Member Deductible across all benefit types. Code decimal point. This field may contain a negative value. 0$ is acceptable. Enter 0 if amount equals zero. Leave null if missing	Integer	varchar	10	90%	Required
60	ME050	Member Deductible Used	Member deductible amount used. Code decimal point. This field may contain a negative value. 0$ is acceptable. Enter 0 if amount equals zero. Leave null if missing	Integer	varchar	10	90%-See above	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
61	ME170-A	Member NAICS Code	Member industry description See Appendix O – External Code Sources	Text	varchar	6	75%	Required
62	ME047	Member PCP Effective Date	PCP Effective Date with Member. Code with 9999-99-99 if not available.-Need to add a 99-99-9999 or xx-xx-xxxx if not applicable or reduce your required percentage	Date	YYYY-MM-DD	10	0%	Optional
63	ME046	Member PCP ID	The NPI of the member's PCP. The value in this element must have a corresponding Provider ID in the Provider File. Report a value of '999999999U' when PCP is unknown or '999999999NA' if the eligibility does not require a PCP	Text	varchar	30	60%	Required
64	ME048	Member PCP Termination Date	Date member terminated PCP association	Date	YYYY-MM-DD	10	0%	Optional
65	ME077	Member SIC Code	Member Standard Industrial Classification (SIC) code Only applicable for commercial See Appendix O - External Sources	Text	char	4	0%	Optional
66	ME010	Member Suffix or Sequence Number	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. Only one record per eligibility month	Text	varchar	9		Required
67	ME120	Actuarial Value	Actuarial value of the risk adjustment covered plan.	Integer	varchar	6	0%	Optional
68	ME124	Attributed Primary Care Provider (PCP) Provider ID	PCP attributed to the patient for prior year. Leave null if unavailable	Text	varchar	30	0%	Optional
69	ME114	Behavioral Health Deductible	Maximum out of pocket amount of member's deductible applied to behavioral health. Code decimal point. This field may contain a negative value. 0$ is acceptable. Enter 0 if amount equals zero. Leave blank if missing. Required when Behavioral Health Benefit indicator = 1	Integer	varchar	10	100%	Required
70	ME066	COBRA Status	COBRA usage indicator 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	98%	Required
71	ME161-A	Consumer Directed Health	Member participates in a Consumer Directed Health Plan	Numeric	int	1	95%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
		Plan (CDHP) with HSA or HRA Indicator	(CDHP) with Health Savings Account (HSA) or Health Resources Account (HRA) indicator 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable					
72	ME162-A	Date of First Enrollment	The date of that the patient was initially enrolled	Date	YYYY-MM-DD	10	99%	Required
73	ME163-A	Date of Disenrollment	End date of enrollment for the patient in this delivery system (in this data submission time period)	Date	YYYY-MM-DD	10	75%	Required
74	ME020	Dental Coverage Indicator	Member's dental coverage status 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	100%	Required (if ME001 = DD)
75	ME115	Dental Deductible	Maximum out of pocket amount of member's deductible applied to dental coverage. Code decimal point. This field may contain a negative value. 0$ is acceptable. Enter 0 if amount equals zero. Leave blank if missing. Required when Dental Coverage indicator = 1	Integer	varchar	10	100%	Required
76	ME171-A	EBD Pool Indicator	Identifies EBD coverage groups: ASE = Arkansas State Employees PSE = Arkansas Public School Employees Null if not applicable	Text	char	3	100%	Required
77	ME045	Exchange Offering	Identifies if policy was purchased through the Arkansas Health Insurance Exchange (HIE) Y = Commercial small or non-group purchased through the Exchange N = Commercial small or non-group purchased outside the Exchange U = Not applicable (plan/product is not offered in the commercial small or non-group market)	Text	char	1	100%	Required
78	ME072	Family Size	Number of individuals covered under the policy/contract of the	Numeric	int	2	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			subscriber Minimum value 1.					
79	ME036	Health Care Home Name	Full name of the provider - facility, organization or individual. If the medical home is an individual, report in the format of last name, first name and middle initial with no punctuation	Text	varchar	60	0%	Optional
80	ME035	Health Care 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 O - External Sources	Text	varchar	20	0%	Optional
81	ME034	Health Care Home Tax ID Number	Federal tax payer's identification number for 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	Text	varchar	10	0%	Optional
82	ME024	Hispanic Indicator	Hispanic Status indicator 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	0%	Optional
83	ME056	Last Activity Date	Date of last activity/change on member enrollment file for this line of eligibility. This includes any/all life change updates, open enrollment changes, or benefit design changes by the carrier	Date	YYYY-MM-DD	10	0%	Optional
84	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) SML = Small Group LRG = Large Group	Text	varchar	4	100%-	Required
85	ME160-A	Medical Services Indicator	Medical Coverage 1 = Yes 2 = No 3 = Unknown	Text	char	1	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			4 = Other 5 = Not Applicable					
86	ME121	Metallic Value	Metal Level (percentage of Actuarial Value) per federal regulations 1 = Platinum 2 = Gold 3 = Silver 4 = Bronze 0 = Not Applicable	Numeric	int	1	100%	Required
87	ME112	Pharmacy Deductible	Maximum out of pocket amount of member's deductible applied to pharmacy coverage. Code decimal point. This field may contain a negative value 0$ is acceptable. Enter 0 if amount equals zero. Leave blank if missing Required when Pharmacy Coverage indicator = 1	Integer	varchar	10	50%	Required
88	ME019	Pharmacy Services Indicator	Pharmacy coverage 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	99%	Required
89	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
90	ME126	Risk Adjusted Plan	Indicates risk adjusted plan 1 = Yes 2 = No	Numeric	int	1	100%	Required
91	ME132	Total Monthly Premium	Employer + subscriber's total contribution to monthly premium. Code decimal point. This field may contain a negative value. 0$ is acceptable. Enter 0 if amount equals zero. Leave blank if missing	Integer	varchar	10	75%	Optional
92	ME118	Vision Benefit Indicator	Vision benefit indicator 1 = Yes	Numeric	int	1	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			2 = No 3 = Unknown 4 = Other 5 = Not Applicable					
93	ME116	Vision Deductible	Maximum out of pocket amount of member's deductible applied to vision coverage. Code decimal point. field may contain a negative value. 0$ is acceptable. Enter 0 if amount equals zero. Leave blank if missing Required when Vision Benefit indicator = 1	Integer	varchar	10	0%	Optional (potential requiremen t for later APCD reporting)

Medical Claims Data

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
1	MC000	Record Type	Record type identifier: DH = Data record column names (third row of data file) DD = Data detail (fourth row and beyond of file until trailer records)	Text	char	2	100%	Required
2	MC001	Payer	Code representing payer submitting claims AM = Ambetter BC = Arkansas Blue Cross and Blue Shield EBD = Employee Benefits Division DD = Delta Dental MCD = Medicaid MCR = Medicare QC = QualChoice of Arkansas	Text	varchar	3	99%	Required
3	MC002	National Plan ID	Do not report any value here until National Plan ID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans	Numeric	int	10	99%	Required
4	MC003	Insurance Type/Product Code	Insurance type or product identification code that indicates the type of insurance coverage the individual has. Code all but MC and XX as 2 characters; MC and XX must include a valid sub-code See Appendix A - Insurance Type/Product Code	Text	varchar	6	99%	Required
5	MC004	Payer Claim Control Number	Claim number used by the data submitter 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 data submitter's system	Text	varchar	35	99%	Required
6	MC005	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 data submitter'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	Text	varchar	4	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
7	MC005A	Version Number	Version number of the claim service line. It begins with 0 and is incremented by 1 for each subsequent version of that service line. This field is used in algorithms to determine the final payment for the service	Text	varchar	4	99%	Required
8	MC005B	Version Number Date	Version number of the claim service line. Value is YYMM to identify the version of the service line and incremented by month for each subsequent version of that service line. Use when the service line version cannot be incremented by 1	Text	varchar	4	99%	Required
9	MC006	Insured Group or Policy Number	The group or policy number associated with the entity that has purchased the insurance. For self-insured individuals this relates to the purchaser. For the majority of eligibility and claims data the group relates to the employer	Text	varchar	30	100%	Required
10	MC008	Plan Specific Contract Number	Data submitter assigned contract number for the subscriber. Set as null if unavailable. Set as null if contract number = subscriber's social security number	Text	varchar	20	50%	Required
11	MC094	Type of Claim	Type of Claim Indicator 001 = Professional 002 = Facility 003 = Reimbursement Form	Text	char	3	100%	Required
12	MC038	Claim Status	This field contains the status of the claim line as reported by the payer 01 = Processed as primary 02 = Processed as secondary 03 = Processed as tertiary 04 = Denied 19 = Processed as primary, forwarded to additional payer(s) 20 = Processed as secondary, forwarded to additional payer(s) 21 = Processed as tertiary, forwarded to additional payer(s) 22 = Reversal of previous payment 25 = Predetermination pricing only – no payment	Text	char	2	100%	Required
13	MC138	Claim Line Type	Claim Line Activity Type Code that defines final version status of claim line. O – Original F – Final	Text	varchar	1	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			R – Replacement B – Backed out (future use) A – Amendment (future use) V – Void (future use)					
14	MC110	Claim Processed Date	Claim Processed Date	Date	YYYY-MM-DD	10	99%	Required
15	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	99% of institutional claims	Required
16	MC061	Patient Account/Control Number	Identifying number assigned by hospital	Text	varchar	20	0%	Optional
17	MC037	Facility Type	For professional claims, this field records the type of facility where the service was performed. The field should be set to null for institutional claims See Appendix E - Facility Type	Text	char	2	99% of professional claims	Required
18	MC038A	Coordination of Benefits (COB) status	Indicates if claim was Coordination of Benefits (COB) claim 1 = Yes 2 = No	Numeric	int	1	100%	Required
19	MC141	Carrier Specific Unique Subscriber ID	Subscriber's Unique ID per carrier	Text	varchar	50	100%	Required
20	MC017	Paid Date	Date the record was approved for payment	Date	YYYY-MM-DD	10	100%	Required
21	MC054	Revenue Code	Revenue code for institutional claims. It is one of three fields used to report type of service. National Uniform Billing Committee Codes are accepted. Code using leading zeroes, left justified and four digits	Text	varchar	4	99.9% (if MC020 <> 9 or null)	Required
22	MC098	Allowed amount	Maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. This will vary by provider contract and most often it is less than or equal to the fee charged by the provider. Report 0 when the claim line is denied. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
23	MC061	Quantity	Count of services performed, which shall be set equal to one on all observation bed service lines and should be set equal to zero on all other room and board service lines, regardless of the length of stay. This field may be negative	Numeric	int	3	100%	Required
24	MC991	Spend down amount	The amount of personal assets that must be exhausted before individual becomes eligible for Medicaid benefits. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	98%	Required
25	MC062	Charge Amount	Total Charges for the service as reported by the provider. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	99%	Required
26	MC066	Coinsurance Amount	Patient's Coinsurance amount. Patient's share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. The patient pays coinsurance plus any deductibles owed. For example, if the health insurance or plan's allowed amount for an office visit is $100 and the patient has met the deductible, the coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	99%	Required
27	MC095	Coordination of Benefits/TPL Liability Amount	Amount due from a Secondary Carrier when known. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	10%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
28	MC065	Copay Amount	Pre-set, fixed dollar amount of copay payable by a member, often on a per visit/service basis. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	99%	Required
29	MC067	Deductible Amount	Amount that is required to be paid by a member before health plan benefits will begin to reimburse for services. It is usually an annual amount of all health care costs that is not covered by the member's insurance plan. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	99%	Required
30	MC097	Medicare Paid Amount	Amount Medicare paid on claim. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	10%	Required
31	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 acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	100%	Required
32	MC096	Other Insurance Paid Amount	Amount that a prior payer has paid for this claim line. Indicates the submitting Payer is 'secondary' to the prior payer. Only report 0 if the Prior Payer paid 0 towards this claim line, else do not report any value here. Code decimal point. This is a money field containing dollars and cents. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	10%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
33	MC063	Paid Amount	Amount paid for claim. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	99%	Required
34	MC063A	Header/ Line Payment Indicator	Flag indicating whether the payment is reported on the header or line level H = Header level - If H, populate each line after the first line with "H" and a paid amount of $0 L = Line level - If L, populate each line as necessary	Text	char	1	100%	Required
35	MC063C	Managed Care Withhold	Amount withheld from payment to a provider by a managed care organization, which may be paid at a later date. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	99%	Required
36	MC067A	Patient pay amount	Amount required if Copay, Coinsurance and Deductible amounts are missing. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	12	5%	Required
37	MC121	Patient Total Out of Pocket Amount	Total amount patient/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 acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	varchar	10	99%	Required
38	MC064	Prepaid Amount	Fee for service equivalent that would have been paid by the health care claims processor for a specific service if the service had not been capitated. "Capitated services" means services rendered by a provider through a contract where payments are based upon a fixed dollar amount for each member on a monthly basis. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative	Integer	±varchar	10	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing					
39	MC116	Withhold Amount	Amount paid to the provider for this claim line if the provider qualified/met performance guarantees. Report 0 if the provider has the agreement but did not satisfy the measure, else do not report any value here. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	0%	Optional
40	MC007	Subscriber Social Security Number	Subscriber's social security number	Text	varchar	9	75%	Required
41	MC102	Subscriber First Name	Subscriber first name	Text	varchar	25	100%	Required
42	MC103	Subscriber Middle Name	Subscriber middle name	Text	varchar	25	100%	Required
43	MC101	Subscriber Last Name	Subscriber last name	Text	varchar	60	100%	Required
44	MC988	Subscriber Street Address 1	Subscriber street address line 1	Text	Varchar	100	100	Required
45	MC989	Subscriber Street Address 2	Subscriber street address line 2	Text	varchar	100	25%	Required
46	MC985	Subscriber City	City of subscriber's residence	Text	varchar	30	100%	Required
47	MC986	Subscriber State	State or province of subscriber'residence See Appendix O - External Code Sources	Text	Varchar	2	100%	Required
48	MC987	Subscriber ZIP code	Five digit USPS ZIP Code of me subscriber'mber's residence See Appendix O - External Code Sources	Text	varchar	5	100%	Required
49	MC990	Subscriber Date of Birth	Subscriber's date of birth	Date	YYYY-MM-DD	10	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
50	MC011	Individual Relationship Code	Member's relationship to the subscriber or the insured See Appendix B - Relationship Code	Text	varchar	2	100%	Required
51	MC009	Member Suffix or Sequence Number	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. Only one record per eligibility month	Text	varchar	20	99%	Required
52	MC010	Member Social Security Number	Member's social security number	Text	varchar	9	0%	Optional
53	MC105	Member First Name	Member first name	Text	varchar	25	100%	Required
54	MC106	Member Middle Name	Member middle name	Text	varchar	25	100%	Required
55	MC104	Member Last Name	Member last name	Text	varchar	60	100%	Required
56	MC107	Member Street Address	Member street address line 1	Text	varchar	100	100%	Required
57	MC140	Member Street Address 2	Member street address line 2	Text	varchar	100	20%	Required
58	MC014	Member City	City of member’s residence	Text	varchar	30	100%	Required
59	MC015	Member State or Province	State or province of member’s residence See Appendix O - External Code Sources	Text	varchar	2	100%	Required
60	MC016	Member ZIP Code	Five digit USPS ZIP Code of member’s residence See Appendix O - External Code Sources	Text	varchar	5	100%	Required
61	MC013	Member Date of Birth	Member's date of birth	Date	YYYY-MM-DD	10	100%	Required
62	MC018	Admission Date	Date of the inpatient admission	Date	YYYY-MM-DD	10	60% (if MC036 = 1)	Required
63	MC012	Member Gender	Gender of the member M = Male F = Female U = Unknown	Text	char	1	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
64	MC019	Admission Hour	Hour the inpatient was admitted to the hospital. Required for all inpatient claims. Time is expressed in military time - HHMM. If only the hour is known, code the minutes as 00. 4 PM would be reported as 1600	Text	varchar	4	0%	Optional
65	MC020	Admission Type	Type of admission for all inpatient hospital claims 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 5 = Trauma Center 9 = Information not Available	Numeric	int	1	0%	Optional
66	MC069	Discharge Date	Date patient discharged. Required for all inpatient claims	Date	YYYY-MM-DD	10	60% (if MC020 <> 9 or null)	Required
67	MC022	Discharge Hour	Hour the inpatient was Discharged from the hospital. Time expressed in military time - HHMM. If only the hour is known, code the minutes as 00. 4 PM would be reported as 1600	Text	varchar	4	0%	Optional
68	MC023	Discharge Status	Status for the patient discharged from the hospital See Appendix C - Discharge Status	Text	char	2	60% if MC020 <> 9 or null	Required
69	MC059	Date of Service - From	First date of service for this service line in a YYYY-MM-DD format	Date	YYYY-MM-DD	10	100%	Required
70	MC060	Date of Service - Thru	Last date of service for this service line in a YYYY-MM-DD format. Future dates are acceptable	Date	YYYY-MM-DD	10	100%	Required
71	MC915_A	ICD Indicator	Indicates use of ICD-9 or ICD-10 code sets. Code sets cannot be mixed on a record 9 = ICD-9 Diagnosis codes 0 = ICD-10 Diagnosis codes	Text	char	1	60% if MC020 <> 9 or null	Required
72	MC040	E-Code	This field describes an injury, poisoning or adverse effect using an ICD-9-CM or ICD-10-CM E-code diagnosis. Decimal point is not coded. Additional E-Codes may be reported in other diagnosis fields MC041 - MC053 See Appendix O - External Code Sources	Text	varchar	5	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
73	MC039	Admitting Diagnosis	This field contains the ICD-9-CM or ICD-10-CM diagnosis code indicating the reason for the inpatient admission. Decimal point is not coded See Appendix O - External Code Sources.	Text	varchar	5	60% (if MC020 <> 9 or null)	Required
74	MC136	Discharge Diagnosis	ICD-9 or ICD-10 Discharge Diagnosis Code See Appendix O – External Code Source	Text	varchar	7	0%	Optional
75	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 O - External Code Sources	Text	varchar	5	100%	Required
76	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 O - External Code Sources	Text	varchar	5	50%	Required
77	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 O - External Code Sources	Text	varchar	5	20%	Required
78	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 O - External Code Sources	Text	varchar	5	5%	Required
79	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 O - External Code Sources	Text	varchar	5	<1%	Required
80	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 O - External Code Sources	Text	varchar	5	<1%	Required
81	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 O - External Code Sources	Text	varchar	5	<1%	Required
82	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 O - External Code Sources	Text	varchar	5	<1%	Required
83	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 O - External Code Sources	Text	varchar	5	<1%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
84	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 O - External Code Sources	Text	varchar	5	<1%	Required
85	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 O - External Code Sources	Text	varchar	5	<1%	Required
86	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 O - External Code Sources	Text	varchar	5	<1%	Required
87	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 O - External Code Sources	Text	varchar	5	<1%	Required
88	MC142	Other Diagnosis - 13	ICD-9-CM or ICD-10-CM [CO] diagnosis code for the thirteenth secondary diagnosis. Decimal point is not coded See Appendix O – External Code Source	Text	varchar	7	<1%	Required
89	MC143	Other Diagnosis - 14	ICD-9-CM or ICD-10-CM [CO] diagnosis code for the fourteenth secondary diagnosis. Decimal point is not coded See Appendix O – External Code Source	Text	varchar	7	<1%	Required
90	MC144	Other Diagnosis - 15	ICD-9-CM or ICD-10-CM [CO] diagnosis code for the fifteenth secondary diagnosis. Decimal point is not coded See Appendix O – External Code Source	Text	varchar	7	<1%	Required
91	MC145	Other Diagnosis - 16	ICD-9-CM or ICD-10-CM [CO] diagnosis code for the sixteenth secondary diagnosis. Decimal point is not coded See Appendix O – External Code Source	Text	varchar	7	<1%	Required
92	MC146	Other Diagnosis - 17	ICD-9-CM or ICD-10-CM [CO] diagnosis code for the seventeenth secondary diagnosis. Decimal point is not coded See Appendix O – External Code Source	Text	varchar	7	<1%	Required
93	MC147	Other Diagnosis - 18	ICD-9-CM or ICD-10-CM [CO] diagnosis code for the eighteenth secondary diagnosis. Decimal point is not coded See Appendix O – External Code Source	Text	varchar	7	<1%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
94	MC148	Other Diagnosis - 19	ICD-9-CM or ICD-10-CM [CO] diagnosis code for the nineteenth secondary diagnosis. Decimal point is not coded See Appendix O – External Code Source	Text	varchar	7	<1%	Required
95	MC149	Other Diagnosis - 20	ICD-9-CM or ICD-10-CM [CO] diagnosis code for the twentieth secondary diagnosis. Decimal point is not coded See Appendix O – External Code Source	Text	varchar	7	<1%	Required
96	MC150	Other Diagnosis - 21	ICD-9-CM or ICD-10-CM [CO] diagnosis code for the twenty-first secondary diagnosis. Decimal point is not coded See Appendix O – External Code Source	Text	varchar	7	<1%	Required
97	MC151	Other Diagnosis - 22	ICD-9-CM or ICD-10-CM [CO] diagnosis code for the twenty-second secondary diagnosis. Decimal point is not coded See Appendix O – External Code Source	Text	varchar	7	<1%	Required
98	MC152	Other Diagnosis - 23	ICD-9-CM or ICD-10-CM [CO] diagnosis code for the twenty-third secondary diagnosis. Decimal point is not coded See Appendix O – External Code Source	Text	varchar	7	<1%	Required
99	MC153	Other Diagnosis - 24	ICD-9-CM or ICD-10-CM [CO] diagnosis code for the twenty-fourth secondary diagnosis. Decimal point is not coded See Appendix O – External Code Source	Text	varchar	7	<1%	Required
100	MC154	Present on Admission Code (POA) - 01	Code indicating the primary diagnosis was present at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	100% (if MC037=21 else NULL)	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
101	MC155	Present on Admission Code (POA) - 02	Code indicating the presence of Other Diagnosis - 1 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required
102	MC156	Present on Admission Code (POA) - 03	Code indicating the presence of Other Diagnosis - 2 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required
103	MC157	Present on Admission Code (POA) - 04	Code indicating the presence of Other Diagnosis - 3 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
104	MC158	Present on Admission Code (POA) - 05	Code indicating the presence of Other Diagnosis - 4 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required
105	MC159	Present on Admission Code (POA) - 06	Code indicating the presence of Other Diagnosis - 5 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required
106	MC160	Present on Admission Code (POA) - 07	Code indicating the presence of Other Diagnosis - 6 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
107	MC161	Present on Admission Code (POA) - 08	Code indicating the presence of Other Diagnosis - 7 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required
108	MC162	Present on Admission Code (POA) - 09	Code indicating the presence of Other Diagnosis - 8 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required
109	MC163	Present on Admission Code (POA) - 10	Code indicating the presence of Other Diagnosis - 9 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
110	MC164	Present on Admission Code (POA) - 11	Code indicating the presence of Other Diagnosis - 10 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required
111	MC165	Present on Admission Code (POA) - 12	Code indicating the presence of Other Diagnosis - 11 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required
112	MC166	Present on Admission Code (POA) - 13	Code indicating the presence of Other Diagnosis - 12 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
113	MC167	Present on Admission Code (POA) - 14	Code indicating the presence of Other Diagnosis - 13 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required
114	MC168	Present on Admission Code (POA) - 15	Code indicating the presence of Other Diagnosis - 14 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required
115	MC169	Present on Admission Code (POA) - 16	Code indicating the presence of Other Diagnosis - 15 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
116	MC170	Present on Admission Code (POA) - 17	Code indicating the presence of Other Diagnosis - 16 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required
117	MC171	Present on Admission Code (POA) - 18	Code indicating the presence of Other Diagnosis - 17 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required
118	MC172	Present on Admission Code (POA) - 19	Code indicating the presence of Other Diagnosis - 18 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
119	MC173	Present on Admission Code (POA) - 20	Code indicating the presence of Other Diagnosis - 19 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required
120	MC174	Present on Admission Code (POA) - 21	Code indicating the presence of Other Diagnosis - 20 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required
121	MC175	Present on Admission Code (POA) - 22	Code indicating the presence of Other Diagnosis - 21 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
122	MC176	Present on Admission Code (POA) - 23	Code indicating the presence of Other Diagnosis - 22 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required
123	MC177	Present on Admission Code (POA) - 24	Code indicating the presence of Other Diagnosis - 23 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required
124	MC178	Present on Admission Code (POA) - 25	Code indicating the presence of Other Diagnosis - 24 at the time of admission 3 = Unknown 1 = Exempt from POA reporting (Use if POA reporting is not required by carrier) N = Other Diagnosis was not present at time of inpatient admission U = Documentation insufficient to determine if condition was present at time of inpatient admission W = Clinically undetermined Y = Diagnosis was present at time of inpatient admission	Text	char	1	10% (if MC037=21 else NULL)	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
125	MC179	Condition Code - 1	Primary condition code related to the first condition in this billing period. Condition codes have values from 01 through 99 and A0 through W0 See Appendix K - Condition Codes	Text	char	2	100% (if MC001 = MCD or MCR, else NULL)	Required
126	MC180	Condition Code - 2	Condition code related to the second condition in this billing period. Condition codes have values from 01 through 99 and A0 through W0 See Appendix K - Condition Codes	Text	char	2	50% (if MC001 = MCD or MCR, else NULL)	Required
127	MC181	Condition Code - 3	Condition code related to the third condition in this billing period. Condition codes have values from 01 through 99 and A0 through W0 See Appendix K - Condition Codes	Text	char	2	30% (if MC001 = MCD or MCR, else NULL)	Required
128	MC182	Condition Code - 4	Condition code related to the fourth condition in this billing period. Condition codes have values from 01 through 99 and A0 through W0 See Appendix K - Condition Codes	Text	char	2	10% (if MC001 = MCD or MCR, else NULL)	Required
129	MC183	Condition Code - 5	Condition code related to the fifth condition in this billing period. Condition codes have values from 01 through 99 and A0 through W0 See Appendix K - Condition Codes	Text	char	2	1% (if MC001 = MCD or MCR, else NULL)	Required
130	MC184	Condition Code - 6	Condition code related to the sixth condition in this billing period. Condition codes have values from 01 through 99 and A0 through W0 See Appendix K - Condition Codes	Text	char	2	1% (if MC001 = MCD or MCR, else NULL)	Required
131	MC185	Condition Code - 7	Condition code related to the seventh condition in this billing period. Condition codes have values from 01 through 99 and A0 through W0 See Appendix K - Condition Codes	Text	char	2	1% (if MC001 = MCD or MCR, else NULL)	Required
132	MC186	Condition Code - 8	Condition code related to the eighth condition in this billing period. Condition codes have values from 01 through 99 and A0 through W0	Text	char	2	1% (if MC001 = MCD or MCR, else NULL)	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			See Appendix K - Condition Codes					
133	MC187	Condition Code - 9	Condition code related to the ninth condition in this billing period. Condition codes have values from 01 through 99 and A0 through W0 See Appendix K - Condition Codes	Text	char	2	1% (if MC001 = MCD or MCR, else NULL)	Required
134	MC188	Condition Code - 10	Condition code related to the tenth condition in this billing period. Condition codes have values from 01 through 99 and A0 through W0 See Appendix K - Condition Codes	Text	char	2	1% (if MC001 = MCD or MCR, else NULL)	Required
135	MC189	Condition Code - 11	Condition code related to the eleventh condition in this billing period. Condition codes have values from 01 through 99 and A0 through W0 See Appendix K - Condition Codes	Text	char	2	1% (if MC001 = MCD or MCR, else NULL)	Required
136	MC190	Condition Code - 12	Condition code related to the twelfth condition in this billing period. Condition codes have values from 01 through 99 and A0 through W0 See Appendix K - Condition Codes	Text	char	2	1% (if MC001 = MCD or MCR, else NULL)	Required
137	MC191	Value Code - 1	Value of a monetary condition which was used by the intermediary to process an institutional claim See Appendix J - Value Codes	Text	char	2	99% (if MC001 = MCD or MCR, else NULL)	Required
138	MC192	Value Amount - 1	Amount related to the condition identified in the value code which was used by the intermediary to process the institutional claim. Code decimal point. This field may contain a negative value. 0$ is acceptable. Enter 0 if amount equals zero. Leave blank if missing	Integer	±varchar	10	99% (if MC001 = MCD or MCR, else NULL)	Required
139	MC193	Value Code - 2	Value of a monetary condition which was used by the intermediary to process an institutional claim See Appendix J - Value Codes	Text	char	2	50% (if MC001 = MCD or MCR, else NULL)	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
140	MC194	Value Amount - 2	Amount related to the condition identified in the value code which was used by the intermediary to process the institutional claim Code decimal point. This field may contain a negative value. 0$ is acceptable. Enter 0 if amount equals zero. Leave blank if missing	Integer	±varchar	10	50% (if MC001 = MCD or MCR, else NULL)	Required
141	MC195	Value Code - 3	Value of a monetary condition which was used by the intermediary to process an institutional claim See Appendix J - Value Codes	Text	char	2	0% (if MC001 = MCD or MCR, else NULL)	Required
142	MC196	Value Amount - 3	Amount related to the condition identified in the value code which was used by the intermediary to process the institutional claim. Code decimal point. This field may contain a negative value. 0$ is acceptable. Enter 0 if amount equals zero. Leave blank if missing	Integer	±varchar	10	1% (if MC001 = MCD or MCR, else NULL)	Required
143	MC197	Value Code - 4	Value of a monetary condition which was used by the intermediary to process an institutional claim. See Appendix J - Value Codes	text	char	2	1% (if MC001 = MCD or MCR, else NULL)	Required
144	MC198	Value Amount - 4	Amount related to the condition identified in the value code which was used by the intermediary to process the institutional claim. Code decimal point. This field may contain a negative value. 0$ is acceptable. Enter 0 if amount equals zero. Leave blank if missing	Integer	±varchar	10	1% (if MC001 = MCD or MCR, else NULL)	Required
145	MC199	Value Code - 5	Value of a monetary condition which was used by the intermediary to process an institutional claim See Appendix J - Value Codes	Text	char	2	1% (if MC001 = MCD or MCR, else NULL)	Required
146	MC200	Value Amount - 5	Amount related to the condition identified in the value code which was used by the intermediary to process the institutional claim. Code decimal point. This field may contain a negative value. 0$ is acceptable. Enter 0 if amount equals zero. Leave blank if missing	Text	char	10	1% (if MC001 = MCD or MCR, else NULL)	Required
147	MC201	Value Code - 6	Value of a monetary condition which was used by the intermediary to process an institutional claim See Appendix J - Value Codes	Text	char	2	1% (if MC001 = MCD or MCR, else NULL)	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
148	MC202	Value Amount - 6	Amount that corresponds to Value Code - 6. Code decimal point. This field may contain a negative value. 0$ is acceptable. Enter 0 if amount equals zero. Leave blank if missing	Integer	±varchar	10	1% (if MC001 = MCD or MCR, else NULL)	Required
149	MC203	Value Code - 7	Value of a monetary condition which was used by the intermediary to process an institutional claim See Appendix J - Value Codes	Text	char	2	1% (if MC001 = MCD or MCR, else NULL)	Required
150	MC204	Value Amount - 7	Amount related to the condition identified in the value code which was used by the intermediary to process the institutional claim. Code decimal point. This field may contain a negative value. 0$ is acceptable. Enter 0 if amount equals zero. Leave blank if missing	Integer	±varchar	10	1% (if MC001 = MCD or MCR, else NULL)	Required
151	MC204A	Value Code - 8	Value of a monetary condition which was used by the intermediary to process an institutional claim See Appendix J - Value Codes	Text	char	2	1% (if MC001 = MCD or MCR, else NULL)	Required
152	MC204A_A	Value Amount - 8	Amount related to the condition identified in the value code which was used by the intermediary to process the institutional claim. Code decimal point. This field may contain a negative value. 0$ is acceptable. Enter 0 if amount equals zero. Leave blank if missing	Integer	±varchar	10	1% (if MC001 = MCD or MCR, else NULL)	Required
153	MC079	Diagnosis Code Pointer -1	Number indicating order of importance for Primary Diagnosis code. For example, if Primary Diagnosis code is the most important diagnosis on the claim line, the value in Diagnosis Code Pointer 1 becomes 1	Numeric	int	1	90%	Required
154	MC080	Diagnosis Code Pointer -2	Number indicating order of importance for Other Diagnosis Code 1. For example, if Other Diagnosis code 3 becomes the most important diagnosis on the claim line, the value in Diagnosis Code Pointer 3 becomes 1	Numeric	int	1	10%	Required
155	MC081	Diagnosis Code Pointer -3	Number indicating order of importance for Other Diagnosis Code 1. For example, if Other Diagnosis code 2 becomes the most important diagnosis on the claim line, the value in Diagnosis Code Pointer 2 becomes 1	Numeric	int	1	<1%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
156	MC082	Diagnosis Code Pointer -4	Number indicating order of importance for Other Diagnosis Code 3. For example, if Other Diagnosis code 3 becomes the most important diagnosis on the claim line, the value in Diagnosis Code Pointer 3 becomes 1	Numeric	int	1	<1%	Required
157	MC207	Value Code - 9	Value of a monetary condition which was used by the intermediary to process an institutional claim See Appendix J - Value Codes	Text	char	2	1% (if MC001 = MCD or MCR, else NULL)	Required
158	MC208	Value Amount - 9	Amount related to the condition identified in the value code which was used by the intermediary to process the institutional claim. Code decimal point. This field may contain a negative value. 0$ is acceptable. Enter 0 if amount equals zero. Leave blank if missing	Integer	±varchar	10	1% (if MC001 = MCD or MCR, else NULL)	Required
159	MC209	Value Code - 10	Value of a monetary condition which was used by the intermediary to process an institutional claim See Appendix J - Value Codes	Text	char	2	1% (if MC001 = MCD or MCR, else NULL)	Required
160	MC210	Value Amount - 10	Amount related to the condition identified in the value code which was used by the intermediary to process the institutional claim. Code decimal point. This field may contain a negative value. 0$ is acceptable. Enter 0 if amount equals zero. Leave blank if missing	Integer	±varchar	10	1% (if MC001 = MCD or MCR, else NULL)	Required
161	MC211	Value Code - 11	Value of a monetary condition which was used by the intermediary to process an institutional claim See Appendix J - Value Codes	Text	char	2	1% (if MC001 = MCD or MCR, else NULL)	Required
162	MC212	Value Amount - 11	Amount related to the condition identified in the value code which was used by the intermediary to process the institutional claim. Code decimal point. This field may contain a negative value. 0$ is acceptable. Enter 0 if amount equals zero. Leave blank if missing	Integer	±varchar	10	1% (if MC001 = MCD or MCR, else NULL)	Required
163	MC213	Value Code - 12	Value of a monetary condition which was used by the intermediary to process an institutional claim See Appendix J - Value Codes	Text	char	2	1% (if MC001 = MCD or MCR, else NULL)	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
164	MC214	Value Amount - 12	Amount related to the condition identified in the value code which was used by the intermediary to process the institutional claim. Code decimal point. This field may contain a negative value. 0$ is acceptable. Enter 0 if amount equals zero. Leave blank if missing	Integer	±varchar	10	1% (if MC001 = MCD or MCR, else NULL)	Required
165	MC215	Occurrence Code - 1	Primary occurrence code related to a specific event in this billing period. Occurrence codes and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9 See Appendix L - Occurrence Codes	Text	char	2	99% (if MC001 = MCD or MCR, else NULL)	Required
166	MC216	Occurrence Date - 1	Date of the first specific event relating to this billing period	Date	YYYY-MM-DD	10	99% (if MC001 = MCD or MCR, else NULL)	Required
167	MC217	Occurrence Code - 2	Second occurrence code related to a specific event in this billing period. Occurrence codes and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9 See Appendix L - Occurrence Codes	Text	char	2	80% (if MC001 = MCD or MCR, else NULL)	Required
168	MC218	Occurrence Date - 2	Date of the second specific event relating to this billing period	Date	YYYY-MM-DD	10	80% (if MC001 = MCD or MCR, else NULL)	Required
169	MC219	Occurrence Code - 3	Third occurrence code related to a specific event in this billing period. Occurrence codes and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9 See Appendix L - Occurrence Codes	Text	char	2	0% (if MC001 = MCD or MCR, else NULL)	Required
170	MC220	Occurrence Date - 3	Date of the third specific event relating to this billing period	Date	YYYY-MM-DD	10	1% (if MC001 = MCD or MCR, else NULL)	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
171	MC221	Occurrence Code - 4	Fourth occurrence code related to a specific event in this billing period. Occurrence codes and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9 See Appendix L - Occurrence Codes	Text	char	2	1% (if MC001 = MCD or MCR, else NULL)	Required
172	MC222	Occurrence Date - 4	Date of the fourth specific event relating to this billing period	Date	YYYY-MM-DD	10	1% (if MC001 = MCD or MCR, else NULL)	Required
173	MC223	Occurrence Code - 5	Fifth occurrence code related to a specific event in this billing period. Occurrence codes and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and A0 through L9 See Appendix L - Occurrence Codes	Text	char	2	1% (if MC001 = MCD or MCR, else NULL)	Required
174	MC224	Occurrence Date - 5	Date of the fifth specific event relating to this billing period	Date	YYYY-MM-DD	10	1% (if MC001 = MCD or MCR, else NULL)	Required
175	MC225	Occurrence Span Code - 1	First significant event relating to an institutional claim that may affect payer-related processing. These codes are claim-related occurrences that are related to a span of dates. Occurrence codes and occurrence span codes are mutually exclusive. Occurrence span codes have values from 70 through 99 and M0 through Z9 See Appendix M - Occurrence Span Codes	Text	char	2	99% (if MC001 = MCD or MCR, else NULL)	Required
176	MC226	Occurrence Span Start Date - 1	Associated start date of the first significant event relating to this billing period	Date	YYYY-MM-DD	10	99% (if MC001 = MCD or MCR, else NULL)	Required
177	MC227	Occurrence Span End Date - 1	Associated end date of the first significant event relating to this billing period	Date	YYYY-MM-DD	10	99% (if MC001 = MCD or MCR, else NULL)	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
178	MC228	Occurrence Span Code - 2	Second significant event relating to an institutional claim that may affect payer-related processing. These codes are claim-related occurrences that are related to a span of dates. Occurrence codes and occurrence span codes are mutually exclusive. Occurrence span codes have values from 70 through 99 and M0 through Z9 See Appendix M - Occurrence Span Codes	Text	char	2	75% (if MC001 = MCD or MCR, else NULL)	Required
179	MC229	Occurrence Span Start Date - 2	Associated start date of the second significant event relating to this billing period	Date	YYYY-MM-DD	10	75% (if MC001 = MCD or MCR, else NULL)	Required
180	MC230	Occurrence Span End Date - 2	Associated end date of the second significant event relating to this billing period	Date	YYYY-MM-DD	10	75% (if MC001 = MCD or MCR, else NULL)	Required
181	MC231	Occurrence Span Code - 3	Third significant event relating to an institutional claim that may affect payer-related processing. These codes are claim-related occurrences that are related to a span of dates. Occurrence codes and occurrence span codes are mutually exclusive. Occurrence span codes have values from 70 through 99 and M0 through Z9. See Appendix M - Occurrence Span Codes	Text	char	2	0% (if MC001 = MCD or MCR, else NULL)	Required
182	MC232	Occurrence Span Start Date - 3	Associated start date of the third significant event relating to this billing period	Date	YYYY-MM-DD	10	1% (if MC001 = MCD or MCR, else NULL)	Required
183	MC233	Occurrence Span End Date - 3	Associated end date of the third significant event relating to this billing period	Date	YYYY-MM-DD	10	1% (if MC001 = MCD or MCR, else NULL)	Required
184	MC234	Occurrence Span Code - 4	Fourth significant event relating to an institutional claim that may affect payer-related processing. These codes are claim-related occurrences that are related to a span of dates. Occurrence codes and occurrence span codes are mutually exclusive. Occurrence span codes have values from 70 through 99 and M0 through Z9 See Appendix M - Occurrence Span Codes	Text	char	2	1% (if MC001 = MCD or MCR, else NULL)	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
185	MC235	Occurrence Span Start Date - 4	Associated start date of the fourth significant event relating to this billing period	Date	YYYY-MM-DD	10	1% (if MC001 = MCD or MCR, else NULL)	Required
186	MC236	Occurrence Span End Date - 4	Associated end date of the fourth significant event relating to this billing period	Date	YYYY-MM-DD	10	1% (if MC001 = MCD or MCR, else NULL)	Required
187	MC237	Occurrence Span Code - 5	Fifth significant event relating to an institutional claim that may affect payer-related processing. These codes are claim-related occurrences that are related to a span of dates. Occurrence codes and occurrence span codes are mutually exclusive. Occurrence span codes have values from 70 through 99 and M0 through Z9 See Appendix M - Occurrence Span Codes	Text	char	2	1% (if MC001 = MCD or MCR, else NULL)	Required
188	MC238	Occurrence Span Start Date - 5	Associated start date of the fifth significant event relating to this billing period	Date	YYYY-MM-DD	10	1% (if MC001 = MCD or MCR, else NULL)	Required
189	MC239	Occurrence Span End Date - 5	Associated end date of the fifth significant event relating to this billing period	Date	YYYY-MM-DD	10	1% (if MC001 = MCD or MCR, else NULL)	Required
190	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 O - External Code Sources	Text	varchar	5	80%	Required
191	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

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
192	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
193	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
194	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
195	MC058	Principal ICD-9-CM or ICD-10-CM Procedure Code	Principal inpatient ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary. This is one of three fields used to report type of service See Appendix O - External Code Sources	Text	varchar	4	55% (if MC020 <> 9 or null)	Required
196	MC058A	Other ICD-9-CM or ICD-10-CM Procedure Code - 1	First secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary See Appendix O - External Code Sources	Text	varchar	4	30% (if MC020 <> 9 or null)	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
197	MC058B	Other ICD-9-CM or ICD-10-CM Procedure Code - 2	Second secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary See Appendix O - External Code Sources	Text	varchar	4	15% (if MC020 <> 9 or null)	Required
198	MC058C	Other ICD-9-CM or ICD-10-CM Procedure Code - 3	Third secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary See Appendix O - External Code Sources	Text	varchar	4	10% (if MC020 <> 9 or null)	Required
199	MC058D	Other ICD-9-CM or ICD-10-CM Procedure Code - 4	Fourth secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary See Appendix O - External Code Sources	Text	varchar	4	5% (if MC020 <> 9 or null)	Required
200	MC058E	Other ICD-9-CM or ICD-10-CM Procedure Code - 5	Fifth secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary See Appendix O - External Code Sources	Text	varchar	4	<1% (if MC020 <> 9 or null)	Required
201	MC058E_A	Other ICD-9-CM or ICD-10-CM Procedure Code - 6	Sixth secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary See Appendix O - External Code Sources	Text	varchar	4	<1% (if MC020 <> 9 or null)	Required
202	MC058F	Other ICD-9-CM or ICD-10-CM Procedure Code - 7	Seventh secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary See Appendix O - External Code Sources	Text	varchar	4	<1% (if MC020 <> 9 or null)	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
203	MC058G	Other ICD-9-CM or ICD-10-CM Procedure Code - 8	Eighth secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary See Appendix O - External Code Sources	Text	varchar	4	<1% (if MC020 <> 9 or null)	Required
204	MC058H	Other ICD-9-CM or ICD-10-CM Procedure Code - 9	Ninth secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary See Appendix O - External Code Sources	Text	varchar	4	<1% (if MC020 <> 9 or null)	Required
205	MC058J	Other ICD-9-CM or ICD-10-CM Procedure Code - 10	Tenth secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary See Appendix O - External Code Sources	Text	varchar	4	<1% (if MC020 <> 9 or null)	Required
206	MC058K	Other ICD-9-CM or ICD-10-CM Procedure Code - 11	Eleventh secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary See Appendix O - External Code Sources	Text	varchar	4	<1% (if MC020 <> 9 or null)	Required
207	MC058L	Other ICD-9-CM or ICD-10-CM Procedure Code - 12	Twelfth secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary See Appendix O - External Code Sources	Text	varchar	4	<1% (if MC020 <> 9 or null)	Required
208	MC058M	Other ICD-9-CM or ICD-10-CM Procedure Code - 13	Thirteenth secondary ICD-9-CM or ICD-10-CM procedure code. The decimal point is not coded. The ICD-9-CM or ICD-10-CM procedure must be repeated for all lines of the claim if necessary See Appendix O - External Code Sources	Text	varchar	4	<1% (if MC020 <> 9 or null)	Required
209	MC205	ICD-9-CM Procedure Date	Date the principle inpatient procedure was performed.	Date	YYYY-MM-DD	10	99% (if MC058 is not NULL, else	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
							NULL)	
210	MC205A	ICD-9-CM Procedure Date 1	Date the first secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	99% (if MC058A is not NULL, else NULL)	Required
211	MC205B	ICD-9-CM Procedure Date 2	Date the second secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	80% (if MC058B is not NULL, else NULL)	Required
212	MC205C	ICD-9-CM Procedure Date 3	Date the third secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	75% (if MC058C is not NULL, else NULL)	Required
213	MC205D	ICD-9-CM Procedure Date 4	Date the fourth secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	<1% (if MC058D is not NULL, else NULL)	Required
214	MC205E	ICD-9-CM Procedure Date 5	Date the fifth secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	<1% (if MC058E is not NULL, else NULL)	Required
215	MC205F	ICD-9-CM Procedure Date 6	Date the sixth secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	<1% (if MC058E_A is not NULL, else NULL)	Required
216	MC205G	ICD-9-CM Procedure Date 7	Date the seventh secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	<1% (if MC058F is not NULL, else NULL)	Required
217	MC205H	ICD-9-CM Procedure Date 8	Date the eighth secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	<1% (if MC058G is not NULL, else NULL)	Required
218	MC205I	ICD-9-CM Procedure Date 9	Date the ninth secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	<1% (if MC058H is not NULL, else NULL)	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
219	MC205J	ICD-9-CM Procedure Date 10	Date the tenth secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	<1% (if MC058J is not NULL, else NULL)	Required
220	MC205K	ICD-9-CM Procedure Date 11	Date the eleventh secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	<1% (if MC058K is not NULL, else NULL)	Required
221	MC205L	ICD-9-CM Procedure Date 12	Date the twelfth secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	<1% (if MC058L is not NULL, else NULL)	Required
222	MC205M	ICD-9-CM Procedure Date 13	Date the thirteenth secondary inpatient procedure was performed	Date	YYYY-MM-DD	10	<1% (if MC058M is not NULL, else NULL)	Required
223	MC108	Service Provider Street Address	Service Provider practice location street address line 1	Text	varchar	100	100%	Required
224	MC026	National Service Provider ID	National Provider Identification (NPI) number for the entity or individual directly providing the service	Text	varchar	20	100%	Required
225	MC027	Service Provider Entity Type Qualifier	HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as "Person" 1 = Person 2 = Non-Person entity	Text	varchar	1	90%	Required
226	MC024	Service Provider Number	Data submitter assigned or legacy rendering/attending provider number. Submit facility for institutional claims; physician or healthcare professional for professional claims	Text	varchar	30	0%	Optional
227	MC025	Service Provider Tax ID Number	Federal tax payer's identification number for rendering/attending provider	Text	varchar	10	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
228	MC028	Service Provider First Name	Service provider first name. Set to null if provider is a facility or an organization	Text	varchar	25	100%	Required
229	MC029	Service Provider Middle Name	Service provider middle name. Set to null if provider is a facility or an organization	Text	varchar	25	0%	Optional
230	MC030	Service Provider Last Name or Organization Name	Service provider last name. Set to null if provider is a facility or an organization	Text	varchar	100	100%	Required
231	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
232	MC033	Service Provider City	City of service provider's address	Text	varchar	30	90%	Required
233	MC034	Service Provider State or Province	State or province of service provider's address See Appendix O - External Code Sources	Text	varchar	2	90%	Required
234	MC035	Service Provider ZIP Code	Five digit USPS ZIP Code of the servicing provider's address, preferably the practice location See Appendix O - External Code Sources	Text	varchar	5	90%	Required
235	MC070	Service Provider Country Code	Country name of the Service Provider. Use 3-digit ISO Country Codes See Appendix O - External Sources	Text	varchar	3	100%	Required
236	MC032	Service Provider Specialty	Code defining provider specialty	Text	varchar	10	90% if MC020 = 9 or null	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
237	MC076	Billing Provider Number	Payer assigned billing provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change. Required if National Billing Provider ID is not filled	Text	varchar	30	10%	Required
238	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	Text	varchar	10	100%	Required
239	MC078	Billing Provider Name	Full name of provider billing organization or last name of individual billing provider	Text	varchar	60	100%	Required
240	MC135	Provider Location	Unique code which identifies the location/site of the service provided by the plan rendering provider identified in Plan Rendering Provider Identifier	Text	varchar	30	100%	Required
241	MC071	DRG	Diagnostic Related Group Code: DRG paid by payer. If not available send billed DRG	Text	varchar	3	20% (if MC020 <> 9 or null)	Required
242	MC072	DRG Version	Diagnostic Related Group Version Number: Version of DRG (inpatient) grouper used	Text	varchar	2	20% (if MC020 <> 9 or null)	Required
243	MC073	APC	Ambulatory Payment Classification Number: Carriers and health care claims processors shall code using CMS methodology. Precedence shall be given to APCs transmitted from the health care provider	Text	varchar	4	0%	Optional
244	MC074	APC Version	Ambulatory Payment Classification Version: Version of APC (outpatient) grouper used	Text	varchar	2	0%	Optional
245	MC075	Drug Code	National Drug Code (NDC): Used only when a medication is paid for as part of a medical claim or when a DME device has an NDC code. J codes should be submitted under procedure code (MC055), and have a procedure code type of 'HCPCS'. Drug Code as defined by the FDA in 11 digit format (5-4-2) without hyphenation	Text	varchar	11	0%	Optional
246	MC090	LOINC Code	Logical Observation Identifiers, Names and Codes (LOINC)	Text	varchar	7	0%	Optional
247	MC092	Covered Days	Covered Inpatient Days	Numeric	int	4	60% (if MC020 <> 9	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
							or null)	
248	MC093	Non Covered Days	Non-covered Inpatient Days	Numeric	int	4	60% (if MC020 <> 9 or null)	Required
249	MC112	Referring Provider ID	Referring Provider ID	Text	varchar	30	0%	Optional
250	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 (tbd) 09 = Payment Amount Per Episode (tbd)	Text	char	2	0%	Optional
251	MC114	Excluded Expenses	Amount not covered at the claim line due to benefit/plan limitation. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	varchar	10	75%	Required
252	MC115	Medicare Indicator	Medicare Payment Applied indicator 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
253	MC117	Authorization Needed	Authorization Needed for service indicator 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	100%	Required
254	MC118	Referral Indicator	Referral Needed indicator 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	100%	Required
255	MC119	PCP Indicator	PCP Rendered Service indicator 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	100%	Required
256	MC120	DRG Level	Diagnostic Related Group Code Severity Level 1 = Minor 2 = Moderate 3 = Major 4 = Extreme	Numeric	int	1	100% (if MC071 is not null)	Required
257	MC122	Global Payment Flag	Global Payment Indicator 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
258	MC123	Denied Flag	Denied Claim Line indicator 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	100%	Required (Must equal 1 when MC038=04)
259	MC124	Denial Reason	Denial Reason Code	Text	char	15	98% (if MC123 = 1)	Required Carrier to provide codes and definitions
260	MC126	Accident Indicator	Accident Related indicator 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	100%	Required
261	MC128	Employment Related Indicator	Employment Related indicator 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	100%	Required
262	MC129	EPSDT Indicator	Service related to Early Periodic Screening, Diagnosis and Treatment (EPSDT) 1 = EPSDT Screen 2 = EPSDT Treatment 3 = EPSDT Referral 4 = Unknown/Not Applicable/Not Available	Numeric	int	1	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
263	MC130	Procedure Code Type	Claim line Procedure Code Type Identifier 1 = CPT or HCPCS Level 1 Code 2 = HCPCS Level II Code 3 = HCPCS Level III Code (State Medicare code) 4 = CPT Code 5 = American Dental Association (ADA) Procedure Code (Also referred to as CDT code) 6 = State defined Procedure Code 7 = CPT Category II	Numeric	int	1	100%	Required
264	MC131	In-Network Indicator	Network Rate Applied indicator 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	100%	Required
265	MC134	Plan Rendering Provider Identifier	Unique NPI code which identifies for the carrier/submitter who cared for the patient for the claim line in question.	Text	varchar	30	100%	Required
266	MC137	Carrier-Specific Unique Member ID	Member's Unique ID per carrier	Text	varchar	50	100%	Required
267	MC139	Former Claim Number	Claim Control Number (MC004) that was originally sent in a prior filing that this line corresponds to. When reported, this data cannot equal its own MC004.	Text	varchar	35	10%	Required
268	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

Pharmacy Claims Data

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
1	PC000	Record Type	Record type identifier: DH = Data record column names (third row of data file) DD = Data detail (fourth row and beyond of file until trailer records)	Text	char	2	100%	Required
2	PC001	Payer	Code representing payer submitting claims. AM = Ambetter BC = Arkansas Blue Cross and Blue Shield EBD = Employee Benefits Division DD = Delta Dental MCD = Medicaid MCR = Medicare QC = QualChoice of Arkansas	Text	varchar	3	99%	Required
3	PC002	National Plan ID	Do not report any value here until National Plan ID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans	Numeric	int	10	0.00%	Required
4	PC003	Insurance Type/Product Code	Insurance type or product identification code that indicates the type of insurance coverage the individual has. Code all but PC and XX as 2 Characters; PC and XX must include a valid sub-code See Appendix A - Insurance Type/Product Code	Text	varchar	6	99%	Required
5	PC004	Payer Claim Control Number	Claim number used by the data submitter 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 data submitter's system	Text	varchar	35	100/%	Required
6	PC005	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 data submitter's processing system assigns an internal line counter for the	Text	varchar	4	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			adjudication process, that number may be submitted in place of the line number submitted by the provider					
7	PC005A	Version Number	Version number of the claim service line. It begins with 0 and is incremented by 1 for each subsequent version of that service line. This field is used in algorithms to determine the final payment for the service	Text	varchar	4	100%	Required
8	PC005B	Version Number Date	Version number of the claim service line. Value is YYMM to identify the version of the service line and incremented by month for each subsequent version of that service line. Use when the service line version cannot be incremented by 1	Text	varchar	4	90%	Required
9	PC006	Insured Group or Policy Number	Group or policy number associated with the entity that has purchased the insurance. For self-insured individuals this relates to the purchaser. For the majority of eligibility and claims data the group relates to the employer	Text	varchar	30	99.90%	Required
10	PC008	Plan Specific Contract Number	Data submitter assigned contract number for the subscriber. Set as null if unavailable. Set as null if contract number = subscriber's social security number	Text	varchar	20	50%	Required
11	PC025	Claim Status	Status of the claim as reported by the payer 01 = Processed as primary 02 = Processed as secondary 03 = Processed as tertiary 04 = Denied 19 = Processed as primary, forwarded to additional payer(s) 20 = Processed as secondary, forwarded to additional payer(s) 21 = Processed as tertiary, forwarded to additional payer(s) 22 = Reversal of previous payment 25 = Predetermination pricing only – no payment	Text	char	2	98%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
12	PC110	Claim Line Type	Claim Line Activity Type Code that defines final version status of claim line. O – Original F – Final R – Replacement B – Backed out (future use) A – Amendment (future use) V – Void (future use)	Text	char	1	98%	Derived
13	PC111	Former Claim Number	Previous Claim Number. Report the Claim Control Number (PC004) that was originally sent in a prior filing that this line corresponds to. When reported, this data cannot equal its own PC004. Use of Previous Claim Number" to version claims can only be used if approved by the APCD	Text	varchar	35	0%	Required
14	PC120	APCD ID Code	Value that describes the member's/subscriber's enrollment into one of the predefined categories; aligns enrollment to appropriate editing and thresholds 1 = FIG - Fully-Insured Commercial Group Enrollee 2 = SIG - Self-Insured Group Enrollee 3 = Not assigned 4 = Managed Care Organization Enrollee 5 = Supplemental Policy Enrollee 6 = ICO - Integrated Care Organization 0 = Unknown/Not Applicable	Numeric	int	1	100%	Required
15	PC108	Carrier Specific Unique Subscriber ID	Subscriber's Unique ID per carrier	Text	varchar	50	100%	Required
16	PC007	Subscriber Social Security Number	Social Security Number for the subscriber. If the social security number was not available from the payer this field will be null and the Patient Specific Contract field will be populated	Text	varchar	9	75%	Required
17	PC102	Subscriber First Name	Subscriber first name	Text	varchar	25	98%	Required
18	PC103	Subscriber Middle	Subscriber middle name	Text	varchar	25	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
		Name						
19	PC101	Subscriber Last Name.	Subscriber last name	Text	varchar	60	98%	Required
20	PC950	Subscriber Address	Subscriber street address line 1	Text	varchar	100	100%	Required
21	PC951	Subscriber Address 2	Subscriber street address line 1	Text	varchar	100	10%	Required
22	PC952	Subscriber City	City of subscriber's address	Text	varchar	30	100%	Required
23	PC953	Subscriber State	State or province of subscriber's residence See Appendix O - External Sources	Text	varchar	2	100%	Required
24	PC954	Subscriber Zip code	Five digit USPS ZIP Code of the subscriber's residence See Appendix O - External Sources	Text	varchar	5	100%	Required
25	PC955	Subscriber Date of Birth	Subscriber's date of birth	Date	YYYY-MM-DD	10	50%	Required
26	PC956	Subscriber Gender	Gender of the subscriber M = Male F = Female O = Other U = Unknown	Text	char	1	50%	Required
27	PC011	Individual Relationship Code	Member's relationship to the subscriber or the insured See Appendix B - Relationship Code	Text	char	2	99%	Required
28	PC107	Carrier Specific Unique Member ID	Member's Unique ID per carrier	Text	varchar	50	100%	Required
29	PC009	Member Suffix or Sequence Number	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. Only one record per eligibility month	Text	varchar	20	98%	Required
30	PC010	Member Social Security Number	Member's social security number when available. If the member is the subscriber, this field should contain the same value as the social security number	Text	char	9	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
31	PC105	Member First Name	Member first name	Text	varchar	25	98%	Required
32	PC106	Member Middle Name	Member middle name	Text	varchar	25	0%	Optional
33	PC104	Member Last Name	Member last name	Text	varchar	60	98%	Required
34	PC061	Member Street Address	Member/Patient street address line 1	Text	varchar	100	90%	Required
35	PC109	Member Street Address 2	Member/Patient street address line 2	Text	varchar	100	50%	Required
36	PC014	Member City	City of member's residence	Text	varchar	30	99%	Required
37	PC015	Member State or Province	State or province of member's residence See Appendix O - External Code Sources	Text	varchar	2	99%	Required
38	PC016	Member ZIP Code	Five digit USPS ZIP Code of member's residence See Appendix O - External Code Sources	Text	varchar	5	99%	Required
39	PC013	Member Date of Birth	Member's date of birth	Date	YYYY-MM-DD	10	99%	Required
40	PC012	Member Gender	Gender of the member M = Male F = Female U = Unknown	Text	char	1	99%	Required
41	PC069	Member Self Pay Amount	Amount member/patient paid out of pocket 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 acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	98%	Required
42	PC017	Date Service Approved	Date that the payer approved this claim line for payment, Also considered paid date	Date	YYYY-MM-DD	10	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
43	PC021	National Provider ID Number - Service Provider	National Provider Identification (NPI) number for the entity or individual directly providing the service. This field will be used to create a master provider index for Arkansas medical service and prescribing providers See Appendix O - External Code Sources	Text	varchar	10	98%	Required
44	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 O - External Code Sources	Text	varchar	30	99%	Required
45	PC019	Pharmacy Tax ID Number	Pharmacy Tax Identification Number - the Federal Tax ID of the Pharmacy. Do not use hyphen or alpha prefix	Text	varchar	9	20%	Required
46	PC020	Pharmacy Name	Name of Pharmacy	Text	varchar	100	90%	Required
47	PC022	Pharmacy Location City	City of Pharmacy location	Text	varchar	30	98%	Required
48	PC023	Pharmacy Location State	State or province of Pharmacy location See Appendix O - External Code Sources	Text	char	2	98%	Required
49	PC024	Pharmacy ZIP Code	Five digit USPS ZIP Code of Pharmacy location See Appendix O - External Code Sources	Text	varchar	9	98%	Required
50	PC024A	Pharmacy Country Code	ISO Country Code of the Pharmacy location See Appendix O - External Code Sources	Text	char	3	90%	Required
51	PC057	Mail Order Pharmacy Indicator	Mail Order Option indicator 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
52	PC056	Product ID Number	Product Identification. Submitter-assigned identifier as it appears in PV001 in the Product File. This element is used to understand Product and Eligibility attributes of the member/subscriber as applied to this record	Text	varchar	30	100%	Required
53	PC058	Script number	Unique Prescription Number	Text	varchar	20	100%	Required
54	PC064	Date Prescription Written	Date prescription was prescribed as indicated by date on prescription or date called-in by physician's office	Date	YYYY-MM-DD	10	98%	Required
56	PC032	Date Prescription Filled	Date the pharmacy filled and dispensed prescription to the patient	Date	YYYY-MM-DD	10	99%	Required
57	PC026	Drug Code	National Drug Code (NDC)	Text	char	11	98%	Required
58	PC966	Drug Class	Drug availability to the consumer according to Federal specifications indicator 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	90%	Required
59	PC027	Drug Name	Name of the drug as supplied	Text	varchar	80	95%	Required
60	PC028	Fill Number	Prescription Status Indicator. For example, 00 = new prescription, 01 = first refill, etc.	Text	char	2	99%	Required
61	PC029	Generic Drug Indicator	Generic Drug indicator 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
62	PC030	Dispense as Written Code	Drug dispense code 1 = Physician dispense as written 2 = Member dispense as written 3 = Pharmacy dispense as written 4 = No generic available 5 = Brand dispensed as generic 6 = Override 7 = Substitution not allowed, brand drug mandated by law 8 = Substitution allowed, generic drug not available in marketplace 9 = Other 0 = Not dispensed as written	Numeric	int	1	98%	Required
63	PC031	Compound Drug Indicator	Compound Drug indicator 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	100%	Required
64	PC033	Quantity Dispensed	Number of metric units dispensed	Text	±varchar	10	99%	Required
65	PC073	Formulary Code	Formulary inclusion identifier 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	100%	Required
66	PC965	USC Code	USC Code (Universal System of Classification)	Text	varchar	5	98%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
67	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 00 = Not Specified	Text	char	2	80%	Required
68	PC075	Drug Unit of Measure	Units of Measure for drug dispensed EA = Each F2 = International Units GM = Grams ML = Milliliters	Text	char	2	80%	Required
69	PC034	Day's Supply	Number of days the prescription will last if taken as prescribed	Text	±varchar	4	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
70	PC963	Dispensing Status	Partial fill or the completion of a partial fill indicator P = Partial fill C = Completion of fill	Numeric	int	1	100%	Required
71	PC964	DrugStrength	Drug Strength (e.g. 500MG, 0.5% etc.)	Text	varchar	10	90%	Required
72	PC035	Charge Amount	Total charges for the service as reported by the provider. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	99%	Required
73	PC036	Paid Amount	Amount paid by the carrier for the claim line as reported by the provider. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	99%	Required
74	PC063	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
75	PC037	Ingredient Cost/List Price	Amount defined as the List Price or Ingredient Cost. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
76	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 acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	99%	Required
77	PC040	Copay Amount	Amount of Copay member/patient is responsible to pay. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	99%	Required
78	PC041	Coinsurance Amount	Amount of coinsurance member/patient is responsible to pay. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	99%	Required
79	PC042	Deductible Amount	Amount of deductible member/patient is responsible to pay on the claim line. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	99%	Required-
80	PC065	Coordination of Benefits/TPL Liability Amount	Amount due from a Secondary Carrier when known. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	98%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
81	PC066	Other Insurance Paid Amount	Amount that a prior payer has paid for 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 acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	98%	Required
82	PC067	Medicare Paid Amount	Amount Medicare paid on claim. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	98%	Required
83	PC068	Allowed amount	Maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. This may be called "eligible expense," "payment allowance" or "negotiated rate." If the patient's provider charges more than the allowed amount, the patient may have to pay the difference. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	98%	Required
84	PC118	Payment Arrangement Type	Payment methodology for this claim line 01 = Capitation 02 = Fee for Service 03 = Percent of Charges 04 = DRG 05 = Pay for Performance 06 = Global Payment 07 = Other 08 = Bundled Payment	Text	char	2	98%	Required
85	PC043	Prescribing ProviderID	Prescribing Provider Number from carrier	Text	varchar	30	98%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
86	PC048	National Provider ID - Prescribing	National Provider Identification (NPI) number for the entity or individual directly prescribing drug. This field will be used to create a master provider index for Arkansas medical service and prescribing providers See Appendix O - External Sources	Text	varchar	10	98%	Required
87	PC044	Prescribing Physician First Name	Prescribing Physician first name	Text	varchar	25	98%	Required
88	PC045	Prescribing Physician Middle Name	Prescribing Physician middle name	Text	varchar	25	50%	Required
89	PC046	Prescribing Physician Last Name	Prescribing Physician last name	Text	varchar	60	98%	Required
90	PC047	Prescribing Physician DEA Number	Prescribing Drug Enforcement Administration (DEA) number for provider	Text	char	10	80%	Required
91	PC049	Prescribing Physician Plan Number	Carrier-assigned Provider Plan ID. Leave null if not contracted with carrier	Text	varchar	30	98%	Required
92	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	10%	Required
93	PC051	Prescribing Physician Street Address	Prescribing Physician street address line 1	Text	varchar	100	50%	Required
94	PC052	Prescribing Physician Street Address 2	Prescribing Physician street address line 2	Text	varchar	100	5%	Required
95	PC053	Prescribing Physician City	City of the Prescribing Physician's address	Text	varchar	30	50%	Required
96	PC054	Prescribing Physician State	State or province of the Prescribing Physician's address	Text	char	2	50%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			See Appendix O - External Code Sources					
97	PC055	Prescribing Physician Zip	Five digit USPS ZIP Code of Prescribing Physician address See Appendix O - External Code Sources	Text	varchar	9	50%	Required
98	PC059	Recipient PCP ID	Member's PCP provider ID Number	Text	varchar	30	0%	Optional
99	PC062	Billing Provider Tax ID Number	The Billing Provider's Federal Tax Identification Number (FTIN)	Text	char	9	90%	Required
100	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	Numeric	char	1	98%	Required
101	PC070	Rebate Indicator	Drug Rebate Eligibility indicator for Medicaid, Medicare Managed Care plans 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	0%	Optional
102	PC112	Medicare Indicator	Medicare Payment Applied in part or in full indicator 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	100%	Required
103	PC116	Denied Flag	Denied Claim Line indicator 1 = Yes 2 = No 3 = Unknown 4 = Other	Numeric	int	1	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			5 = Not Applicable					
104	PC117	Denial Reason	Denial Reason Code.	Text	varchar	30	100% (when PC116 = 1)	Required Carrier to provide
105	PC900_2	Spend Down Amount	The amount of personal assets that must be exhausted before individual becomes eligible for Medicaid benefits. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	98%	Required

Dental Claims Data

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
1	DC000	Record Type	Record type identifier: DH = Data record column names (third row of data file) DD = Data detail (fourth row and beyond of file until trailer records)	Text	char	2	100%	Required
2	DC001	Payer	Code representing payer submitting claims AM = Ambetter BC = Arkansas Blue Cross and Blue Shield EBD = Employee Benefits Division DD = Delta Dental MCD = Medicaid MCR = Medicare QC = QualChoice of Arkansas	Text	char	3	100%	Required
3	DC002	National Plan ID	Do not report any value here until National Plan ID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans	Numeric	int	10	0%	Required
4	DC003	Insurance Type/Product Code	Insurance type or product identification code that indicates the type of insurance coverage the individual has. Code all but MC and XX as 2 characters; MC and XX must include a valid sub-code See Appendix A - Insurance Type/Product Code	Text	varchar	6	98%	Required
5	DC004	Payer Claim Control Number	Claim number used by the data submitter 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 data submitter's system	Text	varchar	35	100%	Required
6	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 data submitter's processing	Text	varchar	4	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			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					
7	DC005A	Version Number	Version number of the claim service line. It begins with 0 and is incremented by 1 for each subsequent version of that service line. This field is used in algorithms to determine the final payment for the service	Text	varchar	4	100/%	Required
8	DC005B	Version Number Date	Version number of the claim service line. Value is YYMM to identify the version of the service line and incremented by month for each subsequent version of that service line. Use when the service line version cannot be incremented by 1	Text	varchar	4	90%	Required
9	DC006	Insured Group or Policy Number	Group or policy number associated with the entity that has purchased the insurance. For self-insured individuals this relates to the purchaser. For the majority of eligibility and claims data the group relates to the employer	Text	varchar	30	98%	Required
10	DC008	Plan Specific Contract Number	Data submitter assigned contract number for the subscriber. Set as null if unavailable. Set as null if contract number = subscriber's social security number	Text	varchar	9	100%	Required
11	DC031	Claim Status	This field contains the status of the claim as reported by the payer 01 = Processed as primary 02 = Processed as secondary 03 = Processed as tertiary 04 = Denied 19 = Processed as primary, forwarded to additional payer(s) 20 = Processed as secondary, forwarded to additional payer(s) 21 = Processed as tertiary, forwarded to additional payer(s) 22 = Reversal of previous payment 25 = Predetermination pricing only – no payment	Text	char	2	98%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
12	DC059	Claim Line Type	Claim Line Activity Type Code that defines final version status of claim line. O – Original F – Final R – Replacement B – Backed out (future use) A – Amendment (future use) V – Void (future use)	Text	char	1	100%	Derived
13	DC060	Former Claim Number	Previous Claim Number. Report the Claim Control Number (PC004) that was originally sent in a prior filing that this line corresponds to. When reported, this data cannot equal its own PC004. Use of previous Claim Number" to version claims can only be used if approved by the APCD	Text	varchar	35	0%	Required
14	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	Text	varchar	2	98%	Required
15	DC057	Carrier Specific Unique Subscriber ID	Subscriber's Unique ID	Text	varchar	50	100%	Required
16	DC007	Subscriber Social Security Number	Social Security Number for the subscriber. If the social security number was not available from the payer this field will be null and the Patient Specific Contract field will be populated	Text	varchar	9	70%	Required
17	DC051	Subscriber First Name	Subscriber first name	Text	varchar	25	98%	Required
18	DC052	Subscriber Middle Name	Subscriber middle name	Text	varchar	25	10%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
19	DC050	Subscriber Last Name	Subscriber last name	Text	varchar	60	98%	Required
20	DC011	Individual Relationship Code	Member's relationship to the subscriber or the insured See Appendix B - Relationship Code	Text	varchar	2	100%	Required
21	DC009	Member Suffix or Sequence Number	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. Only one record per eligibility month	Text	varchar	20	2%	Required
22	DC056	Carrier Specific Unique Member ID	Member's unique ID	Text	varchar	50	100%	Required
23	DC010	Member Social Security Number	Member's social security number when available. If the member is the subscriber, this field should contain the same value as the Social Security Number	Text	varchar	9	100%	Required
24	DC054	Member First Name	Member first name	Text	varchar	25	98%	Required
25	DC055	Member Middle Name	Member middle name	Text	varchar	25	10%	Required
26	DC053	Member Last Name	Member Last Name	Text	varchar	60	98%	Required
27	DC043	Member Street Address	Member street address line 1	Text	varchar	100	98%	Required
28	DC058	Member Street Address 2	Member street address line 2	Text	varchar	100	10%	Required
29	DC015	Member State or Province	State or province of member’s residence See Appendix O - External Sources	Text	char	2	98%	Required
30	DC014	Member City	City of member’s residence	Text	varchar	30	100%	Required
31	DC013	Member Date of Birth	Member's date of birth	Date	YYYY-MM-DD	10	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
32	DC012	Member Gender	Gender of the member M = Male F = Female U = Unknown	Text	char	1	100%	Required
33	DC016	Member ZIP Code	Five digit USPS ZIP code of member's residence See Appendix O - External Sources	Text	varchar	5	98%	Required
34	DC035	Date of Service From	Date of Service for this service line	Date	YYYY-MM-DD	10	YYYY-MM-DD	Required
35	DC036	Date of Service Thru	Last date of service for this service line. It can equal Date of Service From when a single date of service is reported	Date	YYYY-MM-DD	10	YYYY-MM-DD	Required
36	DC046	Allowed Amount	The maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. Code decimal point. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	100%	Required
37	DC037	Charge Amount	Total charges for the service line as reported by the provider. Code decimal point. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	98%	Required
38	DC040	Coinsurance Amount	Patient's share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. The patient pays coinsurance plus any deductibles owed. For example, if the health insurance or plan’s allowed amount for an office visit is $100 and the patient has met the deductible, the coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. This is a money field containing	Integer	±varchar	10	98%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing					
39	DC039	Copay Amount	Pre-set, fixed dollar amount payable by a member, often on a per visit/service basis. Code decimal point. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	98%	Required
40	DC041	Deductible Amount	This is an amount that is required to be paid by a member before health plan benefits will begin to reimburse for services. It is usually an annual amount of all health care costs that is not covered by the member's insurance plan. Code decimal point. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	98%	Required
41	DC038	Paid Amount	Total paid for the service line as reported by the provider. This is a money field containing dollars and cents. Code decimal point. This field may contain a negative value. $0.00 is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999. Leave blank if missing	Integer	±varchar	10	98%	Required
42	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	Date	YYYY-MM-DD	10	99%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			and all types of payment					
43	DC065	Payment Arrangement Type	Payment methodology for this claim line 01 = Capitation 02 = Fee for Service 03 = Percent of Charges 04 = DRG 05 = Pay for Performance 06 = Global Payment 07 = Other 08 = Bundled Payment	Text	char	2	98%	Required
44	DC064	Denial Reason	Denial Reason Code	Text	varchar	30	100% (when DC063 = 1)	Required Carrier to provide
45	DC063	Denied Flag	Denied Claim Line indicator 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	100%	Required
46	DC067	APCD ID Code	Member Enrollment Type Report the value that describes the member's/subscriber's enrollment into one of the predefined categories; aligns enrollment to appropriate editing and thresholds 1 = FIG (Fully-Insured Commercial Group enrollee) 2 = SIG (Self-Insured Group enrollee) 3 = unassigned 4 = MCO (Managed Care Organization enrollee) 5 = Supplemental Policy enrollee 6 = ICO – Integrated Care Organization 0 = Unknown or Not Applicable	Numeric	int	1	100%	Required
47	DC032	HCPCS/CDT Code	Common Dental Terminology Code See Appendix O - External Sources	Text	varchar	5	98%	Required
48	DC033	Procedure Modifier - 1	Common Dental Terminology Code Modifier - Report a valid Procedure modifier when a modifier clarifies/improves the reporting accuracy	Text	varchar	2	98%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			of the associated procedure code. See Appendix O - External Sources					
49	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 O - External Sources	Text	varchar	2	50%	Required
50	DC047	Tooth Number/Letter	Tooth Number or Letter Identification See Appendix O - External Sources	Text	varchar	20	90%	Required
51	DC048	Dental Quadrant	Dental Quadrant See Appendix O - External Sources	Text	char	2	90%	Required
52	DC049	Tooth Surface	Tooth Surface Identification See Appendix O - External Sources	Text	varchar	10	90%	Required
53	DC042	Product ID Number	Submitter-assigned product identifier. This element is used to understand Product and Eligibility attributes of the member/subscriber as applied to this record	Text	varchar	30	100%	Required
54	DC044	Billing Provider Tax ID Number	Billing Provider's Federal Tax Identification Number (FTIN). Do not use hyphen or alpha prefix	Text	varchar	9	50%	Required
55	DC018	Service Provider Number	Data submitter assigned or legacy rendering/attending provider number. This field will be used to create a master provider index for Arkansas providers encompassing both medical service providers and prescribing providers. Submit facility for institutional claims; physician or healthcare professional for professional claims	Text	varchar	30	98%	Required
56	DC019	Service Provider Tax ID Number	Federal tax payer's identification number for rendering/attending provider. This field will be	Text	varchar	10	50%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			used to create a master provider index for Arkansas providers encompassing both medical service providers and prescribing providers					
57	DC020	National Service Provider ID	National Provider Identification (NPI) number for the entity or individual directly providing the service. This field will be used to create a master provider index for medical service and prescribing providers See Appendix O - External Sources	Text	varchar	20	98%	Required
58	DC021	Service Provider Entity Type Qualifier	HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as "Person" 1 = Person 2 = Non-Person entity	Text	char	1	100%	Required
59	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
60	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
61	DC024	Service Provider Last Name or Organization Name	Service provider last name or the full name if the provider is a facility or an organization	Text	varchar	100	98%	Required
62	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
63	DC027	Service Provider City	City of Service Provider address	Text	varchar	30	98%	Required
64	DC028	Service Provider State or Province	State or province of the Service Provider's address See Appendix O - External Sources	Text	varchar	2	98%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
65	DC029	Service Provider ZIP Code	Five digit USPS zip code of Service Provider's address See Appendix O - External Sources	Text	varchar	5	98%	Required
66	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 O - External Sources	Text	varchar	10	90%	Required

Provider Data

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
1	PV000	Record Type	Record type identifier: DH = Data record column names (third row of data file) DD = Data detail (fourth row and beyond of file until trailer records)	Text	char	2	100%	Required
2	PV023	National Service Provider ID	Record the 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	Text	varchar	20	98%	Required
3	PV028	Submitter	Code representing payer submitting provider information AM = Ambetter BC = Arkansas Blue Cross and Blue Shield EBD = Employee Benefits Division DD = Delta Dental MCD = Medicaid MCR = Medicare QC = QualChoice of Arkansas	Text	char	3	100%	Required
4	PV001	Provider ID	Unique identified identifier for the provider as assigned by the reporting entity/carrier	Text	varchar	30	100%	Required
5	PV002	Provider Tax ID	Federal Tax ID for provider. Do not use hyphen or alpha prefix. If Tax ID not available, leave null Required when PV003 = 2, 3, 4, 5, 6, 7, 0	Text	varchar	10	98%	Required
6	PV003	Provider ID Code	Provider Identification Code Report the value that defines type of entity associated with PV002. The value reported here drives intake edits for quality purposes 0 = Other; any type of entity not otherwise defined that performs health care services 1 = Person; physician, clinician, orthodontist, and any individual that is licensed/certified to perform health care services 2 = Facility; hospital, health center, long term care, rehabilitation and any building that is licensed to transact health care services 3 = Professional Group; collection of licensed/certified health care professionals that are practicing health care	Text	char	1	98%	Required

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

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			address for NPI in PV023 See Appendix O - External Code Sources					
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 practice mailing address	Text	varchar	35	25%	Required
19	PV016	Mailing State Code	State or province of provider practice mailing address See Appendix O - External Code Sources	Text	varchar	2	100%	Required
20	PV017	Mailing Country Code	ISO Country code of the Provider/Entity mailing address See Appendix O - External Code Sources	Text	varchar	3	100%	Required
21	PV018	Mailing Zip Code	Zip code of the Provider mailing address. Use USPS Five digit zip code See Appendix O - External Code Sources	Text	varchar	5	100%	Required
22	PV022	Provider DEA Number	A DEA number is a number assigned to a health care provider (such as a medical practitioner, dentist, or veterinarian) by the U.S. Drug Enforcement Administration allowing them to write prescriptions for controlled substances	Text	varchar	12	98%	Required
23	PV025	Provider Title	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	10%	Required
24	PV027	Unique Physician Identifier	This field contains the UPIN code used by CMS. Report the UPIN for the Provider identified in PV001. Required when PV003 = 1	Text	varchar	20	98%	Required
25	PV036	Provider SSN	Provider's Social Security Number	Text	varchar	9	98%	Required
26	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
27	PV033	Provider Date of Birth	Provider's date of birth	Date	YYYY-MM-DD	8	100%	Required
28	PV034	Provider Country Code	Country Code of the Provider	Text		3	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
			See Appendix O - External Code Sources					
30	PV031	Provider Type	Provider type code Report the value that defines the entity provider type. EXAMPLE: 12 = Acute Hospital. Required when PV003 does not = 1 See Appendix N - Provider Entity Codes	Text	char	2	100%	Required
31	PV049	Provider Affiliation	Provider Affiliation Code Report the Provider ID for any affiliation the provider has with another entity or parent company. If the provider is associated only with self, record the same value here as PV002	Text	varchar	30	99%	Required
32	PV053	Provider Affiliation Start Date	Provider Start Date Report the start date of provider's relationship with parent entity/group in PV049 (Provider Affiliation) in YYYY-MM-DD Format. Providers that are self-affiliated have no affiliation should have the same value reported here as in PV038	Date	YYYY-MM-DD	8	99%	Required
33	PV054	Provider Affiliation End Date	Provider End Date Report the end date of provider's relationship with parent entity/group in PV049 (Provider Affiliation) in YYYY-MM-DD Format. Do not report any value here if the affiliation is still active, or if there is no known affiliation in PV049. Self-affiliations should report the same value here as in PV039	Date	YYYY-MM-DD	8	99%	Required
34	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. Required when PV003 = 0, 1, 2, 3, 4, or 5	Text	varchar	30	75%	Required
35	PV038	Begin Date	Provider Start Date Report the date the provider or facility becomes eligible/contracted to perform any services for plan members in YYYY-MM-DD Format. Do not report any value here for providers that do not render services	Date	YYYY-MM-DD	8	98%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
36	PV039	End Date	Provider End Date Report the Date the provider or facility is no longer eligible to perform services for plan members/insureds in YYYY-MM-DD Format. Do not report any value here for providers that are still actively eligible to provide services, or Providers who do not render services (i.e., Parent Organizations). Required when PV003 = 0, 1, 2, 3, 4, or 5	Date	YYYY-MM-DD	8	98%	Required
37	PV052	Prescribing Provider	Prescribing Authority for pharmaceuticals or durable medical equipment indicator 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	100%	Required
38	PV044	Accepting New Patients	New Patients Accepted indicator Report the value that defines the element, e.g., 1 = Yes, provider or provider group is accepting new patients as of the day the file was created for this submission. Required when PV003 = 1, 2, or 3 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	100%	Required
39	PV045	Offers e-Visits	eVisit Option indicator. Required when PV003 = 1, 2, 3, or 4 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	0%	Optional

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
40	PV046	Multiple Offices	Multiple Office Provider indicator Report the value that defines the element. EXAMPLE: 1 = Yes, provider has multiple offices. Required when PV003 = 1, 2, or 3 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	100%	Required
41	PV047	Medical/Healthcare Home ID	Medical Home Identification Number Report the identifier of the patient-centered medical home the provider is linked-to here. The value in this element must have a corresponding Provider ID (PV002) in this or a previously submitted provider file. Require when PV003 = 1, 2, or 3	Text	varchar	15	50%	Required
42	PV048	PCP Flag	Provider is a PCP indicator Required when PV003 = 1 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	100%	Required
43	PV051	Office Type	Office Type Code. Required when PV003 = 0, 1, 2, 3, 4, or 5 indicator 0 = Other 1 = Facility 2 = Doctors office 3 = Clinic 4 = Walk in Clinic 5 = Laboratory	Numeric	int	1	100%	Required

ID	Data Element ID	Data Element	Description	Type	Format	Length	Threshold	Required
44	PV055	PPO Indicator	Provider PPO Contract indicator. Required when PV003 = 0, 1, 2, 3, 4, or 5 1 = Yes 2 = No 3 = Unknown 4 = Other 5 = Not Applicable	Numeric	int	1	100%	Required
45	PV057	Organization Name	Full name of provider organization. Set to null if provider is individual only.	Text	Varchar	100	100%	Required
46	PV019	Provider Specialty	Primary specialty associated with provider	Text	varchar	50	100%	Required
47	PV020	Provider second specialty	Second specialty associated with provider	Text	varchar	10	2%	Required
48	PV021	Provider third specialty	Third specialty identified for provider. Required if available	Text	varchar	50	2%	Required
49	PV024	Provider State License Number	State specific license number. Prefix with two-character state of licensure	Text	varchar	20	100%	Required
50	PV026	Taxonomy Code	This field is used to standardize the specialty coding of provider records	Text	varchar	10	100%	Required

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
  - "Encrypt" with the recipient's RSA key
  - "Sign" with the sender's RSA key
  - Resulting "encrypted+signed" file extension should be ".gpg"
- "Detach-sign" the "encrypted+signed" file using the sender's DSA key
  - Resulting "Detached-signature" file extension should be ".sig"
- Zip the "encrypted+signed" and "detached-signature" files into one archive
  - Name the zip archive as follows:
    1. Carrier_FileType_FilePeriod_RSA-keyID_DSA-keyID.zip
    2. e.g., "MCR_CLAIMS_2014A_RSA-A4E5919D_DSA-C55BD3C3.zip"
  - Resulting zipped archive file extension should be ".zip"

Encryption Software Recommendations

ACHI requires all submitters to use the following software recommendations for file encryption:

- Windows Operating Systems
  - Gpg4Win
    - Kleopatra (key generation, import, export, management)
    - GPA (key generation, management)
    - GPG command-line encryption operations
  - GpgEx
    - Context-menu encrypt, sign, verify, decrypt

      NOTE: Installed as part of the aforementioned Gpg4Win distribution
  - 7-Zip (64-bit, 32-bit)
    - Context-menu zipping and unzipping of files
    - 7z command-line zipping/encryption operations
    - Optional AES-256 symmetric encryption via password
- Linux Operating Systems
  - GnuPG
    - Kleopatra (key generation, import, export, management)
    - GPA (key generation, management)

        - GPG command-line encryption operations
        - Ubuntu install: sudo apt-get install gnupg
    - Seahorse
        - Context-menu encrypt, sign, verify, decrypt
          NOTE: May not be installed when GnuPG is installed; if so, then see following install
        - Ubuntu install: sudo apt-get install seahorse-plugins
    - 7-Zip
        - Context-menu zipping and unzipping of files
        - 7z command-line zipping/encryption operations
        - Optional AES-256 symmetric encryption via password
        - Ubuntu install: sudo apt-get install p7zip-full

Command Line Examples

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

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

EXHIBIT C – DATA EXCEPTION REQUEST FORM

Data Submitter			
Submission Date		**Review Date**	
APCD Review Team			
Data Submitter Review Team			

#	DSG Data Element ID	DSG Data Element	Exception Reason	Future Availability	Impact to APCD /Workarounds
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

Appendix A: Insurance Type Procedure Code

Value	Description
11	Other non-Federal program
12	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
13	Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month Coordination Period with an Employer's Group Health Plan
15	Medicare Secondary Worker's Compensation
16	Medicare Secondary Public Health Service or Other Federal Agency
41	Medicare Secondary Black Lung
42	Medicare Secondary Veteran's Administration
43	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health
47	Medicare Secondary, Other Liability Insurance is Primary
AM	Auto Insurance policy
CP	Medicare Conditionally Primary D Disability
DB	Disability Benefits
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
MA	Medicare Part A
MB	Medicare Part B
MC	Medical Assistance (must include sub-code)
MD	Medicare Part D
MH	Medigap Part A
MI	Medigap Part B
MP	Medicare Primary
PR	Preferred Provider Organization (PPO)
PS	Point of Service (POS)
QM	Qualified Medicare Beneficiary
SP	Supplemental Policy
XX	Non-Medical-Assistance Public Program (must include sub-code)
FFSM	Fee-for-service Medical Assistance
PMAP	Prepaid Medical Assistance Program
MDHO	AR Disability Health Options
MSHO	AR Senior Health Options
SNBC	Special Needs Basic Care
MISC	Other managed care program within Medical Assistance
CDEP	Chemical Dependency
GAMC	General Assistance Medical Care
HIVA	HIV/AIDS
MISC	Other non-Medical Assistance public program
MCD	Medicaid

Appendix B: Relationship Code

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

Appendix C: Discharge Status

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

Appendix D: Type of Bill

Value	Description
Type of Facility – First Digit	
1	Hospital
2	Skilled Nursing
3	Home Health
4	Christian Science Hospital
5	Christian Science Extended Care
6	Intermediate Care
7	Clinic
8	Special Facility
Bill Classification – Second Digit, if First Digit = 1 – 6	
1	Inpatient (Including Medicare Part A)
2	Inpatient (Medicare Part B Only)
3	Outpatient
4	Other (for hospital referenced diagnostic services or home health not under a plan of treatment)
5	Nursing Facility Level I
6	Nursing Facility Level II
7	Intermediate Care - Level III Nursing Facility
8	Swing Beds
Bill Classification – Second Digit, if First Digit = 7	
1	Rural Health
2	Hospital Based or Independent Renal Dialysis Center
3	Free Standing Outpatient Rehabilitation Facility (ORF)
5	Comprehensive Outpatient Rehabilitation Facilities (CORFs)
6	Community Mental Health Center
9	Other

Appendix E: Facility Type

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

Appendix F: Procedure Modifier Codes

Value	Description
22	Unusual procedural services
23	Unusual anesthesia
24	Unrelated evaluation and management service by the same physician during a postoperative period
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service
26	Professional component
32	Mandated services
47	Anesthesia by surgeon
50	Bilateral procedure
51	Multiple procedures
52	Reduced services
53	Discontinued procedure
54	Surgical care only
55	Post-operative management only
56	Pre-operative management only
57	Decision for surgery
58	Staged or related procedure or service by the same physician during the post-operative period
59	Distinct procedural service
62	Two surgeons
63	Procedure performed on infants
66	Surgical team
73	Discontinued outpatient procedure prior to anesthesia administration
74	Discontinued outpatient procedure after anesthesia administration
76	Repeat procedure by same physician
77	Repeat procedure by another physician
78	Unplanned return to the operating room/procedure room by the same physician following initial procedure for a related procedure during the post-operative period
79	Unrelated procedure or service by the same physician during the post-operative period
80	Assistant surgeon
81	Minimum assistant surgeon
82	Assistant surgeon (when qualified resident surgeon not available)
90	Reference (outside) laboratory
91	Repeat clinical diagnostic laboratory test
92	Alternative laboratory platform testing
99	Multiple modifiers
A1	Dressing for one wound
A2	Dressing for two wounds
A3	Dressing for three wounds
A4	Dressing for four wounds
A5	Dressing for five wounds
A6	Dressing for six wounds
A7	Dressing for seven wounds
A8	Dressing for eight wounds
A9	Dressing for nine or more wounds
AA	Anesthesia services performed personally by anesthesiologist

Value	Description
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures
AH	Clinical psychologist
AI	Principal physician of record
AJ	Clinical social worker
AM	Physician Assistant (PA) services
AP	Determination of refractive state was not performed in the course of diagnostic ophthalmologic examination
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery
AT	Acute treatment (this modifier should be used when reporting services 98940, 98941, 98942)
AU	Item furnished in conjunction with a urological, ostomy, or tracheostomy supply
AV	Item furnished in conjunction with a prosthetic device, prosthetic or orthotic
AW	Item furnished in conjunction with a surgical dressing
AX	Item furnished in conjunction with dialysis Modifier Narrative
BA	Item furnished in conjunction with parenteral enteral nutrition (PEN) services
BO	Orally administered nutrition, not by feeding tube
BP	The beneficiary has been informed of the purchase and rental options and has elected to purchase the item
BR	The beneficiary has been informed of the purchase and rental options and has elected to rent the item
BU	The beneficiary has been informed of the purchase and rental options and after 30 days has not informed the supplier of his/her decision
CC	Procedure code change (use CC when procedure code submitted was changed either for administrative reasons or because an incorrect code was filed)
E1	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid
E4	Lower right, eyelid
EJ	Subsequent claims for a defined course of therapy (e.g., EPO, sodium hyaluronate, infliximab)
EM	Emergency reserve supply (for ESRD benefit only)
EP	Service provided as part of Medicaid early periodic screening diagnosis and treatment (EPSDT) program
ET	Emergency treatment (dental procedures performed in emergency situations should show the modifier ET)
EY	No physician or other licensed health care provider order for this item or service
F1	Left hand, second digit
F2	Left hand, third digit
F3	Left hand, fourth digit
F4	Left hand, fifth digit
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit
FA	Left hand, thumb
FP	Service provided as part of Medicaid family planning program
G1	Most recent urea reduction ration (URR) reading of less than 60
G2	Most recent urea reduction ration (URR) reading of 60 to 64.9
G3	Most recent urea reduction ration (URR) reading of 65 to 69.9
G4	Most recent urea reduction ration (URR) reading of 70 to 74.9
G5	Most recent urea reduction ration (URR) reading of 75 or greater
G6	ESRD patient for whom less than six dialysis sessions have been provided in a month
G7	Pregnancy resulted from rape or incest or pregnancy certified by physician as life threatening

Value	Description
G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure
G9	Monitored anesthesia care for patient who has history of severe cardio-pulmonary condition
GA	Waiver of liability statement on file
GB	Claim being re-submitted for payment because it is no longer covered under a global payment demonstration
GC	This service has been performed in part by a resident under the direction of a teaching physician
GE	This service has been performed by a resident without the presence of teaching physician under the primary care exception
GG	Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day
GH	Diagnostic mammogram converted from screening mammogram on same day
GJ	Physician or practitioner emergency or urgent service
GK	Actual item/service ordered by a physician, item associated with GA or GZ modifier
GL	Medically unnecessary upgrade provided instead of standard item, no charge, no advance beneficiary notice (ABN)
GM	Multiple patients on one ambulance trip
GN	Service delivered personally by a speech-language pathologist or under an outpatient speech-language pathology plan of care
GO	Service delivered personally by an occupational therapist or under an outpatient occupational therapy plan of care
GP	Service delivered personally by a physical therapist or under an outpatient physical therapy plan of care
GQ	Via asynchronous telecommunications system
GT	Via interactive audio and video telecommunication systems
GV	Attending physician not employer-paid under arrangement by the patient's hospice provider
GW	Service not related to the hospice patient's terminal condition
GY	Item or service statutorily excluded or does not meet the definition of any Medicare benefit
GZ	Item or service expected to be denied as not reasonable and necessary
HA	Child/adolescent program
HB	Adult program, non-geriatric
HC	Adult program, geriatric
HD	Pregnant/parenting women's program
HE	Mental health program
HF	Substance abuse program
HG	Opioid addiction treatment program
HH	Integrated mental health/substance abuse program
HI	Integrated mental health and mental retardation/developmental disabilities program
HJ	Employee assistance program
HK	Specialized mental health programs for high-risk populations
HL	Intern
HM	Less than bachelor degree level
HN	Bachelors' degree level
HO	Masters' degree level
HP	Doctoral level
HQ	Group setting
HR	Family/couple with client present
HS	Family/couple without client present
HT	Multi-disciplinary team
HU	Funded by child welfare agency
HV	Funded by state addictions agency

Value	Description
HW	Funded by state mental health agency
HX	Funded by county/local agency
HY	Funded by juvenile justice agency
HZ	Funded by criminal justice agency
JW	Drug amount discarded/not administered to any patient
K0	Lower extremity prosthesis functional level 0 - does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility
K1	Lower extremity prosthesis functional level 1 - has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.
K2	Lower extremity prosthesis functional level 2 - has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs, or uneven surfaces. Typical of the limited community ambulator.
K3	Lower extremity prosthesis functional level 3 - has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to transverse most environmental barriers and or exercise activity that demands prosthetic utilization beyond simple locomotion. May have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
K4	Lower extremity prosthesis function level 4 - has the ability or potential for prosthetic ambulation that exceeds the basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.
KA	Add-on option/accessory for wheelchair
KB	Beneficiary-requested upgrade for ABN, more than four modifiers indicated on claim
KH	DMEPOS item, initial claim, purchase or first month rental
KI	DMEPOS item, second or third month rental
KJ	DMEPOS item, parenteral enteral nutrition (PEN) pump or capped rental, months four to fifteen
KM	Replacement of facial prosthesis including new impression/moulage
KN	Replacement of facial prosthesis using previous master model
KO	Single drug unit dose formulation
KP	First drug of a multiple drug unit dose formulation
KQ	Second or subsequent drug of a multiple drug unit dose formulation
KR	Rental item, billing for partial month
KS	Glucose monitor supply for diabetic beneficiary not treated with insulin
KX	Specific required documentation on file
LC	Left circumflex coronary artery
LD	Left anterior descending coronary artery
LL	Lease/rental (use LL modifier when DME equipment rental is to be applied against the purchase price)
LR	Laboratory round trip
LS	FDA-monitored intraocular lens implant
LT	Left side (used to identify procedures performed on the left side of the body)
MS	Six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty
NR	New when rented (use the NR modifier when DME that was new at the time of rental is subsequently purchased)
NU	New equipment (for DME equipment)
P1	A normal healthy patient
P2	A patient with mild systemic disease
P3	A patient with severe systemic disease
P4	A patient with severe systemic disease that is a constant threat to life
P5	A moribund patient who is not expected to survive without the operation

Value	Description
P6	A declared brain-dead patient whose organs are being removed for donor purposes shows the code for the part, followed by the RP modifier and the charge for the part.
PL	Progressive addition lenses
Q2	CMS/ORD demonstration project procedure/service
Q3	Live kidney donor; Services associated with post-operative medical complications directly related to the donation.
Q4	Service for ordering/referring physician qualifies as a service exemption
Q5	Service furnished by a substitute physician under a reciprocal billing arrangement
Q6	Service furnished by locum tenens physician
Q7	One class A finding
Q8	Two class B findings
Q9	One class B and two class C findings
QA	FDA investigational device exemption
QB	Physician providing service in a rural HPSA
QC	Single channel monitoring
QD	Recording and storage in solid state memory by a digital recorder
QE	Prescribed amount of oxygen is less than 1 liter per minute (LPM)
QF	Prescribed amount of oxygen exceeds 4 liters per minute (LPM) and portable oxygen is prescribed
QG	Prescribed amount of oxygen is greater than 4 liters per minute (LPM)
QH	Oxygen conserving device is being used with an oxygen delivery system
QJ	Services/items provided to a prisoner or patient in state or local custody however the state or local government as applicable, meets the requirements in 42 CFR 411.4 (B)
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
QL	Patient pronounced dead after ambulance called
QM	Ambulance service provided under arrangement by a provider of services
QN	Ambulance service furnished directly by provider of services
QP	Documentation is on file showing that the laboratory test(s) as ordered individually or ordered as a CPT recognized panel other than automated profile codes 80002-80019, G0058, G0059, and G0060
QQ	Claim submitted with a written statement of intent
QS	Monitored anesthesia care service
QT	Recording and storage on tape by an analog tape recorder
QU	Physician provider service in an urban HPSA
QV	Item or service provided as routine care in a Medicare-qualifying clinical trial
QW	CLIA-waived test
QX	Certified Registered Nurse Anesthetist (CRNA) service with medical direction by a physician
QY	Medical direction of one Certified Registered Nurse Anesthetist (CRNA) by an anesthesiologist
QZ	Certified Registered Nurse Anesthetist (CRNA) service without medical direction by a physician
RC	Right coronary artery
RP	Replacement and repair. RP may be used to indicate replacement of DME, orthotic,
RT	Right side (used to identify procedures performed on the right side of the body)
SA	Nurse practitioner rendering service in collaboration with a physician
SB	Nurse midwife
SC	Medically necessary service or supply
SD	Services provided by registered nurse with specialized, highly technical home infusion
SE	State and/or federally-funded programs/services
SF	Second opinion ordered by professional review organization (PRO) per section 9401, pl 99-272 (100% reimbursement ¾ no Medicare deductible or coinsurance)

Value	Description
SG	Ambulatory surgical center (ASC) facility service
SH	Second concurrently administered infusion therapy
SJ	Third or more concurrently administered infusion therapy
SK	Member of high risk population (use only with codes for immunization)
SL	State-supplied vaccine
SQ	Item ordered by home health
ST	Related to trauma or injury
SU	Procedure performed in physician's office (to denote use of facility equipment)
SV	Pharmaceuticals delivered to patient's home but not utilized
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit
TA	Left foot, great toe
TC	Technical component
TD	RN
TE	LPN/LVN
TF	Intermediate level of care
TG	Complex/high tech level of care
TH	Obstetrical treatment/services, pre-natal or post-partum
TJ	Program group, child and/or adolescent
TK	Extra patient or passenger, non-ambulance (established for state Medicaid agencies)
TL	Early intervention/individualized family services plan (IFSP) (established for state Medicaid agencies)
TM	Individualized education program (IEP) (established for state Medicaid agencies)
TN	Rural/outside providers customary service area (established for state Medicaid agencies)
TP	Medical transport, unloaded vehicle (established for state Medicaid agencies)
TQ	Basic life support transport by a volunteer ambulance provider (established for state Medicaid agencies)
TR	School-based individualized education program (IEP) services provided outside the public school district responsible for the student
TS	Follow-up service
TT	Individualized service provided to more than one patient in same setting
TU	Special payment rate, overtime
TV	Special payment rate, holidays/weekends
TW	Back-up equipment
U1	Medicaid level of care 1
U2	Medicaid level of care 2
U3	Medicaid level of care 3
U4	Medicaid level of care 4
U5	Medicaid level of care 5
U6	Medicaid level of care 6
U7	Medicaid level of care 7
U8	Medicaid level of care 8

Value	Description
U9	Medicaid level of care 9
UA	Medicaid level of care 10
UB	Medicaid level of care 11
UC	Medicaid level of care 12
UD	Medicaid level of care 13
UE	Used durable medical equipment
VP	Aphakic patient

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

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

Appendix G: Language

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

Appendix H: Race

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

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

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

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

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

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

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

Value	Description
1282-3	Iowa of Kansas-Nebraska
1283-1	Iowa of Oklahoma
1552-9	Iowa Sac and Fox
1920-8	Iqurmuit (Russian Mission)
2121-2	Iranian
2122-0	Iraqi
2113-9	Irish
1285-6	Iroquois
1494-4	Isleta
2127-9	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
1496-9	Keres
1059-5	Kern River
1826-7	Ketchikan
1131-2	Keweenaw
1198-1	Kialegee
1864-8	Kiana
1305-2	Kickapoo
1520-6	Kikiallus
2014-9	King Cove
1978-6	King Salmon

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

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

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

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

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

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

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

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

Value	Description
1645-1	Spokane
1533-9	Squaxin Island
2045-3	Sri Lankan
1144-5	St. Croix Chippewa
2021-4	St. George
1963-8	St. Mary's
1951-3	St. Michael
2022-2	St. Paul
1633-7	Standing Rock Sioux
1203-9	Star Clan of Muscogee Creeks
1955-4	Stebbins
1534-7	Steilacoom
1796-2	Stevens
1647-7	Stewart
1535-4	Stillaguamish
1649-3	Stockbridge
1797-0	Stony River
1471-2	Stonyford
2002-4	Sugpiaq
1472-0	Sulphur Bank
1434-0	Summit Lake
2004-0	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
1801-0	Tanana
1802-8	Tanana Chiefs
1511-5	Taos
1969-5	Tatitlek
1803-6	Tazlina
1804-4	Telida
1883-8	Teller
1338-3	Temecula
1596-6	Te-Moak Western Shoshone
1832-5	Tenakee Springs

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

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

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

Appendix I: Ethnicity

Ethnicity codes are based on Arkansas Medicaid ethnicity codes.

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

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

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

Appendix J: Value Codes

Value	Description
01	Most Common Semi-Private Rate - to provide for the recording of hospital's most common semi-private rate.
02	Hospital Has No Semi-Private Rooms - Entering this code requires $0.00 amount.
03	Reserved for national assignment.
04	Inpatient professional component charges which are combined billed - For use only by some all-inclusive rate hospitals. (effective 9/93)
05	Professional component included in charges and also billed separately to carrier - For use on Medicare and Medicaid bills if the state requests this information.
06	Medicare blood deductible - Total cash blood deductible (Part A blood deductible).
07	Medicare cash deductible (term 9/30/93) reserved for national assignment.
08	Medicare Part A lifetime reserve amount in first calendar year - Lifetime reserve amount charged in the year of admission. (not stored in NCH until 2/93)
09	Medicare Part A coinsurance amount in the first calendar year - Coinsurance amount charged in the year of admission. (not stored in NCH until 2/93)
10	Medicare Part A lifetime reserve amount in the second calendar year - Lifetime reserve amount charged in the year of discharge where the bill spans two calendar years. (in NCH until 2/93)
11	Medicare Part A coinsurance amount in the second calendar year - Coinsurance amount charged in the year of discharge where the bill spans two calendar years (not stored in NCH until 2/93)
12	Amount is that portion of higher priority EGHP insurance payment made on behalf of aged beneficiary provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional Medicare payment.
13	Amount is that portion of higher priority EGHP insurance payment made on behalf of ESRD beneficiary provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
14	That portion of payment from higher priority no fault auto/other liability insurance made on behalf of beneficiary provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional payment
15	That portion of a payment from a higher priority WC plan made on behalf of a beneficiary that the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
16	That portion of a payment from higher priority PHS or other federal agency made on behalf of a beneficiary the provider applied to Medicare covered services on this bill. Six zeroes indicate provider claimed conditional Medicare payment.
17	Operating Outlier amount - Providers do not report this. For payer internal use only. Indicates the amount of day or cost outlier payment to be made. (Do not include any PPS capital outlier payment in this entry).
18	Operating Disproportionate share amount - Providers do not report this. For payer internal use only. Indicates the disproportionate share amount applicable to the bill. Use the amount provided by the disproportionate share field in PRICER. (Do not include any PPS capital DSH adjustment in this entry).
19	Operating Indirect medical education amount - Providers do not report this. For payer internal use only. Indicates the indirect medical education amount applicable to the bill. (Do not include PPS capital IME adjustment in this entry).
20	Total payment sent provider for capital under PPS, including HSP, FSP, outlier, old capital, DSH adjustment, IME adjustment, and any exception amount. (used 10/1/91 - 3/1/92 for provider reporting. Payer only code effective 9/93.)
21	Catastrophic - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)
22	Surplus - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)

Value	Description
23	Recurring monthly income - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)
24	Medicaid rate code - Medicaid - Eligibility requirements to be determined at state level. (Medicaid specific/deleted 9/93)
25	Offset to the Patient Payment Amount (Prescription Drugs) - Prescription drugs paid for out of a long-term care facility resident/patient's fund in the billing period submitted (Statement Covers Period).
26	Prescription Drugs Offset to Patient (Payment Amount - Hearing and Ear Services) Hearing and ear services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement covers period).
27	Offset to the Patient (Payment Amount - Vision and Eye Services) - Vision and eye services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
28	Offset to the Patient (Payment Amount - Dental Services) - Dental services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
29	Offset to the Patient (Payment Amount - Chiropractic Services) - Chiropractic services paid for out of a long term care facility resident/patient's funds in the billing period submitted (Statement Covers Period).
31	Patient liability amount - Amount shown is that which you or the PRO approved to charge the beneficiary for non-covered accommodations, diagnostic procedures or treatments.
32	Multiple patient ambulance transport - The number of patients transported during one ambulance ride to the same destination. (effective 4/1/2003)
33	Offset to the Patient Payment Amount (Podiatric Services) -- Podiatric services paid out of a long-term care facility resident/patient's funds in the billing period submitted.
34	Offset to the Patient Payment Amount (Medical Services) -- Other medical services paid out of a long-term care facility resident/patient's funds in the billing period submitted.
35	Offset to the Patient Payment Amount (Health Insurance Premiums) -- Other medical services paid out of a long-term care facility resident/patient's funds in the billing period submitted.
37	Pints of blood furnished - Total number of pints of whole blood or units of packed red cells furnished to the patient. (effective 10/93)
38	Blood deductible pints - The number of un-replaced pints of whole blood or units of packed red cells furnished for which the patient is responsible. (effective 10/93)
39	Pints of blood replaced - The total number of pints of whole blood or units of packed red cells furnished to the patient that have been replaced by or on behalf of the patient. (effective 10/93)
40	New coverage not implemented by HMO - amount shown is for inpatient charges covered by HMO (effective 3/92). (use this code when the bill includes inpatient charges for newly covered services which are not paid by HMO.)
41	Amount is that portion of a payment from higher priority BL program made on behalf of beneficiary the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
42	Amount is that portion of a payment from higher priority VA made on behalf of beneficiary the provider applied to Medicare covered services on this bill. Six zeroes indicate the provider claimed conditional Medicare payment.
43	Disabled beneficiary under age 65 with LGHP - Amount is that portion of a payment from a higher priority LGHP made on behalf of a disabled Medicare beneficiary the provider applied to Medicare covered services on this bill.
44	Amount provider agreed to accept from primary payer when amount less than charges but more than payment received - When a lesser amount is received and the received amount is less than charges a Medicare secondary payment is due.
45	Accident Hour - The hour the accident occurred that necessitated medical treatment.
46	Number of grace days - Following the date of the PRO/UR determination, this is the number of days determined by the PRO/UR to be necessary to arrange for the patient's post-discharge care. (effective 10/93)

Value	Description
47	Any liability insurance - Amount is that portion from a higher priority liability insurance made on behalf of Medicare beneficiary the provider is applying to Medicare covered services on this bill. (Effective 9/93)
48	Hemoglobin reading - The patient's most recent hemoglobin reading taken before the start of the billing period (effective 1/3/2006). Prior to 1/3/2006 defined as the latest hemoglobin reading taken during the billing cycle.
49	Hematocrit reading - The patient's most recent hematocrit reading taken before the start of the billing period (effective 1/3/2006). Prior to 1/3/2006 defined as hematocrit reading taken during the billing cycle.
50	Physical therapy visits - Indicates the number of physical therapy visits from onset (at billing provider) through this billing period.
51	Occupational therapy visits - Indicates the number of occupational therapy visits from onset (at the billing provider) through this billing period.
52	Speech therapy visits - Indicates the number of speech therapy visits from onset (at billing provider) through this billing period.
53	Cardiac rehabilitation - Indicates the number of cardiac rehabilitation visits from onset (at billing provider) through this billing period.
54	New birth weight in grams - Actual birth weight or weight at time of admission for an extramural birth. Required on all claims with type of admission of '4' and on other claims as required by law.
55	Eligibility Threshold for Charity Care - code identifies the corresponding value amount at which a health care facility determines the eligibility threshold of charity care.
56	Hours skilled nursing provided - The number of hours skilled nursing provided during the billing period. Count only hours spent in the home.
57	Home health visit hours - The number of home health aide services provided during the billing period. Count only the hours spent in the home.
58	Arterial blood gas - Arterial blood gas value at beginning of each reporting period for oxygen therapy. This value or value 59 will be required on the initial bill for oxygen therapy and on the fourth month's bill.
59	Oxygen saturation - Oxygen saturation at the beginning of each reporting period for oxygen therapy. This value or value 58 will be required on the initial bill for oxygen therapy and on the fourth month's bill.
60	HHA branch MSA - MSA in which HHA branch is located.
61	Location of HHA service or hospice service - the balanced budget act (BBA) requires that the geographic location of where the service was provided be furnished instead of the geographic location of the provider. NOTE: HHA claims with a thru date on or before 12/31/05, the value code amount field reflects the MSA code (followed by zeroes to fill the field). HHA claims with a thru date after 12/31/05, the value code amount field reflects the CBSA code.
62	Number of Part A home health visits accrued during a period of continuous care - necessitated by the change in payment basis under HH PPS (effective 10/00)
63	Number of Part B home health visits accrued during a period of continuous care - necessitated by the change in payment basis under HH PPS (effective 10/00)
64	Amount of home health payments attributed to the Part A trust fund in a period of continuous care - necessitated by the change in payment basis under HH PPS (effective 10/00)
65	Amount of home health payments attributed to the Part B trust fund in a period of continuous care - necessitated by the change in payment basis under HH PPS (effective 10/00)
66	Medicare Spend-down Amount -- The dollar amount that was used to meet th4e recipient's spend-down liability for this claim.
67	Peritoneal dialysis - The number of hours of peritoneal dialysis provided during the billing period (only the hours spent in the home). (effective 10/97)
68	EPO drug - Number of units of EPO administered relating to the billing period.
69	Reserved for national assignment
70	Interest amount - (Providers do not report this.) Report the amount applied to this bill.

Value	Description
71	Funding of ESRD networks - (Providers do not report this.) Report the amount the Medicare payment was reduced to help fund the ESRD networks.
72	Flat rate surgery charge - Code indicates the amount of the charge for outpatient surgery where the hospital has such a charging structure.
73	Drug deductible - (For internal use by third party payers only). Report the amount of the drug deductible to be applied to the claim.
74	Drug coinsurance - (For internal use by third party payers only). Report the amount of drug coinsurance to be applied to the claim.
75	Gramm/Rudman/Hollings - (Providers do not report this.) Report the amount of the sequestration applied to this bill.
76	Report provider's percentage of billed charges interim rate during billing period. Applies to OP hospital, SNF and HHA claims where interim rate is applicable. Report to left of dollar/cents delimiter. (TP payers internal use only)
77	New Technology Add-on Payment Amount - Amount of payments made for discharges involving approved new technologies. If the total covered costs of the discharge exceed the DRG payment for the case (including adjustments for IME and disproportionate share hospitals (DSH) but excluding outlier payments) an add-on amount is made indicating a new technology was used in the treatment of the beneficiary. (effective 4/1/03, under Inpatient PPS)
78	Payer code - This code is set aside for payer use only. Providers do not report these codes.
79	Payer code - This code is set aside for payer use only. Providers do not report these codes.
80 - 99	Reserved for state assignment.
A0	Special Zip Code Reporting - five digit zip code of the location from which the beneficiary is initially placed on board the ambulance. (effective 9/01)
A1	Deductible Payer A - The amount assumed by the provider to be applied to the patient's deductible amount to the involving the indicated payer. (effective 10/93) - Prior value 07
A2	Coinsurance Payer A - The amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer. (effective 10/93)
A3	Estimated Responsibility Payer A - The amount estimated by the provider to be paid by the indicated payer.
A4	Self-administered drugs administered in an emergency situation - Ordinarily the only non-covered self-administered drug paid for under Medicare in an emergency situation is insulin administered to a patient in a diabetic coma. (effective 7/97)
A5	Covered self-administered drugs -- The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administered in the form and situation in which it was furnished to the patient.
A6	Covered self-administered drugs -Diagnostic study and Other --- the amount included in covered charges for self-administrable drugs administered to the patient because the drug was necessary for diagnostic study or other reasons. For use with Revenue Center 0637.
A7	Copayment A -- The amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer.
A8	Patient Weight -- Weight of patient in kilograms. Report this data only when the health plan has a predefined change in reimbursement that is affected by weight.
A9	Patient Height - Height of patient in centimeters. Report this data only when the health plan has a predefined change in reimbursement that is affected by height.
AA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer A) -- The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer (effective 10/2003).
AB	Other Assessments or Allowances (Payer A) -- The amount of other assessments or allowances pertaining to the indicated payer. (effective 10/2003).

Value	Description
B1	Deductible Payer B - The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (effective 10/93) - Prior value 07
B2	Coinsurance Payer B - the amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer. (effective 10/93)
B3	Estimated Responsibility Payer B - The amount estimated by the provider to be paid by the indicated payer.
B7	Copayment B -- The amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer.
BA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer B) -- The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer (effective 10/2003).
BB	Other Assessments or Allowances (Payer B) -- The amount of other assessments or allowances pertaining to the indicated payer. (effective 10/2003).
C1	Deductible Payer C - The amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer. (effective 10/93) - Prior value 07
C2	Coinsurance Payer C - The amount assumed by the provider to be applied to the patient's Part B coinsurance amount involving the indicated payer. (effective 10/93)
C3	Estimated Responsibility Payer C
C7	Copayment C -- The amount assumed by the provider to be applied toward the patient's copayment amount involving the indicated payer.
CA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes (Payer C) -- The amount of regulatory surcharges, assessments, allowances or health care related taxes pertaining to the indicated payer (effective 10/2003).
CB	Other Assessments or Allowances (Payer C) -- The amount of other assessments or allowances pertaining to the indicated payer. (effective 10/2003).
D3	Estimated Responsibility Patient - The amount estimated by the provider to be paid by the indicated patient.
D4	Clinical Trial Number Assigned by NLM/NIH - Eight digit numeric National Library of Medicine/National Institute of Health clinical trial registry number or a default number of '99999999' if the trial does not have an 8-digit registry number. (effective 10/1/07)
G8	Facility Where Inpatient Hospice Service Is Delivered - MSA or Core Based Statistical Area (CBSA) number (or rural state code) of the facility where inpatient hospice is delivered. (effective 1/1/08)
XX	Total Charge Amount for all Part A visits on RIC 'U' claims - for Home Health claims containing both Part A and Part B services this code identifies the total charge amount for the Part A visits (based on revenue center codes 042X, 043X, 044X, 055X, 056X, & 057X). Code created internally in the CWFMQA system (effective 10/31/01 with HHPPS).
XY	Total Charge Amount for all Part B visits on RIC 'U' claims - for Home Health claims containing both Part A and Part B services this code identifies the total charge amount for the Part B visits (based on revenue center codes 042X, 043X, 044X, 055X, 056X, & 057X). Code created internally in the CWFMQA system (effective 10/31/01 with HHPPS).
XZ	Total Charge Amount for all Part B non-visit charges on the RIC 'U' claims - for Home Health claims containing both Part A & Part B services, this code identifies the total charge amount for the Part B non-visit charges. Code created internally in the CWFMQA system (effective 10/31/01 with HHPPS).
Y1	Part A demo payment - Portion of the payment designated as reimbursement for Part A services under the demonstration. This amount is instead of the traditional prospective DRG payment (operating and capital) as well as any outlier payments that might have been applicable in the absence of the demonstration. No deductible or coinsurance has been applied. Payments for operating IME and DSH which are processed in the traditional manner are also not included in this amount.
Y2	Part B demo payment - Portion of the payment designated as reimbursement for Part B services under the demonstration. No deductible or coinsurance has been applied.

Value	Description
Y3	Part B coinsurance - Amount of Part B coinsurance applied by the intermediary to this demo claim. For demonstration claims this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group).
Y4	Conventional Provider Payment Amount for Non-Demonstration Claims - This the amount Medicare would have reimbursed the provider for Part A services if there had been no demonstration. This should include the prospective DRG payment (both capital as well as operational) as well as any outlier payment, which would be applicable. It does not include any pass through amounts such as that for direct medical education nor interim payments for operating IME and DSH.

Appendix K: Condition Codes

Value	Description
01	Military service related - Medical condition incurred during military service.
02	Employment related - Patient alleged that the medical condition causing this episode of care was due to environment/events resulting from employment.
03	Patient covered by insurance not reflected here - Indicates that patient or patient representative has stated that coverage may exist beyond that reflected on this bill.
04	Health Maintenance Organization (HMO) enrollee - Medicare beneficiary is enrolled in an HMO. Effective 9/93, hospital must also expect to receive payment from HMO
05	Lien has been filed - Provider has filed legal claim for recovery of funds potentially due a patient as a result of legal action initiated by or on behalf of the patient.
06	ESRD patient in 1st 18 months of entitlement covered by employer group health insurance - indicates Medicare may be secondary insurer. Effective 3/1/96, ESRD patient in 1st 30 months of entitlement covered by employer group health insurance.
07	Treatment of nonterminal condition for hospice patient - The patient is a hospice enrollee, but the provider is not treating a terminal condition and is requesting Medicare reimbursement.
08	Beneficiary would not provide information concerning other insurance coverage.
09	Neither patient nor spouse is employed - Code indicates that in response to development questions, the patient and spouse have denied employment.
10	Patient and/or spouse is employed but no EGHP coverage exists or (effective 9/93) other employer sponsored/provided health insurance covering patient.
11	The disabled beneficiary and/or family member has no group coverage from a LGHP or (effective 9/93) other employer sponsored/provided health insurance covering patient.
12	Payer code - Reserved for internal use only by third party payers. HCFA will assign as needed. Providers will not report them.
13	Payer code - Reserved for internal use only by third party payers. HCFA will assign as needed. Providers will not report them.
14	Payer code - Reserved for internal use only by third party payers. HCFA will assign as needed. Providers will not report them.
15	Clean claim (effective 10/92)
16	SNF transition exemption - An exemption from the post-hospital requirement applies for this SNF stay or the qualifying stay dates are more than 30 days prior to the admission date
17	Patient is over 100 years old - Code indicates that the patient was over 100 years old at the date of admission.
18	Maiden name retained - A dependent spouse entitled to benefits who does not use her husband's last name.
19	Child retains mother's name - A patient who is a dependent child entitled to CHAMPVA benefits that does not have father's last name.
20	Beneficiary requested billing - Provider realizes the services on this bill are at a non-covered level of care or otherwise excluded from coverage, but the beneficiary has requested formal determination
21	Billing for denial notice - The SNF or HHA realizes services are at a non-covered level of care or excluded, but requests a Medicare denial in order to bill Medicaid or other insurer
22	Patient on multiple drug regimen - A patient who is receiving multiple intravenous drugs while on home IV therapy

23	Home caregiver available - The patient has a caregiver available to assist him or her during self-administration of an intravenous drug
24	Home IV patient also receiving HHA services - the patient is under care of HHA while receiving home IV drug therapy services
25	Reserved for national assignment
26	VA eligible patient chooses to receive services in Medicare certified facility rather than a VA facility (effective 3/92)
27	Patient referred to a sole community hospital for a diagnostic laboratory test - (sole community hospital only). (effective 9/93)
28	Patient and/or spouse's EGHP is secondary to Medicare - Qualifying EGHP for employers who have fewer than 20 employees. (effective 9/93)
29	Disabled beneficiary and/or family member's LGHP is secondary to Medicare - Qualifying LGHP for employer having fewer than 100 full and part-time employees
31	Patient is student (full time - day) - Patient declares that he or she is enrolled as a full time day student.
32	Patient is student (cooperative/work study program)
33	Patient is student (full time - night) - Patient declares that he or she is enrolled as a full time night student.
34	Patient is student (part time) - Patient declares that he or she is enrolled as a part time student.
36	General care patient in a special unit - Patient is temporarily placed in special care unit bed because no general care beds were available.
37	Ward accommodation is patient's request - Patient is assigned to ward accommodations at patient's request.
38	Semi-private room not available - Indicates that either private or ward accommodations were assigned because semi-private accommodations were not available.
39	Private room medically necessary - Patient needed a private room for medical reasons.
40	Same day transfer - Patient transferred to another facility before midnight of the day of admission.
41	Partial hospitalization - Effective 3/92, indicates claim is for partial hospitalization services. For OP services, this includes a variety of psychiatric programs.
42-45	Reserved for national assignment.
46	Non-availability statement on file for CHAMPUS claim for nonemergency IP care for CHAMPUS beneficiary residing within the catchment area (usually a 40 mile radius) of a uniform services hospital.
47	Reserved for CHAMPUS.
48-54	Reserved for national assignment.
55	SNF bed not available - The patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
56	Medical appropriateness - Patient's SNF admission was delayed more than 30 days after hospital discharge because physical condition made it inappropriate to begin active care within that period
57	SNF readmission - Patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
58	Payment of SNF claims for beneficiaries dis-enrolling from terminating M+C plans who have not met the 3-day hospital stay requirement (effective 10/1/00)
59	Reserved for national assignment.
60	Operating cost day outlier - PRICER indicates this bill is length of stay outlier (PPS)
61	Operating cost outlier - PRICER indicates this bill is a cost outlier (PPS)

62	PIP bill - This bill is a periodic interim payment bill.
63	PRO denial received before batch clearance report - The HCSSACL receipt date is used on PRO adjustment if the PRO's notification is before original bill's acceptance report. (Payer only code effective 9/93)
64	Other than clean claim - The claim is not a 'clean claim'
65	Non-PPS code - The bill is not a prospective payment system bill.
66	Outlier not claimed - Bill may meet the criteria for cost outlier, but the hospital did not claim the cost outlier (PPS)
67	Beneficiary elects not to use LTR days
68	Beneficiary elects to use LTR days
69	Operating IME Payment Only - providers request for IME payment for each discharge of MCO enrollee, beginning 1/1/98, from teaching hospitals (facilities with approved medical residency training program); not stored in NCH. Exception: problem in startup
70	Self-administered EPO - Billing is for a home dialysis patient who self-administers EPO.
71	Full care in unit - Billing is for a patient who received staff assisted dialysis services in a hospital or renal dialysis facility.
72	Self-care in unit - Billing is for a patient who managed his own dialysis services without staff assistance in a hospital or renal dialysis facility.
73	Self-care training - Billing is for special dialysis services where the patient and helper (if necessary) were learning to perform dialysis.
74	Home - Billing is for a patient who received dialysis services at home.
75	Home 100% reimbursement - (not to be used for services after 4/15/90) The billing is for home dialysis patient using a dialysis machine that was purchased under the 100% program.
76	Back-up facility - Billing is for a patient who received dialysis services in a back-up facility.
77	Provider accepts or is obligated/required due to contractual agreement or law to accept payment by a primary payer as payment in full - Medicare pays nothing.
78	New coverage not implemented by HMO - effective 3/92, indicates newly covered service under Medicare for which HMO does not pay.
79	CORF services provided off site - Code indicates that physical therapy, occupational therapy, or speech pathology services were provided off site.
80 - 99	Reserved for state assignment.
A0	CHAMPUS external partnership program special program indicator code. (effective 10/93)
A1	EPSDT/CHAP - Early and periodic screening diagnosis and treatment special program indicator code. (effective 10/93)
A2	Physically handicapped children's program - Services provided receive special funding through Title 8 of the Social Security Act or the CHAMPUS program for the handicapped. (effective 10/93)
A3	Special federal funding - Designed for uniform use by state uniform billing committees. Special program indicator code (effective 10/93)
A4	Family planning - Designed for uniform use by state uniform billing committees. Special program indicator code (effective 10/93)
A5	Disability - Designed for uniform use by state uniform billing committees. Special program indicator code (effective 10/93)
A6	PPV/Medicare - Identifies that pneumococcal pneumonia 100% payment vaccine (PPV) services should be reimbursed under a special Medicare program provision. Special program indicator code (effective 10/93)

A7	Induced abortion to avoid danger to woman's life. Special program indicator code (effective 10/93)
A8	Induced abortion - Victim of rape/incest. Special program indicator code (effective 10/93)
A9	Second opinion surgery - Services requested to support second opinion on surgery. Part B deductible and coinsurance do not apply. Special program indicator code (effective 10/93)
B0 –B9	Special program indicator. Reserved for national assignment.
C0	Reserved for national assignment.
C1	Approved as billed - The services provided for this billing period have been reviewed by the PRO/UR or intermediary and are fully approved including any day or cost outlier. (effective 10/93)
C2	Automatic approval as billed based on focused review. (No longer used for Medicare) PRO approval indicator services (effective 10/93)
C3	Partial approval - The services provided for this billing period have been reviewed by the PRO/UR or intermediary and some portion has been denied (days or services). (effective 10/93)
C4	Admission/services denied - Indicates that all of the services were denied by the PRO/UR. PRO approval indicator services (effective 10/93)
C5	Post-payment review applicable - PRO/UR review to take place after payment. PRO approval indicator services (effective 10/93)
C6	Admission preauthorization - The PRO/UR authorized this admission/service but has not reviewed the services provided. PRO approval indicator services (effective 10/93)
C7	Extended authorization - the PRO has authorized these services for an extended length of time but has not reviewed the services provided. PRO approval indicator services (effective 10/93)
C8	Reserved for national assignment. PRO approval indicator services (effective 10/93)
C9	Reserved for national assignment. PRO approval indicator services (effective 10/93)
D0	Changes to service dates. Change condition (effective 10/93)
D1	Changes in charges. Change condition (effective 10/93)
D2	Changes in revenue codes/HCPCS. Change condition (effective 10/93)
D3	Second or subsequent interim PPS bill. Change condition (effective 10/93)
D4	Change in grouper input (diagnosis and/or procedures are changed resulting in a different DRG). Change condition (effective 10/93)
D5	Cancel only to correct a beneficiary claim account number or provider identification number. Change condition (effective 10/93)
D6	Cancel only to repay a duplicate payment or OIG overpayment (includes cancellation of an OP bill containing services required to be included on the IP bill). Change condition effective 10/93.
D7	Change to make Medicare the secondary payer. Change condition (effective 10/93)
D8	Change to make Medicare the primary payer. Change condition (effective 10/93)
D9	Any other change. Change condition (effective 10/93)
E0	Change in patient status. Change condition (effective 10/93)
EY	National Emphysema Treatment Trial (NETT) or Lung Volume Reduction Surgery (LVRS) clinical study (effective 11/97)
G0	Multiple medical visits occur on the same day in the same revenue center but visits are distinct and constitute independent visits (allows for payment under outpatient PPS -- effective 7/3/00).
M0	All inclusive rate for outpatient services. (payer only code)

M1	Roster billed influenza virus vaccine. (payer only code) Effective 10/96, also includes pneumococcal pneumonia vaccine (PPV)
M2	HH override code - home health total reimbursement exceeds the $150,000 cap or the number of total visits exceeds the 150 limitation. (effective 4/3/95) (payer only code)
W0	United Mine Workers of America (UMWA) SNF demonstration indicator (effective 1/97); Reserved for national assignment.

Appendix L: Occurrence Codes

Value	Description
01	Auto accident - The date of an auto accident.
02	No-fault insurance involved, including auto accident/other - The date of an accident where the state has applicable no-fault liability laws, (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/tort liability - The date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
04	Accident/employment related - The date of an accident relating to the patient's employment.
05	Other accident - The date of an accident not described by the codes 01 thru 04.
06	Crime victim - Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
07	Reserved for national assignment.
08	Reserved for national assignment.
11	Onset of symptoms/illness - The date the patient first became aware of symptoms/illness.
12	Date of onset for a chronically dependent individual - Code indicates the date the patient/beneficiary became a chronically dependent individual.
13	Reserved for national assignment.
14	Reserved for national assignment.
15	Reserved for national assignment.
16	Reserved for national assignment.
17	Date outpatient occupational therapy plan established or last reviewed - Code indicating the date an occupational therapy plan was established or last reviewed (effective 3/93)
18	Date of retirement (patient/beneficiary) - Code indicates the date of retirement for the patient/beneficiary
19	Date of retirement spouse - Code indicates the date of retirement for the patient's spouse.
20	Guarantee of payment began - The date on which the provider began claiming Medicare payment under the guarantee of payment provision.
21	UR notice received - Code indicating the date of receipt by the hospital of the UR committee's finding that the admission or future stay was not medically necessary.
22	Active care ended - The date on which a covered level of care ended in a SNF or general hospital, or date active care ended in a psychiatric or tuberculosis hospital. (For use by intermediary only)
23	Reserved for national assignment (effective 10/93). Benefits exhausted - The last date for which benefits can be paid. (term 9/30/93; replaced by code A3)
24	Date insurance denied - The date the insurer's denial of coverage was received by a higher priority payer.
25	Date benefits terminated by primary payer - The date on which coverage (including worker's compensation benefits or no-fault coverage) is no longer available to the patient.
26	Date skilled nursing facility (SNF) bed available - The date on which a SNF bed became available to a hospital inpatient requiring only SNF level of care.
27	Date home health plan established or last reviewed - Code indicating the date a home health plan of treatment was established or last reviewed. Not used by hospital unless owner of facility
28	Date comprehensive outpatient rehabilitation plan established or last reviewed - Code indicating the date a comprehensive outpatient rehabilitation plan was established or last reviewed. Not used by

	hospital unless owner of facility
29	Date OPT plan established or last reviewed - the date a plan of treatment was established for outpatient physical therapy. Not used by hospital unless owner of facility
30	Date speech pathology plan treatment established or last reviewed - The date a speech pathology plan of treatment was established or last reviewed. Not used by hospital unless owner of facility
31	Date beneficiary notified of intent to bill (accommodations) - The date of the notice provided to the patient by the hospital stating that he no longer required a covered level of IP care.
32	Date beneficiary notified of intent to bill (procedures or treatment) - The date of the notice provided to the patient by the hospital stating requested care (diagnostic procedures or treatments) is not considered reasonable or necessary.
33	First day of the Medicare coordination period for ESRD beneficiary - During which Medicare benefits are secondary to benefits payable under an EGHP. Required only for ESRD beneficiaries.
34	Date of election of extended care facilities - The date the guest elected to receive extended care services (used by Christian Science Sanatoria only).
35	Date treatment started for physical therapy - Code indicates the date services were initiated by the billing provider for physical therapy.
36	Date of discharge for the IP hospital stay when patient received a transplant procedure - Hospital is billing for immunosuppressive drugs.
37	The date of discharge for the IP hospital stay when patient received a non-covered transplant procedure - Hospital is billing for immunosuppresive drugs.
38	Date treatment started for home IV therapy - Date the patient was first treated in his home for IV therapy.
39	Date discharged on a continuous course of IV therapy - Date the patient was discharged from the hospital on a continuous course of IV therapy.
40	Scheduled date of admission - The date on which a patient will be admitted as an inpatient to the hospital. (This code may only be used on an outpatient claim.)
41	The date on which the first outpatient diagnostic test was performed as part of a pre-admission testing (PAT) program. This code may only be used if a date of admission was scheduled prior to the administration of the test(s).
42	Date of discharge/termination of hospice care - for the final bill for hospice care. Effective 5/93, definition revised to apply only to date patient revoked hospice election.
43	Reserved for national assignment.
44	Date treatment started for occupational therapy - Code indicates the date services were initiated by the billing provider for occupational therapy.
45	Date treatment started for speech therapy - Code indicates the date services were initiated by the billing provider for speech therapy.
46	Date treatment started for cardiac rehabilitation - Code indicates the date services were initiated by the billing provider for cardiac rehabilitation.
47	Non-covered Outlier Stay Began- code indicates the date that cost outlier status began and no Medicare payment will be made because all benefits have been exhausted during the inlier stay or the beneficiary does not elect to use life time reserve days
48	Payer code - Code reserved for internal use only by third party payers. HCFA assigns as needed for your use. Providers will not report it.
49	Payer code - Code reserved for internal use only by third party payers. HCFA assigns as needed for use. Providers will not report it.

50 - 69	Reserved for state assignment
A1	Birthdate, Insured A - The birthdate of the individual in whose name the insurance is carried. (Effective 10/93)
A2	Effective date, Insured A policy - A code indicating the first date insurance is in force. (effective 10/93)
A3	Benefits exhausted - Code indicating the last date for which benefits are available and after which no payment can be made to payer A. (effective 10/93)
B1	Birthdate, Insured B - The birthdate of the individual in whose name the insurance is carried. (effective 10/93)
B2	Effective date, Insured B policy - A code indicating the first date insurance is in force. (effective 10/93)
B3	Benefits exhausted - code indicating the last date for which benefits are available and after which no payment can be made to payer B. (effective 10/93)
C1	Birthdate, Insured C - The birthdate of the individual in whose name the insurance is carried. (effective 10/93)
C2	Effective date, Insured C policy - A code indicating the first date insurance is in force. (effective 10/93)
C3	Benefits exhausted - Code indicating the last date for which benefits are available and after which no payment can be made to payer C. (effective 10/93)

Appendix M: Occurrence Span Codes

Value	Description
70	Effective 10/93, payer use only, the non-utilization from/thru dates for PPS-inlier stay where beneficiary had exhausted all full/coinsurance days, but covered on cost report. SNF qualifying hospital stay from/thru dates.
71	Hospital prior stay dates - the from/thru dates of any hospital stay that ended within 60 days of this hospital or SNF admission.
72	First/last visit - the dates of the first and last visits occurring in this billing period if the dates are different from those in the statement cover period.
73	Benefit eligibility period - the inclusive dates during which CHAMPUS medical benefits are available to a sponsor's beneficiary as shown on the beneficiary's ID card.
74	Non-covered level of care - The from/thru dates of period at non-covered level of care in an otherwise covered stay, excluding any period reported with occurrence span code 76, 77, or 79.
75	The from/thru dates of SNF level of care during IP hospital stay. Shows PRO approval of patient remaining in hospital because SNF bed not available. Not applicable to swing bed cases. PPS hospitals use in day outlier cases only.
70	Patient liability - From/thru dates of period of non-covered care for which hospital may charge beneficiary. The FI or PRO must have approved such charges in advance. Patient must be notified in writing 3 days prior to non-covered period.
77	Provider liability - The from/thru dates of period of non-covered care for which the provider is liable. Effective 3/92, applies to provider liability where beneficiary is charged with utilization and is liable for deductible/coinsurance.
78	SNF prior stay dates - The from/thru dates of any SNF stay that ended within 60 days of this hospital or SNF admission.
79	Payer code. Effective 3/92, from/thru dates of period of non-covered care where beneficiary is not charged with utilization, deductible, or coinsurance, and provider is liable. Effective 9/93, non-covered period of care due to lack of medical necessity.
80-99	Reserved for state assignment
M0	PRO/UR approved stay dates - Effective 10/93, the first and last days that were approved where not all of the stay was approved.

Appendix N: Provider Entity Codes

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

Appendix O: External Code Sources

Look-up	Link
State codes, zip codes and other geographic associations	https://www.usps.com/
Provider names associated with National Provider Identifier (NPI) number	https://nppes.cms.hhs.gov/NPPES/
Health care provider taxonomy codes	http://www.wpc-edi.com/reference/
Definitions of ICD-9 and ICD-10 diagnosis codes	http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html
Definitions of ICD-9 and ICD-10 Procedure codes	
Definitions of HCPCS, CPTs and Modifier codes	
Dental procedure and identifier codes	http://www.ada.org/
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://www.iso.org/iso/country_codes.htm
National Council for Prescription Drug Programs (NCPDP)	http://www.ncpdp.org
National Association of Boards of Pharmacy (NABP)	http://www.nabp.net