ONPOINT Health Data

Technical Specifications Manual

Rhode Island's All-Payer Claims Database (APCD)

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Welcome!

First things first: Welcome to the Rhode Island All-Payer Claims Database (RI APCD).

The RI APCD is a collaboration among the Rhode Island Department of Health (HEALTH), the Office of the Health Insurance Commissioner (OHIC), the Health Benefits Exchange, and the Executive Office of Health and Human Services (EOHHS). This critical resource will be used to study healthcare utilization, cost, and trends to inform both consumers and policy decisions, to allow for cost comparisons, and to provide information for researchers studying healthcare quality in Rhode Island.

Your organization will play a critical part in creating this important resource, providing the foundational data needed to enhance understanding of the use, cost, quality, and delivery of healthcare across Rhode Island. We're glad you're part of this exciting initiative — and we're here to help.

We're Onpoint Health Data, the State's contracted vendor to perform the initial stages of RI APCD activities: data intake, cleansing, and consolidation. We've been doing this work for more than 15 years, helping launch seven statewide APCDs from Maine to Minnesota. We're a nonprofit company committed to a singular mission: advancing informed decision making by providing independent and reliable health data services.

We'll work closely with you to help explain Rhode Island's submission requirements and how to meet them as efficiently as possible. This *RI APCD Technical Specifications Manual* is the place to start. On the following pages, we'll outline the process from start to finish, walking you through each step of working with Onpoint CDM (Claims Data Manager), our data integration solution for commercial, Medicaid, and Medicare files alike.

For new submitters, this is the place to familiarize yourself with the ins and outs of data submissions, including information on how data fields should be prepared, how to protect and transmit data for the RI APCD, and who to contact when questions arise. For submitters already familiar with Onpoint, these pages may provide a helpful refresher on coding specifications and program milestones. Whether new or veteran, welcome! We're glad you're part of the RI APCD.

We're Here to Help.

Meeting the requirements of APCD reporting can seem sometimes like a complicated process. Onpoint is here to help. Our intake staff are trained, experienced, and ready to work with you. If you have a question, we'll help find the answer.

How to Reach Onpoint

Onpoint's data intake specialists are available to answer your questions regarding the mechanics of APCD collection, use of Onpoint's hashing and submission tools, and technical issues regarding the population, intent, or contents of submitted fields. We can be reached using the information below.

207-623-2555, 8:00am – 4:30pm (Eastern)

ri-support@onpointhealthdata.org

www.onpointcdm.org

Onpoint Health Data
Attn: RI APCD Intake Specialist
254 Commercial Street, Suite 257
Portland, ME 04101

How to Reach the State

The state agency serving as the primary contact for the RI APCD is the Rhode Island Office of the Health Insurance Commissioner (OHIC). For questions about the APCD's statutory regulations and other issues under the State's purview, including submission compliance, please use the contact information below.

James Lucht, Informatics Manager at OHIC
401-462-2144 (Eastern)

james.lucht@ohic.ri.gov

www.ohic.ri.gov/index.php

Rhode Island Office of the Health Insurance Commissioner
Attn: James Lucht, Informatics Manager
1511 Pontiac Ave, Building #69, First floor
Cranston, RI 02920

401-462-9645

Introductions – State Agencies

About the Rhode Island Department of Health

The primary mission of the Rhode Island Department of Health is to prevent disease and to protect and promote the health and safety of the people of Rhode Island.

The Department of Health is a diverse and interactive state agency with broad-ranging public health responsibilities. As Rhode Island has no local health departments, the agency coordinates public health activities across the state. The Department's main areas of responsibility include: emergency preparedness and response, environmental and health services regulation, health data and analysis, health information technology, health laboratories, infectious disease and epidemiology, management services, medical examiners, public health communication, community/family health, and vital records.

Learn more by visiting their website: www.health.ri.gov

About the Rhode Island Office of the Health Insurance Commissioner

Established in 2004 by the Rhode Island General Assembly, the Office of the Health Insurance Commissioner (OHIC) is the first RI agency dedicated solely to health insurance oversight. Compared to traditional insurance regulators, OHIC plays an expanded role, focusing additionally on consumer protections and insurer solvency. Such a role, laid out in the OHIC Purposes Statute, must balance traditional regulation with policy development. OHIC's primary goal: "ensuring solvency, protecting consumers, engaging providers, and improving the system."

Learn more by visiting their website: www.ohic.ri.gov

About the Rhode Island Executive Office of Health and Human Services

The Executive Office of Health and Human Services (EOHHS) was created in 2005 to facilitate cooperation and coordination among the state departments that administer Rhode Island's health and social service programs.

The departments within EOHHS — the Department of Children, Youth and Families; the Department of Human Services; the Division of Elderly Affairs; the Division of Veterans Affairs; the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals; and the Department of Health — collectively impact the lives of virtually all Rhode Islanders, providing direct services and benefits to more

than 300,000 citizens while working to protect the overall health, safety, and independence of all Rhode Islanders.

Learn more by visiting their website: www.eohhs.ri.gov

About the Rhode Island Health Benefits Exchange

Rhode Island's Health Benefits Exchange — HealthSourceRI — was created in 2011 by Gov. Lincoln Chaffee to connect Rhode Island small businesses and consumers to affordable, high-quality health insurance. The Exchange is designed to strengthen the state's primary care system, develop health information technology, and encourage innovations in hospital quality.

On behalf of employers, the Exchange will actively negotiate with health insurance companies to develop new and innovative insurance products. In addition, it will offer easy comparisons, access to tax credits for qualifying businesses, and new ways to buy insurance that provide value to employers. The Health Benefits Exchange will push to make insurance choices clearer and costs more affordable and predictable.

The Health Benefits Exchange, which will be operational in fall 2013, also will allow Rhode Islanders who are unable to get insurance through their employers access to federal tax credits or Medicaid coverage to help cover the cost of insurance and choose high-quality plans from a variety of insurance carriers.

Learn more by visiting their website: www.healthsourceri.com

Introductions – APCD Vendors

About Onpoint Health Data

Onpoint Health Data is Rhode Island's contracted vendor for data collection, cleansing, validation, and consolidation of all RI APCD submissions (i.e., the "Data Aggregator"). We are a Maine-based independent, nonprofit organization formed in 1976 by key stakeholders from the state's healthcare community. We are a full-service health data organization with two primary divisions: Data Management Services and Analytic Services. Our Data Management Services team — data intake specialists, data architects, and systems and data analysts — collect and integrate data from payers, helping them meet our clients' quality thresholds. Onpoint's Analytics Services team — additional systems analysts, quality assurance staff, health services researchers, and senior consultants — put the data to use through customized analysis, reporting, data linkage, and Business Intelligence tools.

Learn more by visiting us online: www.onpointhealthdata.org

About Arcadia Healthcare Solutions

Founded in 2002, Arcadia Healthcare Solutions is an innovative and nationally recognized leader in the healthcare consulting industry. With a focus on both healthcare provider and payer solutions, they have a unique cross-industry perspective on Health IT and healthcare transformation. The company's primary focus areas include EHR outsourcing and consulting, data integration and population analytics, and practice transformation and coaching.

For the RI APCD, Arcadia will be serving as the Unique Encrypted Identifier Vendor (known informally as the Lockbox Vendor), playing two key roles: (1) administering the RI APCD's public-facing Opt-Out Portal and (2) assigning, maintaining, and providing members' opt-out flagging and Unique Member Identifiers to the health plans for de-identified submission to the RI APCD.

Learn more by visiting their website: www.arcadiasolutions.com

The Basics

Who Must Register & Submit Data?

Rhode Island regulations — formally, the State's *Rules and Regulations Pertaining to the Rhode Island All-Payer Claims Database* (R23-17.17-RIAPCD) — require covered insurers to register with Onpoint prior to beginning test submissions. This step allows our team to become familiar with yours so we can assign usernames and passwords, prepare systems, triage questions, and provide answers most efficiently.

Rhode Island's R23-17.17-RIAPCD requires all covered health insurers and related parties to register and participate in the RI APCD. The regulations specifically state that any insurer, third-party administrator (TPA), pharmacy benefits manager (PBM), or carve-out payer that meets the following criteria must register with Onpoint and submit data to the RI APCD:

- A Rhode Island plan covering more than 3,000 Rhode Island residents/members as of January 1
- A Rhode Island small employer health insurance plan (as defined by Rhode Island General Law §27-50-3) covering more than 3,000 members regardless of the state of residency of the member

As explained in R23-17.17 §1.18 ("Definitions: Insurer"):

> "Insurer" means any entity subject to the insurance laws and regulations of Rhode Island, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including, without limitation, an insurance company offering accident and sickness insurance, a health maintenance organization, as defined by RIGL §27-41-1, a nonprofit hospital or medical service corporation, as defined by RIGL §§ 27-19 and 27-20, or any other entity providing a plan of health insurance or health benefits. For the purpose of these Regulations, a third-party payer, third-party administrator, or Medicare or Medicaid health plan sponsor is also deemed to be an Insurer.

The RI APCD regulations' §2.3 ("General Provisions: Exemptions") specifically exempt the following from APCD submissions:

(a) An Insurer that on January 1 of a reporting year with less than three thousand (3,000) enrolled or covered members; or

(b) Insurance coverage providing benefits for:

  (1) Hospital confinement indemnity;

  (2) Disability income;

  (3) Accident only;

  (4) Long-term care;

  (5) Medicare supplement;

  (6) Limited benefit health insurance as defined by RIGL §27-50-3(x);

  (7) Specified disease indemnity;

  (8) Sickness or bodily injury or death by accident or both; or

  (9) Other limited benefit policies, including but not limited to those exempt from the application of RIGL § 27-50-3 pursuant to subsection (t)(2)-(4) of that statute.

Mandatory re-registration is due each year prior to December 31 to ensure that the State's records are kept current. See §4.2.a or contact Onpoint's intake specialists for further details or clarification regarding registration requirements. For Rhode Island's APCD, initial registration will be conducted online through fillable forms that will be distributed immediately following the Submitter Orientation Meeting.

The Opt-Out Option

Rhode Island's regulations require that participating insurers notify their members of their right to opt out of having their data included in the APCD. As explained in R23-17.17 §2.4 ("General Provisions: Optional Consent"):

> A covered insurer must permit enrolled or covered members to "opt out" of having any information or health care claims relating to them submitted to the RIAPCD. Each covered Insurer shall develop an "Opt out" process independently to create a system that works most efficiently for that entity.

To help insurers implement this new process, the State will be contracting with a commercial vendor to deploy a secure online portal to administer members' opt-out requests. The portal, available on the web 24 hours a day, will allow members to enter a handful of critical data points — name, date of birth, insuring health plan, and policy ID number among them — that will be used to locate their record in the APCD's master patient index (MPI) and toggle their opt-out status accordingly.

As noted in Figure 1 below, the Lockbox Vendor will include each member's current opt-out status in the standard Response File to submitters, allowing their submitter to update members' records if needed. Since members' opt-out status is maintained within the MPI, their flag can be sent across plans in cases of multiple coverage or to their new insurer when they have a change in health plan.

When a member's opt-out status is set to "O" (opted out), only their Unique Member Identifier and opt-out status will be sent to Onpoint to allow for quality assurance and opt-out safeguarding; no eligibility or claims information will be supplied to the APCD for these members.

Under this framework, insurers' responsibility lies in notifying all current and new members of their right to opt out and then in maintaining members' opt-out status in their own records based on flagging supplied by the Lockbox Vendor over the course of the initiative. For further information on the opt-out process, please see the "All-Payer Claims Database Operations Guidance Memorandum" provided by the Rhode Island Department of Health, which is available from the Office of the Health Insurance Commissioner (OHIC).

For further assistance or questions regarding the opt-out requirement or APCD-related issues, please contact James Lucht at OHIC:

James Lucht, Informatics Manager at OHIC
401-462-2144 (Eastern)

james.lucht@ohic.ri.gov

www.ohic.ri.gov/index.php

Rhode Island Office of the Health Insurance Commissioner
Attn: James Lucht, Informatics Manager
1511 Pontiac Ave, Building #69, First floor
Cranston, RI 02920

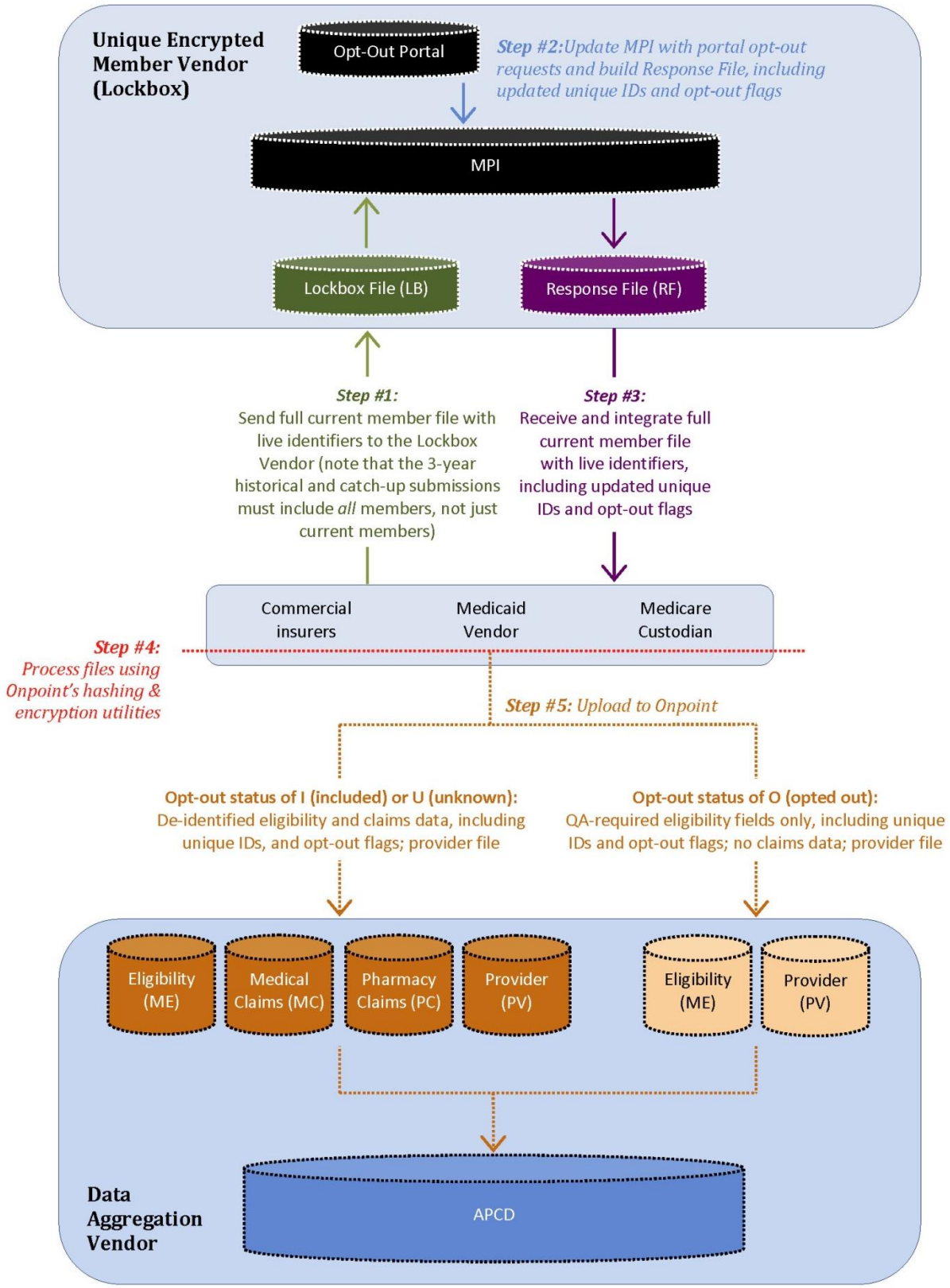
James Lucht, Informatics Manager at OHIC
401-462-2144 (Eastern)

APCD Mechanics & Data Flow

Rhode Island's *Rules and Regulations Pertaining to the Rhode Island All-Payer Claims Database* (R23-17.17-RIAPCD) require insurers to engage in a multi-step data exchange process to further secure members' privacy. Details of this five-part process are summarized below, diagrammed in Figure 1, and outlined in the timelines in Table 1 and Table 2 below. Basic data flow includes the following steps:

1. First, submitters will supply healthcare eligibility data to the Lockbox Vendor (cited in the regulations as the "Unique Encrypted Member Identifier Vendor") for the assignment of Unique Member Identifiers ("unique IDs") and opt-out status flagging. Submitters' first submission to the Lockbox Vendor must include all current members for March 2014. The historical file to the Lockbox Vendor must include all members, regardless of coverage length, for calendar years 2011–2013. The calendar-year catch-up file (CYCU) file must be comprised of members for January 2014 through November 2014. (Note that you may resubmit your March 2014 data in the CYCU file if wanted.) Each ongoing production file to the Lockbox Vendor, beginning with December 2014 data, must contain your full current membership, including full data on all members regardless of opt-out status. (Note that this schedule previously offered the option of submitting CYCU data with historical data; this is no longer allowable due to the need to provide distinct flagging to historical members.)
2. Next, the Lockbox Vendor will (a) cross-check opt-out requests received to date from the online opt-out portal, updating members' opt-out flagging as required; (b) process the newly received eligibility file for inclusion and updates within Rhode Island's master patient index (MPI); and (c) construct the Response File for the submitter, including each member's unique ID and opt-out status as well as additional administrative elements needed to enable quality assurance review and accurate integration and assignment by the submitter.
3. Submitters will receive and integrate the Response File, using the returned eligibility data points to locate the same member within their own system(s). Submitters will then integrate the Lockbox Vendor's value-added elements into their system(s), updating unique IDs and opt-out flags as necessary. For members with an opt-out status of I (included) and U (unknown), submitters will populate the full eligibility and claims files. For members with an opt-out status of O (opted out), only a narrow subset of the de-identified eligibility data must be supplied (i.e., Submitter Code (ME001), Year (ME004), Month (ME005), Unique Member Identifier (ME010A), Member Opt-Out Status (ME010D), and Record Type (ME899)) to enable QA review; no claims data will be sent for these members. Along with the appropriate eligibility and claims data, submissions must include the required provider file on a quarterly basis.
4. Before transmitting any data to the APCD, each submitter must use one of Onpoint's hashing applications (detailed later in this manual). These applications first perform preliminary file validation (to preempt subsequent file failure for nonconformity with basic requirements) then hash/de-identify all PHI as required by RI regulations.
5. The final step is transferring the APCD submission to Onpoint. If using Onpoint's AutoUploader, the process is fully automated, including hashing, encryption, and file transfer. If using one of our manual applications, submitters must log in to Onpoint CDM's secure portal, move to the Manual Hashing & Upload page, and initiate their upload.

Figure 1. A Visual View of the RI APCD's Five-Part Submission Process



RI APCD Milestones & Timeline

Table 1. Timeline for Key Start-Up Milestones as Outlined in the RI APCD Regulations

Phase	Rule Ref.	Event	Days Since Previous Step	Deadline
Administration	N/A	Rule takes effect	N/A	July 9, 2013
	N/A	Final version of Technical Specifications Manual released	30	January 15, 2014
Initial, Single-Month Data Submissions for Testing Data Range: March 2014	5.2.a.1	Insurers submit full data for the most recent full month's membership to the Lockbox Vendor: 1-month of eligibility data	90	May 15, 2014
	5.2.a.2	Lockbox Vendor returns response files with Unique Member Identifiers and opt-out status to insurers	15	June 1, 2014
	5.2.a.3	Insurers submit test files to Onpoint: 1 month of eligibility (containing Unique Member Identifiers and opt-out flags), medical claims, pharmacy claims, and provider data*	15	June 15, 2014
Historical Data Submissions Data Range: January 1, 2011 – December 31, 2013 (may include Calendar-Year Catch-Up if wanted)	5.2.b.1	Insurers submit historical files to the Lockbox Vendor: 3 years of eligibility data (calendar years 2011–2013)	120	October 15, 2014
	5.2.b.2	Lockbox Vendor returns response files with Unique Member Identifiers and opt-out status to insurers	30	November 15, 2014
	5.2.b.3	Insurers submit historical files to Onpoint: 3 years of eligibility (containing Unique Member Identifiers and opt-out flags), medical claims, pharmacy claims, and provider data (calendar years 2011–2013)	30	December 15, 2014
Calendar-Year Catch-Up Data Range: January 1, 2014 – November 30, 2014 (if not included in historical submissions)	5.2.b.4	Lockbox: If part-way through a calendar year, insurers submit eligibility data through the preceding month to the Lockbox Vendor	0	December 31, 2014
	5.2.b.4	ID assignment: Lockbox Vendor returns catch-up response files with Unique Member Identifiers and opt-out status to submitters	15 days	January 15, 2015
	5.2.b.4	Onpoint: Insurers submit catch-up eligibility (containing Unique Member Identifiers and opt-out flags), medical claims, pharmacy claims, and provider data	15 days	January 31, 2015
Regular Data Submissions (Monthly or Quarterly)	5.2.c.2.i	Insurers enter production mode with the Lockbox Vendor: monthly or quarterly submission of eligibility data	21 business days from 5.2.b.4	January 31, 2015
	5.2.c.3	Lockbox Vendor returns response files with Unique Member Identifiers and opt-out status to submitters	10 business days	February 15, 2015
	5.2.c.4	Insurers enter production mode with Onpoint: monthly or quarterly submission of eligibility (containing Unique Member Identifiers and opt-out flags), medical claims, pharmacy claims, and provider data	10 business days	February 28, 2015

* Onpoint's testing protocol has been designed to bring payers online as efficiently and accurately as possible. For the RI APCD, we will begin with one complete month of submitted payer data, evaluating three key components:

- The completeness of individual data elements
- The relationships between data elements
- The relationships between data types (eligibility and claims data)

Once that single month of data has been approved, submitters will begin the historical load, reporting the first six historical months of each data type (i.e., January 2011 – June 2011). This larger volume of data will be evaluated on the same three components; this time, however, we also will examine utilization rates, per member per month

(PMPM) measures, and longitudinal trends. PMPM statistics will be generated on this larger data set, including member months by product type, total number of claims, total payments, total number of high-cost claims, total member payments by month, and the number of unique members. Following this step, payers will be asked to supply the remainder of their historical data (i.e., July 2011 – December 2013).

Please note: Under the authority of the State, submitters will have the option to supply their production files on a monthly or quarterly basis (in adherence to standard calendar-year quarters). For example, Q1 submissions must be sent to the Lockbox Vendor by April 30 and to Onpoint by May 31. Note, too, that the 10 business days allotted for the Lockbox Vendor to assign and return Unique Member IDs remains in place as does the limit of 10 business days allotted for submitters to incorporate the Unique Member IDs into their eligibility file for Onpoint.

Table 2. Timeline for Key Production Submission Milestones & Deliverables

Submission	Reporting Period *	Notify Members of Opt-Out by…	Send Eligibility Header & Member Files to Arcadia	Arcadia Returns Response Files to Submitters by…	Send All Files to Onpoint by…		Onpoint Delivers Extract to 3M	Data/Reports Available to State
					Monthly Submitters	Quarterly Submitters		
July 2015	July 1–31, 2015	8/15/2015	8/31/2015	9/15/2015	9/30/2015	Or all three months by 11/30/2015	2/1/2016	3/31/2016
August 2015	August 1–31, 2015	9/15/2015	9/30/2015	10/15/2015	10/31/2015			
September 2015	September 1–30, 2015	10/15/2015	10/31/15	11/15/2015	11/30/2015			
October 2015	October 1–31, 2015	11/15/2015	11/30/2015	12/15/2015	12/31/2015	Or all three months by 2/29/2016	5/1/2016	6/30/2016
November 2015	November 1–30, 2015	12/15/2015	12/31/2015	1/15/2016	1/31/2016			
December 2015	December 1–31, 2015	1/15/2016	1/31/2016	2/15/2016	2/29/2016			
January 2016	January 1–31, 2016	2/15/2016	2/29/2016	3/15/2016	3/31/2016	Or all three months by 5/31/2016	8/1/2016	9/30/2016
February 2016	February 1–29, 2016	3/15/2016	3/31/2016	4/15/2016	4/30/2016			
March 2016	March 1–31, 2016	4/15/2016	4/30/2016	5/15/2016	5/31/2016			
April 2016	April 1–30, 2016	5/15/2016	5/31/2016	6/15/2016	6/30/2016	Or all three months by 8/31/2016	11/1/2016	12/31/2016
May 2016	May 1–31, 2016	6/15/2016	6/30/2016	7/15/2016	7/31/2016			
June 2016	June 1–30, 2016	7/15/2016	7/31/2016	8/15/2016	8/31/2016			
July 2016	July 1–31, 2016	8/15/2016	8/31/2016	9/15/2016	9/30/2016	Or all three months by 11/30/2016	2/1/2017	3/31/2017
August 2016	August 1–31, 2016	9/15/2016	9/30/2016	10/15/2016	10/31/2016			
September 2016	September 1–30, 2016	10/15/2016	10/31/2016	11/15/2016	11/30/2016			
October 2016	October 1–31, 2016	11/15/2016	11/30/2016	12/15/2016	12/31/2016	Or all three months by 2/28/2017	5/1/2017	6/30/2017
November 2016	November 1–30, 2016	12/15/2016	12/31/2016	1/15/2017	1/31/2017			
December 2016	December 1–31, 2016	1/15/2017	1/31/2017	2/15/2017	2/28/2017			

* Eligibility file must include all members enrolled at any time/ for any duration during reporting period.

Medical and pharmacy claims files must include all claims paid during the reporting period for eligible members.

Provider file must include all providers who rendered services associated with the claims within the reporting period.

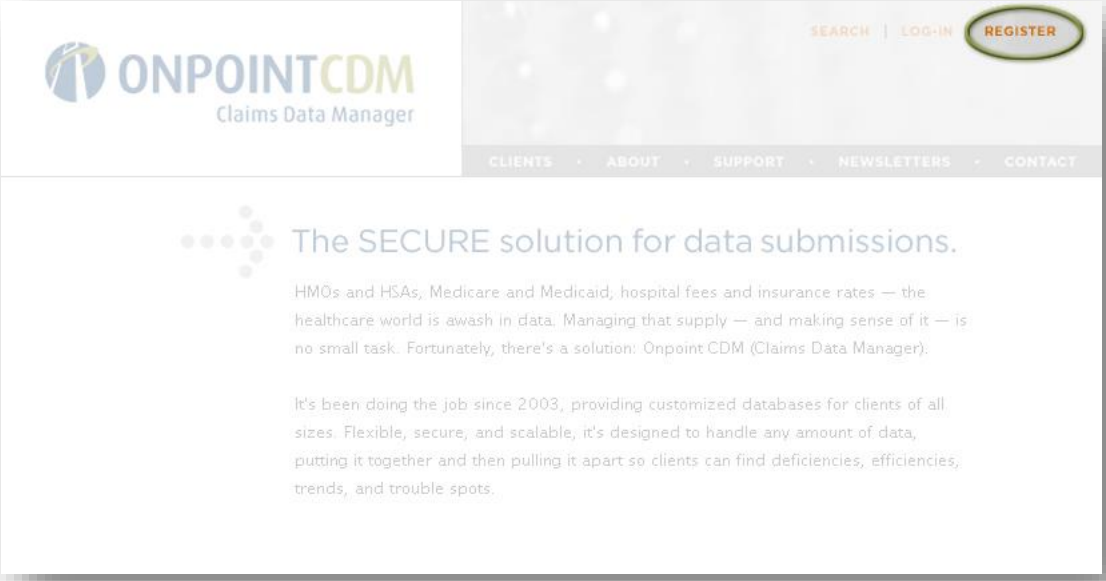
Step 1. Registering with Onpoint

To satisfy the first step of Rhode Island's R23-17.17, submitters must register with Onpoint, supplying all required information. (Note that if you already submit data to Onpoint for another state or client, you still need to register for Rhode Island submissions. To keep things simple, though, we'll extend your state authorizations appropriately, enabling you to use your existing Onpoint CDM login and password for RI APCD submissions.)

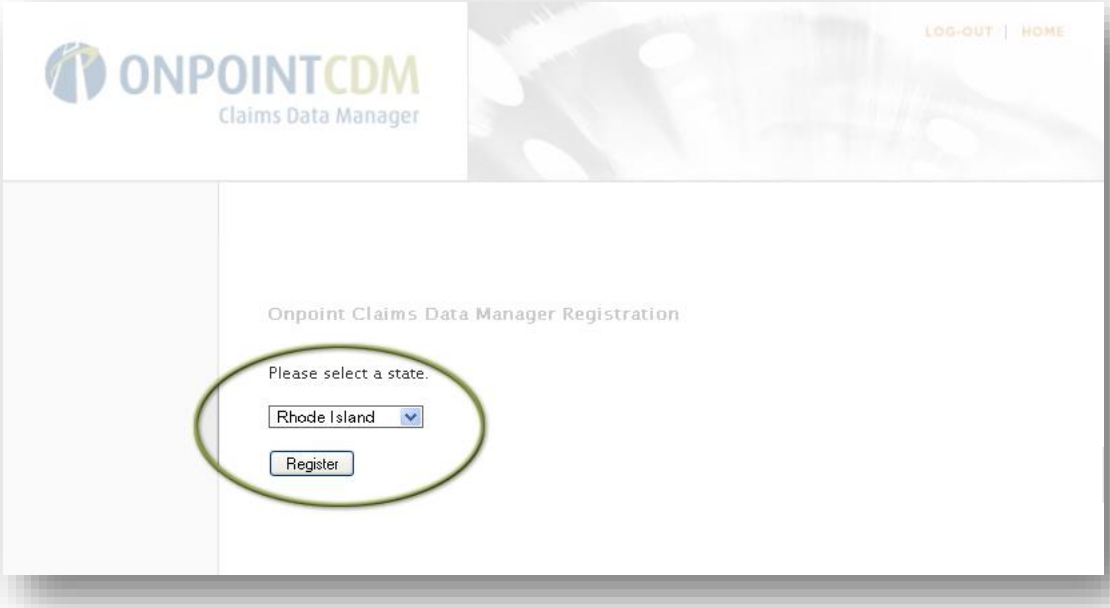
Information included on the standard registration form includes:

- Company address(es)
- Use of TPAs, PBMS, and carve-out payers
- Number of covered lives
- Lives covered by Medicare managed care products
- Adjustment-reporting methodology
- Contacts for questions regarding eligibility, medical claims, pharmacy claims, compliance, and provider file
- Required APCD elements that your system does not record

To get started, please visit www.onpointcdm.org, select "Register" from the home page's upper menu (see below).



Next, simply select “Rhode Island” from the list of states and click the “Register” button, which will direct you to the online registration form.



After registration, each of your organization’s identified contacts will receive an email with their assigned login and password. Each contact will receive a copy of all Onpoint CDM emails. Contacts who wish to receive email regarding only a subset of topics (e.g., compliance, newsletters, etc.) must send an email specifying their preferences to ri-support@onpointhealthdata.org to restrict their email distribution.

Please remember that mandatory re-registration is due each year prior to December 31 to ensure that the State’s records are kept current. See §4.2.a or contact Onpoint’s intake specialists for further details or clarification regarding registration requirements.

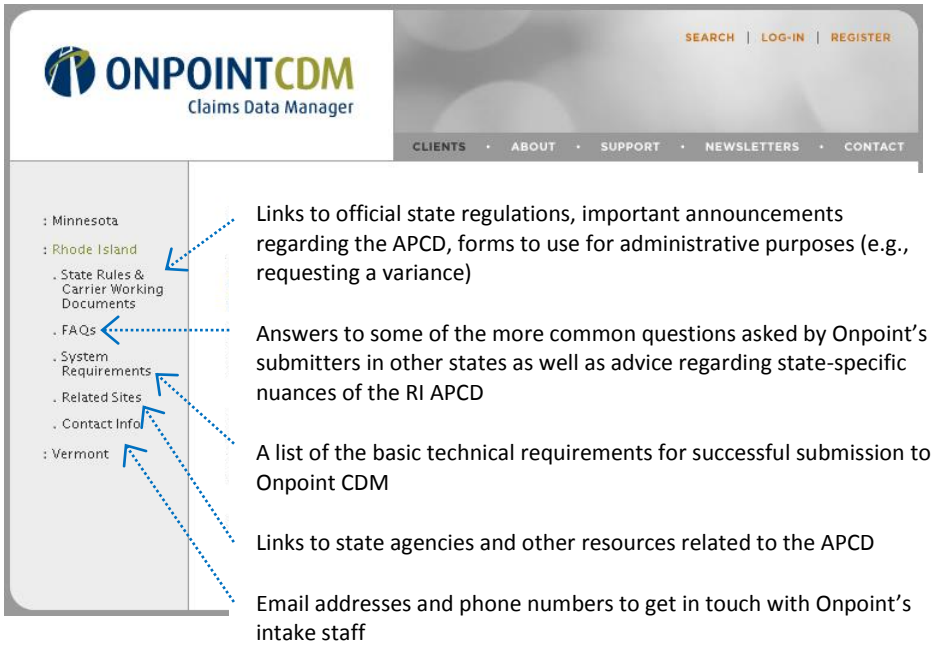
Getting Oriented at Onpoint CDM

Onpoint CDM begins with payer registration and ends with processed, standardized data. In between, it spans a series of complicated steps that include mapping payers’ data, benchmarking data, tuning validations, testing submissions, refining thresholds, validating intake, verifying quality, mapping identifiers, compiling records, and consolidating the resulting data into an accurate resource for follow-on research. Throughout the process, Onpoint CDM’s online interface — www.onpointcdm.org — serves as a resource for data reporters and state agencies alike.

Options at the Public Level

Onpoint CDM's public zone offers quick access to publicly available reference materials, maintenance announcements, answers to frequently asked questions, and links to relevant state agencies and resources (see Figure 2). Rhode Island's APCD section can be found here.

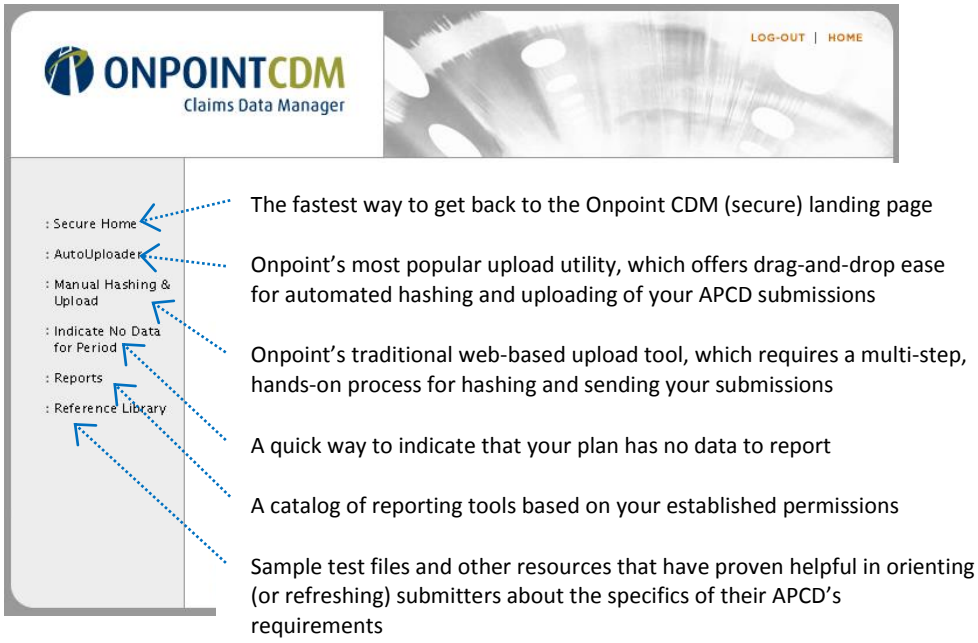
Figure 2. Onpoint CDM Options — Public Zone



Options at the Secure Level

Once registered with Onpoint, credentialed users may access Onpoint CDM's secure portal, which facilitates actual data collection and submission monitoring and includes secure access to Onpoint's hashing application and upload utilities (see Figure 3).

Figure 3. Onpoint CDM Options — Secure Zone



Step 2. Registering with Arcadia

Each insurer submitting data to the Rhode Island APCD must provide contact information to the Lockbox Vendor, Arcadia Healthcare Solutions, prior to transferring any files. This information will be collected using the RI APCD unified registration form administered by Onpoint Health Data. Arcadia will work with registered APCD submitters to establish data exchange protocols, resolve any data exchange issues, and provide technical support to facilitate the start of testing.

As requested by RI APCD submitters, registration for the RI APCD has been adjusted to offer a unified process that collects the information needed by both Onpoint and Arcadia using a single form. An outline of the key steps follows:

1. Submitters will complete the online registration form available at www.onpoincdm.org using the steps described earlier in this document.
2. Upon receiving a completed registration form, Onpoint staff will assign a payer code and unique submitter code that will be used in file layouts sent to both Onpoint and Arcadia. (Note that if you currently submit data for another APCD operated by Onpoint, you will continue to use your existing submitter code.)
3. Onpoint next will relay your assigned codes and other necessary information to Arcadia.
4. Arcadia will contact each registered submitter to confirm their assigned submitter code and provide information related to next steps.

Data Exchange Procedures

Eligibility files submitted to Arcadia must (1) be transmitted via SFTP using public-key authentication, and (2) conform to a flat file specification (in compliance with the file layout and specifications included below in Step 3), and (3) must be encrypted according to the following protocol:

1. **Test File Submission (05/15/2014):** For the May 15, 2014, test file submission, submitters must use a Windows-based software to zip and password-protect all submitted files. Submitters should reach out to Arcadia immediately (if they have not already done so) for clarification on the software applications supported for this password protection, minimum requirements, or if they have concerns with meeting this requirement. Although SFTP transmission automatically encrypts data in motion and is HIPAA compliant, the State has determined that additional encryption-/password-protection is necessary to further reduce possible vulnerabilities to data "at rest."
2. **Historic File Submission and Onwards:** Starting with the October 15, 2014, historic file submission, all files submitted to Arcadia must be encrypted using the "gold standard" of PGP encryption. This will not be a requirement until the October 15, 2014, submission, giving submitters enough lead time to obtain necessary internal approvals and procure the software. If you foresee an issue with getting PGP encryption prior to the historic file submission, please reach out to Arcadia and/or the State directly.

File-Naming Convention

The required file-naming convention, delimited with underscores, follows:

- Date of file upload
- Time (in HHMMSS format using military time)
- Client ID (i.e., the submitter code assigned by Onpoint Health Data; in this example, RIC0100)
- File type (i.e., header vs. member)
- File number

Example: "20130127_134555_RIC0100_member_1.zip"

Please note: The Member and Header files must be zipped independently. The zip file name must match the file inside per the naming convention described above.

Data Delimiters for Flat-File Specification

Delimiter Type	Value	Usage
Record Separator	Carriage return	Records are separated by a carriage return (line feed permitted) (i.e., ASCII character 13).
Field Separator	,	Data fields are separated by the comma character (i.e., ASCII character 44).
Component Separator	"	Adjacent components of data fields, where allowed, are separated by the double-quotation mark character (i.e., ASCII character 34).

Notes: (1) The column headers are to be included at the top of each file (i.e., for both the member file and the header file). (2) All columns are to be submitted. If there is no data for a specific field, two double-quotation marks (i.e., "") will represent that field.

SFTP Server Specification

The SFTP server DNS name is: SFTP.arcadiaanalytics.com

Folder Paths

- Test – Eligibility File Submission: /TEST/Submit
- Test – Response File Receipt: /TEST/Receive
- Production – Eligibility File Submission: /PROD/Submit
- Production – Response File Receipt: /PROD/Receive

In the event that public-key exchange is not supported by a submitter, their assigned username and password will be provided following the registration process with Onpoint.

Validation

All files received by Arcadia will be reviewed for conformity with the required eligibility field layout specified below in Step 3 as well as for validity and quality, including (but not limited to):

- Consistent field formatting (e.g., numeric fields are truly numeric fields, date fields are formatted as true dates, etc.)
- Valid field value lists (e.g. opt-out/opt-in code values adhere to valid values, etc.)

Response File

Arcadia will acknowledge receipt of each eligibility file submitted by sending an initial notification (acknowledgement message) informing the submitter whether or not the file passed initial validation. For eligibility files that have passed the initial validation, a response file will be transmitted within ten (10) business days from date of acknowledged receipt. While submitters are expected to monitor the appropriate directory, Arcadia also will send a notification that the file is ready.

Response files will be available from the SFTP server via the appropriate path as specified above.

Data Security

All participants in the exchange of protected health information (PHI) are bound by appropriate Business Associate Agreements to ensure the appropriate protection of patient privacy. Arcadia Healthcare Solutions maintains physical, administrative, and technical controls that meet or exceed relevant federal and state data security regulations and guidelines.

Arcadia Solutions performs an annual security audit and risk assessment of the hosted environment based on multiple regulatory and compliance guidelines, including HIPAA, HITECH, PCI, MA 201 CMR 17, and NIST. Risk scoring is performed using a best-of-breed framework and specific remediation steps are taken to ensure ongoing compliance. Detailed security processes and procedures along with a well-defined change control process help Arcadia identify and quantify risk and take appropriate actions to secure protected patient (member) and client data. Arcadia also contracts with third-party penetration testing services to simulate malicious attacks against the code base and security infrastructure at least twice annually.

Physical Controls

Physical security of the data center and hardware are strictly managed by Arcadia Solutions. Only authorized Arcadia personnel have physical access to the technical infrastructure; all vendor interactions are escorted by Arcadia personnel. Arcadia performs annual security audits that meet or exceed SSAE 16 SOC1 Type II requirements.

Administrative Controls

Arcadia has a Security Officer and Compliance Review Group to ensure that all employees have current compliance awareness training and are well versed in protecting PHI. Incident management policies are documented to provide a clear escalation path and lockdown procedures in the event of a suspected breach.

Technical Controls

Arcadia's MPI platform employs a layered security approach: Each component of the hosted environment is configured with specific security controls following the principle of least privilege to protect data during transfer and at rest. These security controls include:

- VLAN segmentation
- Access control lists
- Deep-packet inspection
- Intrusion detection/prevention systems
- Application traffic inspection
- SSL encrypted web portal
- SQL database encryption
- Back-up data encryption at rest
- Application logging and auditing
- Antivirus and malware inspection
- Active Directory integrated user access
- Penetration testing (twice per year)
- External and internal vulnerability scanning (quarterly)

Submitter Support

Arcadia Solutions will support submitters throughout the testing and production phases to answer questions and assist submitters in resolving challenges and staying on schedule. For support, contact: ri-apcd-lockbox-support@arcadiasolutions.com.

Step 3. Sending & Receiving Data — Arcadia Solutions

The Basics

Key References R23-17.17-RIAPCD §1.21 and §4.3.c

Covered Parties All

Required Frequency Either monthly or quarterly (in adherence to calendar-year quarters; for example, Q1 data should be submitted to the Lockbox Vendor prior to April 30)

Specific Deadline Within 21 business days of the preceding month's end (§5.2.c.2.i)

Important Notes

- One record must be submitted for each member who had coverage during the period reported in the header and trailer records.
- Submissions must include a complete month's data; partial months must not be reported.
- Every member who had coverage during the period reported, regardless of opt-out status, must be included in the file sent to the Lockbox Vendor.
- Please note that **two files** are expected with each submission: (1) A header file that contains meta data (e.g., record counts, period beginning/ending dates, submitter code, etc.) pertaining to the member data file, and (2) a member file that contains the member-specific information (e.g., member IDs, demographic information, etc.).
- You may send as many file sets (see bullet above) as needed to report your full historical membership. There is no longer a requirement to limit files to a maximum of 500,000 member records.
- Please note: The element ID provided in the layout table's second column (e.g., LBH001 for "Create Timestamp") is for administrative purposes only. These IDs, which can change as file layouts change, should not be incorporated into the field names used for your submissions.

File Layout & Specifications — Eligibility File to Arcadia (Header File)

ELIGIBILITY FILE TO ARCADIA (HEADER FILE)							
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	REQUIRED?
1	LBH001	Create Timestamp	N	Date	8	Use this field to report the date on which the file was created using an 8-digit format of YYYYMMDD (e.g., January 18, 1972, would be coded as “19720118”).	Y
2	LBH002	Period Beginning Date	N	Date	8	Use this field to report the first month of the reporting period for this submission using an 8-digit format of YYYYMMDD (e.g., January 18, 1972, would be coded as “19720118”).	Y
3	LBH003	Period Ending Date	N	Date	8	Use this field to report the last month of the reporting period for this submission using an 8-digit format of YYYYMMDD (e.g., January 18, 1972, would be coded as “19720118”).	Y
4	LBH004	Record Count	N	Integer	6	Use this field to report the total number of member entries in the accompanying member file. If the count of records within the submission does not equal the number reported in this field, the submission will fail.	Y
5	LBH005	Submitter Code	N	String	8	Use this field to report the submitter code assigned to you by Onpoint Health Data.	Y

File Layout & Specifications — Eligibility File to Arcadia (Member File)

ELIGIBILITY FILE TO ARCADIA (MEMBER FILE)							
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	REQUIRED?
1	LBM001	Submitter Code	N	String	8	Use this field to report the submitter code assigned to you by Onpoint Health Data.	Y
2	LBM002	Policy ID Number	N	String	30	Use this field to report the submitter-assigned contract number for the subscriber.	Y
3	LBM003	Subscriber Last Name	N	String	120	Use this field to report the subscriber’s last name.	N
4	LBM004	Subscriber First Name	N	String	120	Use this field to report the subscriber’s first name.	N
5	LBM005	Subscriber Middle Initial	N	String	1	Use this field to report the subscriber’s middle initial.	N
6	LBM006	Subscriber Street Address 1	N	String	100	Use this field to report the first line of the subscriber’s street address of residence.	N
7	LBM007	Subscriber Street Address 2	N	String	100	Use this field to report the second line of the subscriber’s street address of residence.	N
8	LBM008	Subscriber City	N	String	100	Use this field to report the name of the subscriber’s city of residence.	N
9	LBM009	Subscriber State or Province	N	String	2	Use this field to report the subscriber’s state or province of residence using the two-character abbreviation code defined by the U.S. Postal Service (for U.S. states) and Canada Post (for Canadian provinces).	N
10	LBM010	Subscriber ZIP/Postal Code	N	String	9	Use this field to report the ZIP/postal code of the subscriber’s residence. **Notes:** For U.S. ZIP codes, include the ZIP+4 (also referred to as the “plus-four” or “add-on” code). Do not code dashes or spaces within ZIP/postal codes.	N

ELIGIBILITY FILE TO ARCADIA (MEMBER FILE)							
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	REQUIRED?
11	LBM011	Subscriber Date of Birth	N	Date	8	Use this field to report the subscriber's date of birth using an 8-digit format of YYYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	N
12	LBM012	Subscriber Social Security Number	N	String	9	Use this field to report the subscriber's 9-digit Social Security number.	N
13	LBM013	Subscriber Gender	N	String	1	Use this field to report the subscriber's gender. The only valid codes for this field are: F ..... Female M..... Male U..... Unknown	N
14	LBM014	Plan-Specific Member ID	N	String	255	Use this field to report the plan-assigned member identifier.	Y
15	LBM015	Member Suffix or Sequence Number	N	String	20	Use this field to report the unique number of the member within the contract.	Y
16	LBM016	Member Last Name	N	String	120	Use this field to report the member's last name.	Y
17	LBM017	Member First Name	N	String	120	Use this field to report the member's first name.	Y
18	LBM018	Member Middle Initial	N	String	1	Use this field to report the member's middle initial.	N
19	LBM019	Member Street Address 1	N	String	100	Use this field to report the first line of the member's street address of residence.	N
20	LBM020	Member Street Address 2	N	String	100	Use this field to report the second line of the member's street address of residence.	N
21	LBM021	Member City	N	String	100	Use this field to report the name of the member's city of residence.	N
22	LBM022	Member State or Province	N	String	2	Use this field to report the member's state or province of residence using the two-character abbreviation code defined by the U.S. Postal Service (for U.S. states) and Canada Post (for Canadian provinces).	N
23	LBM023	Member ZIP/Postal Code	N	String	9	Use this field to report the ZIP/postal code of the member's residence. **Notes:** For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code). Do not code dashes or spaces within ZIP/postal codes.	N
24	LBM024	Member Date of Birth	N	Date	8	Use this field to report the member's date of birth using an 8-digit format of YYYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	Y
25	LBM025	Member Social Security Number	N	String	9	Use this field to report the member's 9-digit Social Security number.	N
26	LBM026	Member Gender	N	String	1	Use this field to report the member's gender. The only valid codes for this field are: F ..... Female M..... Male U..... Unknown	N
27	LBM027	Member Coverage Start Date	N	Date	8	Use this field to report the member's coverage start date using an 8-digit format of YYYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	N
28	LBM028	Member Coverage End Date	N	Date	8	Use this field to report the member's coverage end date using an 8-digit format of YYYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	N
29	LBM029	Member's Relationship to Subscriber	N	String	100	Use this field to report the member's relationship to the subscriber using codes maintained by the Accredited Standards Committee (ASC) in the ASC X12 transaction set (i.e., 271/2100C/INS/Y/02 and 271/2100D/INS/N/02).	N

ELIGIBILITY FILE TO ARCADIA (MEMBER FILE)							
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	REQUIRED?
30	LBM030	Individual ID	N	String	25	Use this field to report a member's unique identifier in the payer system as a result of an internal MPI or member de-duplication across internal payer systems.	N
31	LBM031	Unique Member Identifier	N	String	32	Use this field to report the Unique Member Identifier most recently assigned to this member by Arcadia Solutions. This ID was reported to you in the Response File provided by Arcadia following your preceding submission.	Y unless new member
32	LBM032	Member Opt-Out Status	N	String	1	Use this field to report the Opt Out Status most recently reported by Arcadia Solutions. The only valid codes for this field are: I ..... Included O ..... Omitted U..... Unknown	Y unless new member

* Note that these fields will be supplied by the Lockbox Vendor. For initial submissions, these fields should be reported as null for all members. Thereafter, only new members in a submitter's historical, calendar-year catch-up, and production files should be reported as null to the Lockbox Vendor.

Receiving the Response File

Following assignment of the Unique Member Identifier (UMI), the Lockbox Vendor will supply each health plan with a Response File that includes their members' assigned UMIs, opt-out status, and sufficient substantiating information to allow plans to accurately locate the member in their own files, accurately transfer the UMI to the member's record for APCD submissions, and verify that the UMI has not changed (unless the member's Merge/Split Indicator [RF019] and Unique Member Identifier (Legacy) [RF020] have been populated).

File Layout & Specifications — Response File from Arcadia

RESPONSE FILE FROM ARCADIA						
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION
1	RF002	Submitter Code	N	String	8	This field contains the submitter code assigned to you by Onpoint Health Data.
2	RF003	Policy ID Number	N	String	30	This field contains the submitter-assigned contract number for the subscriber.
3	RF004	Plan-Specific Member ID	N	String	255	This field contains the plan-assigned member identifier.
4	RF005	Member Suffix or Sequence Number	N	String	20	This field contains the unique number of the member within the contract.
5	RF006	Member Last Name	N	String	120	This field contains the member's last name.
6	RF007	Member First Name	N	String	120	This field contains the member's first name.
7	RF008	Member Middle Initial	N	String	1	This field contains the member's middle initial.
8	RF009	Member Street Address 1	N	String	100	This field contains the first line of the member's street address of residence.
9	RF010	Member Street Address 2	N	String	100	This field contains the second line of the member's street address of residence.
10	RF011	Member City	N	String	100	This field contains the name of the member's city of residence.
11	RF012	Member State or Province	N	String	2	This field contains the member's state or province of residence using the two-character abbreviation code defined by the U.S. Postal Service (for U.S. states) and Canada Post (for Canadian provinces).
12	RF013	Member ZIP/Postal Code	N	String	9	This field contains the ZIP/postal code of the member's residence.
13	RF014	Member Date of Birth	N	Date	8	This field contains the member's date of birth using an 8-digit format of YYYYMMDD (e.g., January 18, 1972, would be coded as "19720118").
14	RF015	Member Social Security Number	N	String	9	This field contains the member's 9-digit Social Security number.
15	RF016	Member Gender	N	String	1	This field contains the member's gender. The only valid codes for this field are: F.....Female M .....Male U .....Unknown

RESPONSE FILE FROM ARCADIA						
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION
16	RF017	Unique Member Identifier	N	String	32	This field contains the Unique Member Identifier assigned to this member by Arcadia Solutions. This field should be reported identically in your APCD submissions to Onpoint using the following fields: ME010A, MC010A, PC010A. **Notes:** Please take great care when transferring this ID into your system. It is critical that this field be assigned to the correct member and reported accurately in your APCD submission.
17	RF018	Member Opt-Out Status	N	String	1	This field contains the last known opt-out status, which indicates whether a member's information should be included in the RI APCD or instead omitted in the case of a member who has opted out. The only valid codes for this field are: I .....Included O.....Omitted U .....Unknown **Notes:** Even though your insurer may have submitted a value of I for this field, indicating inclusion in the APCD, the member may have requested to opt out via the Opt-Out Portal or another insurer, therefore requiring a value of O to be returned to all insurers providing coverage for the same individual.
18	RF019	Merge/Split Indicator	N	String	1	This field contains a code that indicates whether a legacy ID (RF020) was created because a member's ID was merged with another ID (for a member identified by the Lockbox Vendor as being reported duplicatively) or split into a different ID (for a member identified by the Lockbox Vendor as incorrectly previously grouped under a single Unique Member ID). The only valid codes for this field are: M .....Merged S.....Split
19	RF020	Unique Member Identifier (Legacy)	N	String	32	This field contains the original Unique Member Identifier assigned to this member by the Lockbox Vendor (prior to merges or splits). This field should be reported identically in your APCD submissions to Onpoint using the eligibility field ME010B. **Notes:** This legacy ID has been replaced by the Unique Member Identifier reported above in RF017. This change is due to the merging or splitting of the member's previously assigned Unique Member Identifier as identified by the code reported above in RF019.
20	RF021	Date Processed	N	Date	8	This field contains the date on which the MPI was run using an 8-digit format of YYYYMMDD (e.g., January 18, 1972, would be coded as "19720118").

Incorporating the Unique Member Identifier

The next step for insurers is to incorporate the Unique Member Identifier — both the currently assigned (RF017) and any reported as legacy (RF020) from the Lockbox Vendor into their file layout for submissions to Onpoint. This UMI will serve as the best means of ensuring longitudinal and lateral integrity for members across both payers and time. Its accurate incorporation is the responsibility of payers and critical to the success of the RI APCD.

Please remember: As noted in §3.4.a and its subsections, it is the responsibility of each insurer and/or payer to "maintain a record of the assignment of the encrypted unique identifier assigned to each member in such a way that would permit an audit or ongoing maintenance by the Director if necessary. Under no circumstance shall such audit or ongoing maintenance allow the Department, the Director, the Data Aggregator, or the RIAPCD to re-identify a Member."

Step 4. Sending & Receiving Data — Onpoint

Setting Up for Secure Transfers

Onpoint's data collection system ensures that direct member identifiers remain secure — both at rest and in motion — through the use of a federally recommended hashing algorithm. This hashing is not performed by Onpoint; instead, it is performed locally by health plans. Using Onpoint's system, all direct member identifiers, as identified in Rhode Island's R23-17.17-RIAPCD, are hashed upon preparation for submission, remain solely within the health plan's platform, and are neither transmitted nor received by Onpoint.

For the RI APCD, Table 3 identifies the fields that will be rendered de-identified through non-reversible hashing prior to transmission to Onpoint.

Table 3. APCD Elements to be Hashed Prior to Submission to Onpoint

Eligibility File		Medical Claims		Pharmacy Claims	
ME008	Subscriber Social Security Number	MC007	Subscriber Social Security Number	PC007	Subscriber Social Security Number
ME009	Plan-Specific Contract Number	MC008	Plan-Specific Contract Number	PC008	Plan-Specific Contract Number
ME011	Member Social Security Number	MC010	Member Social Security Number	PC010	Member Social Security Number
ME014	Member Date of Birth	MC013	Member Date of Birth	PC013	Member Date of Birth
ME101	Subscriber Last Name	MC101	Subscriber Last Name	PC101	Subscriber Last Name
ME102	Subscriber First Name	MC102	Subscriber First Name	PC102	Subscriber First Name
ME103	Subscriber Middle Initial	MC103	Subscriber Middle Initial	PC103	Subscriber Middle Initial
ME104	Member Last Name	MC104	Member Last Name	PC104	Member Last Name
ME105	Member First Name	MC105	Member First Name	PC105	Member First Name
ME106	Member Middle Initial	MC106	Member Middle Initial	PC106	Member Middle Initial

* Note: No elements in the Provider File are hashed prior to submission.

All data submitted to Onpoint CDM are processed first by our hashing and upload applications, which safeguard electronic protected health information (ePHI) both at rest (within applications at the point of capture) and in motion (during transmission from payers to Onpoint using HTTPS and SSL protocols). These applications also provide preliminary validation of the data being submitted, zip the file for more efficient transmission, and rename the file according to normalizing conventions.

Onpoint CDM also features success verification and viewable logs to provide reassurance to carriers and clients alike. Our software additionally validates the contents of submissions at a very high level, providing a preliminary safeguard against critical flaws.

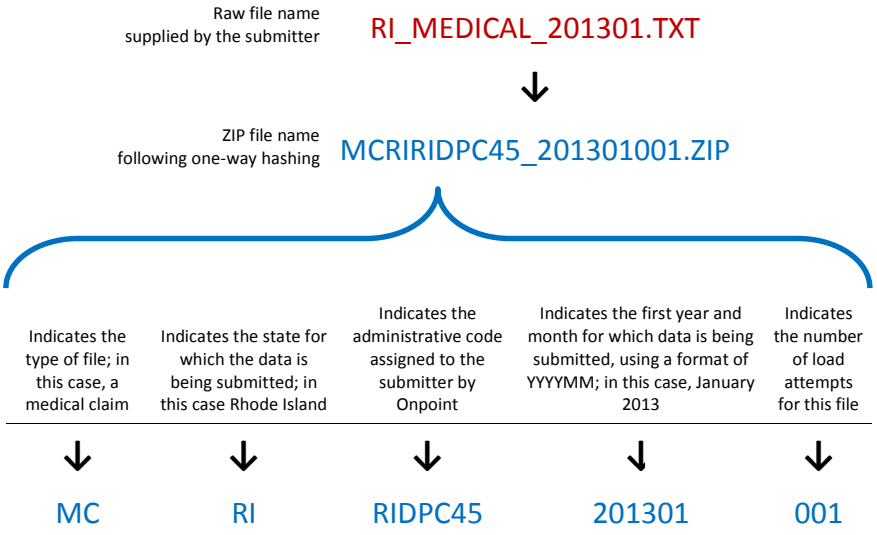
Files that fail any of the following checks are rejected prior to completing the hashing process:

1. The file contains one header record and one trailer record, both of which are formatted correctly
2. The correct number of fields appears in each record
3. The number of data records matches the count in the header record
4. The data type is valid
5. The length and format of submitted Social Security numbers are valid
6. Each file's last record element (i.e., **899 — Record Type) is populated correctly (i.e., ME for eligibility, MC for medical claims, PC for pharmacy claims, and PV for provider); this field is required even on opt-out eligibility records
7. For eligibility data, the year and month of eligibility are within the period beginning and period ending values cited in the header record
8. For claims data, the date approved for payment is within the period beginning and period ending values cited in the header record

For RI APCD submissions, the hashing application performs a critical, additional function: Immediately prior to hashing this field, Onpoint's hashing application calculates a member's age in months based on the Member Date of Birth field (ME014, MC013, PC013). The Member Date of Birth field is then hashed and both the hashed value and the value-added Age in Months element are submitted to the APCD — the hashed value to allow for quality assurance review, the de-identified Age in Months to enable analytic use of the APCD.

After hashing, a ZIP file is created following Onpoint CDM's naming conventions. If the user renames the ZIP file before submission, the submission will be rejected. An example of Onpoint CDM's hashing name convention is included below in Figure 4:

Figure 4. Naming Convention for Zipped, Hashed Files



Providing hashing software that is run by all submitters ensures that all identifiers are hashed consistently and without exception. Since this hashing is done at the carrier's site, the carrier can verify easily that all PHI processed by the hashing software have been removed and replaced with an unrecognizable, hashed 128-character field.

The time from receipt of the data by Onpoint CDM to notification of success or failure (due to quality checks) depends on a number of variables, including system load, file size, data type. Submissions of fewer than one million records generally will be processed within one to two hours. The average processing time for a six-million record medical file is six hours. In general, submitters should expect an email regarding their submission within 24 hours of receipt.

Upon receipt, data submissions are unzipped and inspected for quality and compliance with submission requirements. Onpoint CDM includes complex and customizable programming that fine-tunes data quality validations and thresholds to ensure that collected data meets Rhode Island's research needs. Onpoint staff will continue to work with Rhode Island to set these thresholds and then with reporters to make sure that they can meet them. Onpoint CDM currently employs a library of more than 500 distinct data quality validations that vet submissions for anomalies and errors before they can make their way into the data warehouse.

Step 1: Verifying the Presence of Java Runtime Environment (JRE)

All of Onpoint CDM's hashing and upload utilities employ a Java Web Start application that assists in the execution of the SHA-512 hashing algorithm necessary to de-identify any PHI on incoming submissions. Before you can use any of our submission tools, you will need to verify that your system has Oracle's Java Runtime Environment (JRE) properly installed.

Perhaps the easiest way to do this is to install the AutoUploader (see below) and try to submit a test file. If you have JRE installed, the application will first prepare the Java environment on your computer and then install. Two notes about this process:

1. If you have Java installed, but are questioning whether it is JRE, Oracle notes that Java Runtime Environment goes by many names, including Java Runtime, Runtime, Java Virtual Machine, Virtual Machine, Java VM, Java plug-in, Java add-on, and Java download.
2. It may appear that the installer is done, but nothing happens; do not be alarmed. This step sometimes takes a few minutes. If this happens, check your computer's task bar to see if a Web Start button has appeared and if a Java warning message is there. Clicking YES at this point will allow you to proceed with hashing, but you will receive the same prompt each time you run the hashing software. Clicking NO will not install the hashing software. By clicking ALWAYS, you will be able to proceed with hashing and will not be prompted again.

If you are prompted to choose an application to launch the hashing application, you most likely do not have JRE installed. In that case, please visit Oracle's website to download the latest version here: http://java.com/en/download/index.jsp.

Step 2: Choosing Your Upload Option

Onpoint offers carriers two options for securely submitting their data — AutoUploader and a web-based utility that requires manual operation. Both options utilize our one-way hashing algorithms to eliminate the possibility of ePHI re-identification or recovery.

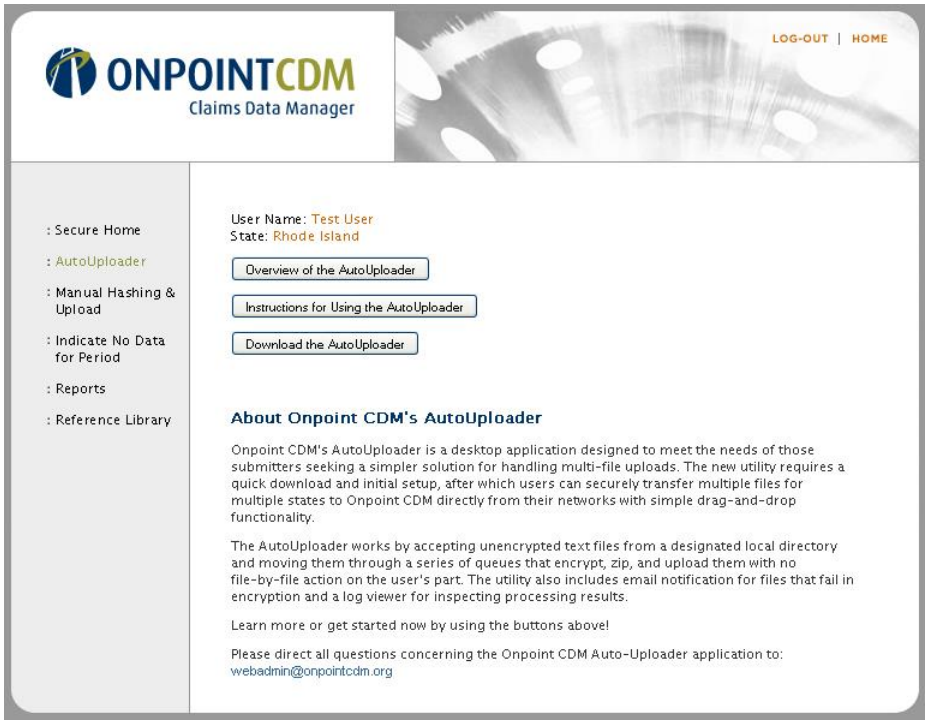
The tool most preferred by our submitters is Onpoint CDM's AutoUploader. The AutoUploader works by accepting unencrypted text files from a designated local directory and moving them through a series of queues that hash, zip, and upload them. Key features include:

- **Easy installation.** The utility, which is compatible with Windows, Linux, and UNIX, is distributed as an executable file that runs as a self-contained console/desktop application.
- **Robust scope.** Any number of files for any number of clients may be queued as long as the data requires hashing prior to submission.
- **Customizable configuration.** The AutoUploader allows each user to tailor their alerts for efficient usage.
- **Durable sessions.** Since the utility runs entirely on the user's network, there is no login and no session expiration to disrupt uploads midstream.
- **Viewable logs.** The application provides a log viewer, allowing users to see key details and track the status of their submissions.
- **Secure uploads.** Users' original files are never seen by Onpoint; only hashed contents are viewable after being uploaded to Onpoint CDM.

Upload Option 1: AutoUploader

To get started with AutoUploader, log in to Onpoint CDM and select the AutoUploader link from the page's left menu (see Figure 5). Also be sure to download the latest instructions using the on-page link.

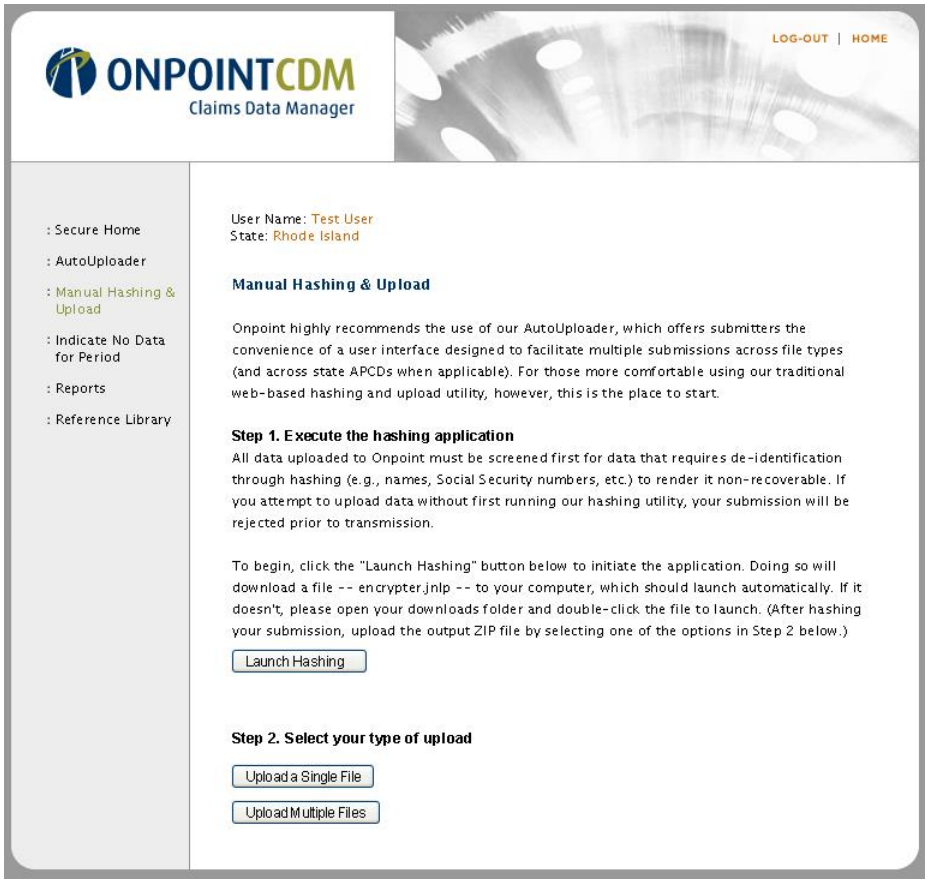
Figure 5. Onpoint CDM (Secure) — AutoUploader Page



Upload Option 2: Manual Hashing & Uploading

Onpoint highly recommends the use of our AutoUploader, but for those more comfortable using our manual web-based hashing and upload utility, this is the place to start. Start by selecting the Manual Hashing & Upload option from the screen's left menu (see Figure 6).

Figure 6. Onpoint CDM (Secure) — Manual Hashing & Upload Page

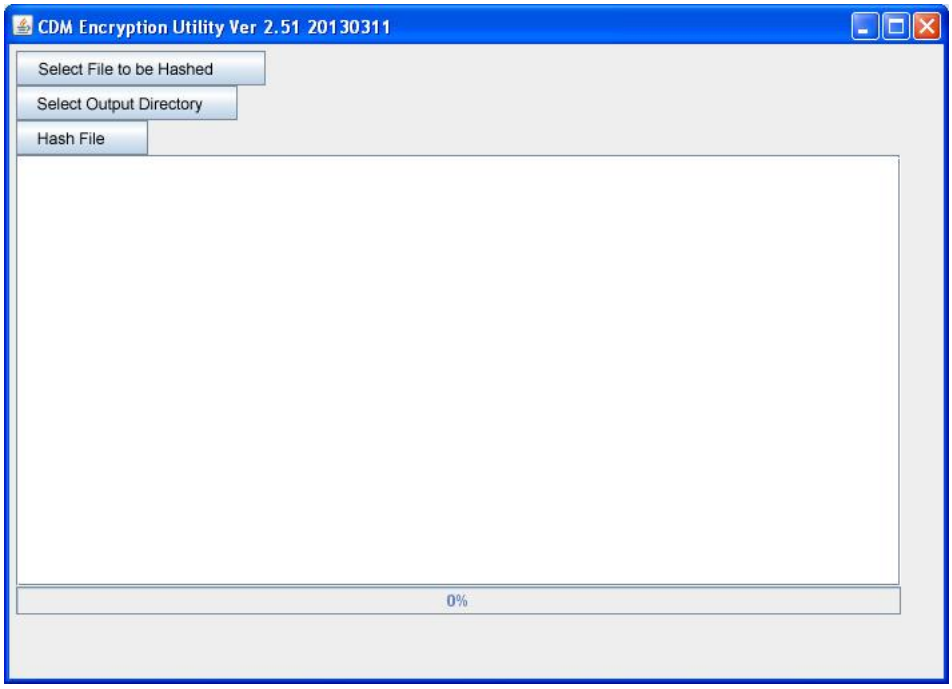


Upload Option 2 (Part 1): Manually Hash Your Data

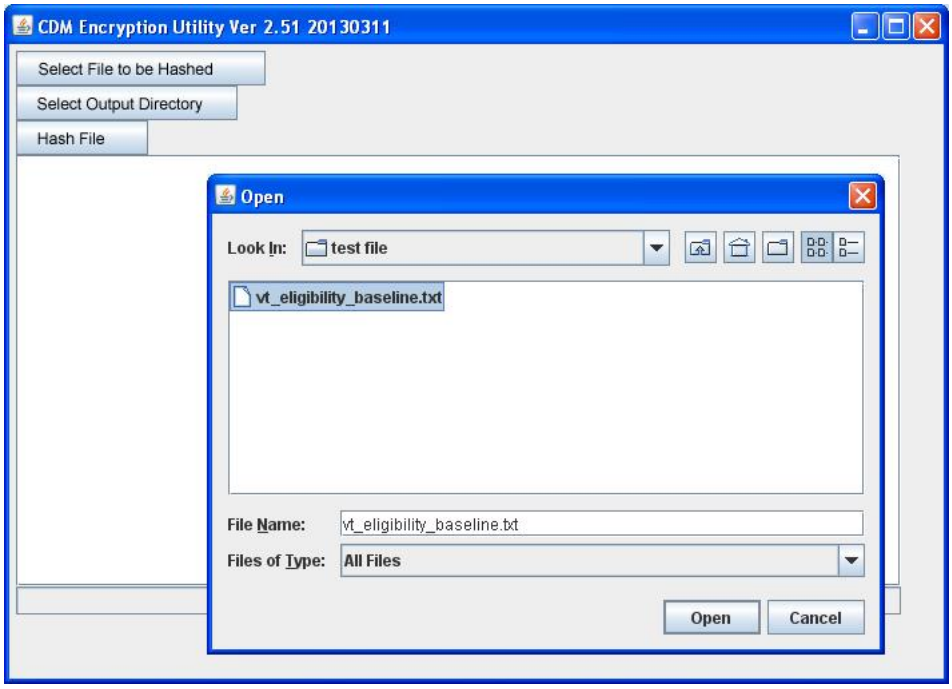
1. All data uploaded to Onpoint must undergo screening and hashing to prevent PHI from being transmitted to the APCD. To begin, click the LAUNCH HASHING button under the page's Step 1 narrative.

2. Doing so will download a file — ENCRYPTER.JNLP — to your computer, which is designed to launch automatically. (If it does not launch due to local settings, please open your downloads folder and double-click the file to launch.)

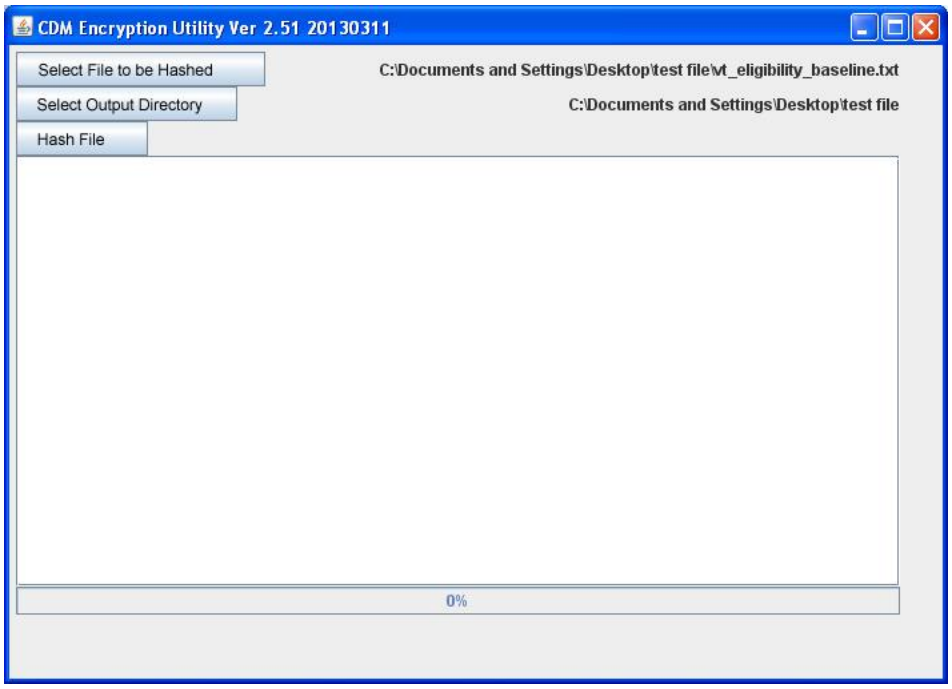
3. In the hashing application, you will be required to select a target file to be screened and hashed. To do so, click the SELECT FILE TO BE HASHED button. (Note that the manual upload utility allows the selection of only a single file at a time; for expedited and batch processing, please use the AutoUploader.)



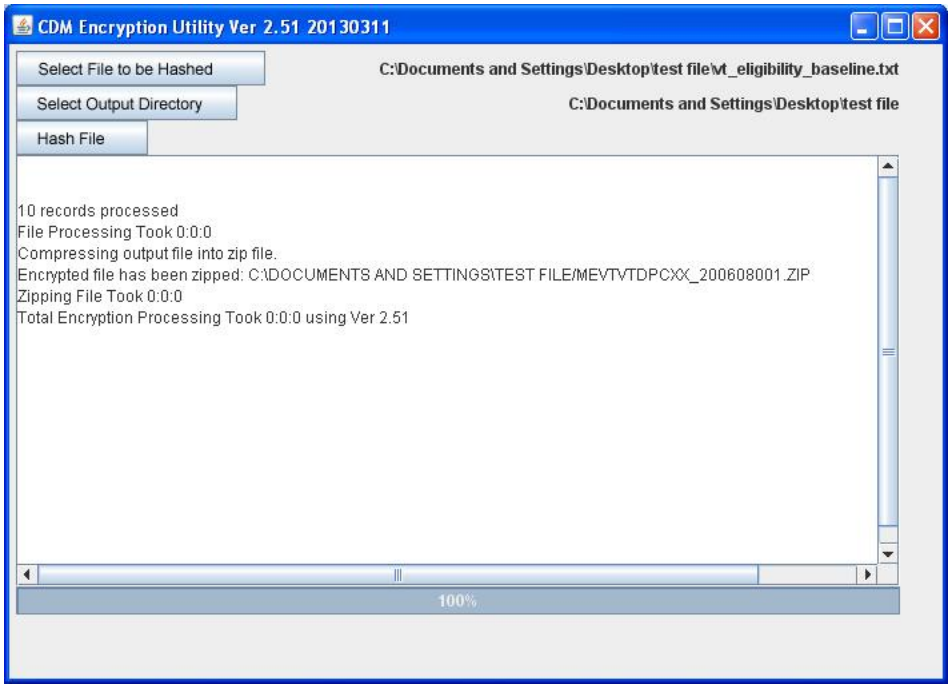
4. In the pop-up dialog box, locate the file within your local system, then click OPEN. You can verify the selected file by checking the path name to the right of the button.



5. Next, identify the desired location for the output file by clicking the SELECT OUTPUT DIRECTORY and designating the desired location on your local system. This selection also can be verified by checking the path to the right of the button.



6. After verifying both the target file and the output location, click the HASH FILE button. The application will process the file, display its progress, and output two files: (1) a compressed ZIP file that contains your hashed data for submission and (2) a non-zipped copy of the TXT file for rapid verification of successful hashing.

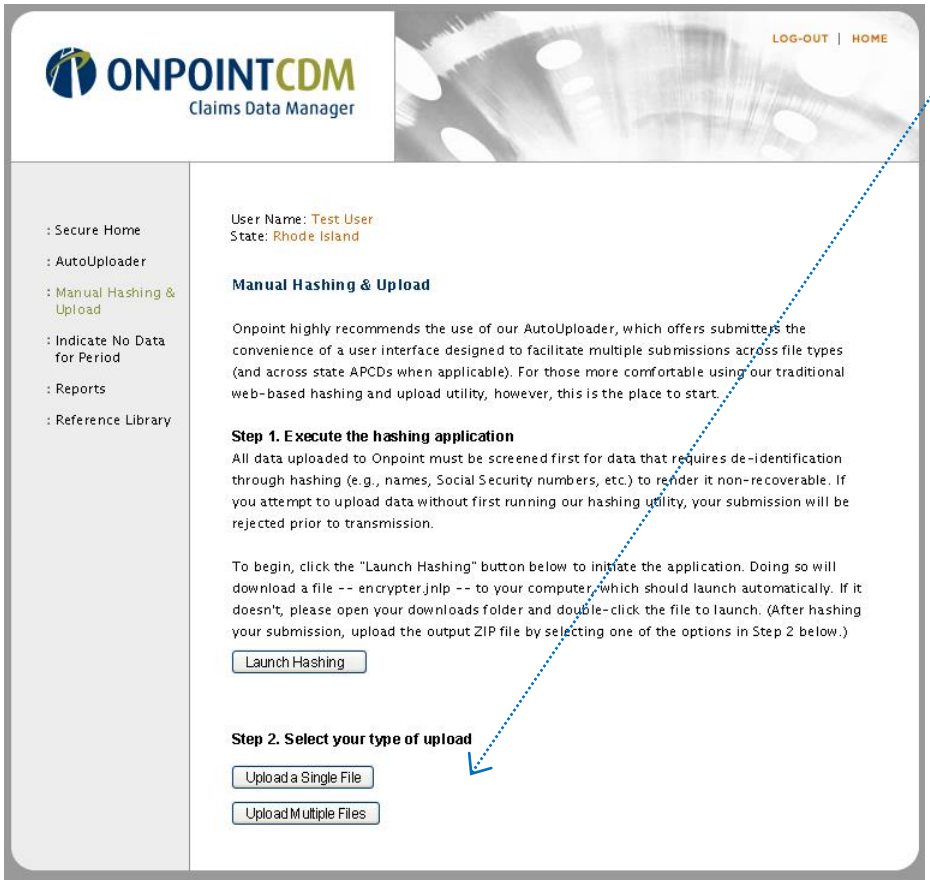


Name	Size	Type
vt_eligibility_baseline.txt	3 KB	Text Document
MEVTVTDPCXX_200608001.ZIP	8 KB	Compressed (zippe...
MEVTVTDPCXX_200608001.TXT	13 KB	Text Document

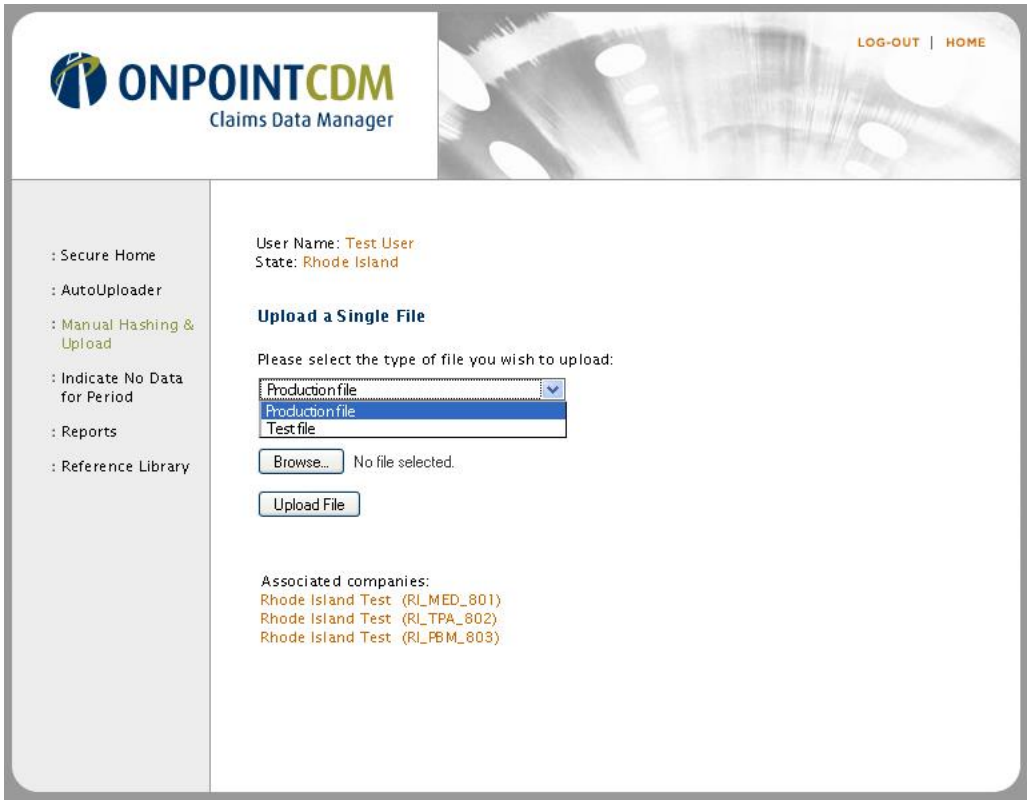
7. After this step, return to your web browser to begin the upload process.

Upload Option 2 (Part 2): Manually Uploading Your File

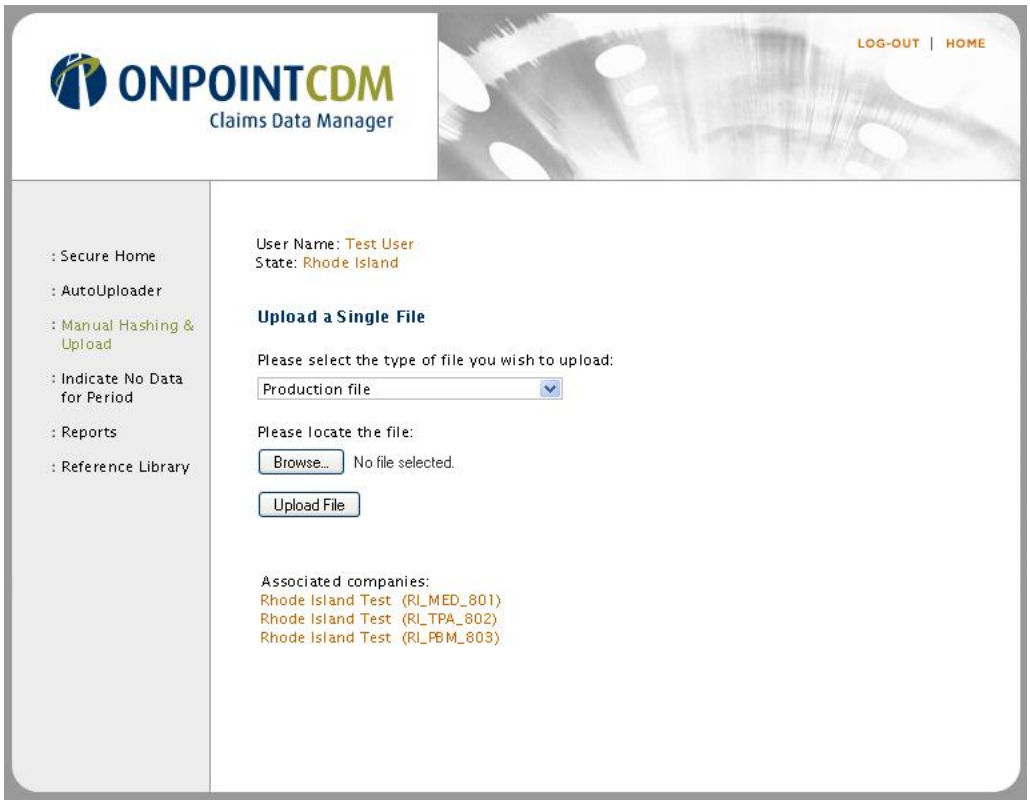
1. The next step of the manual process requires you to designate whether you plan to upload a single file or multiple files instead. Do so by clicking the appropriate button under Step 2. (The following directions will discuss uploading a single file; skip to the next section if uploading multiple files.)

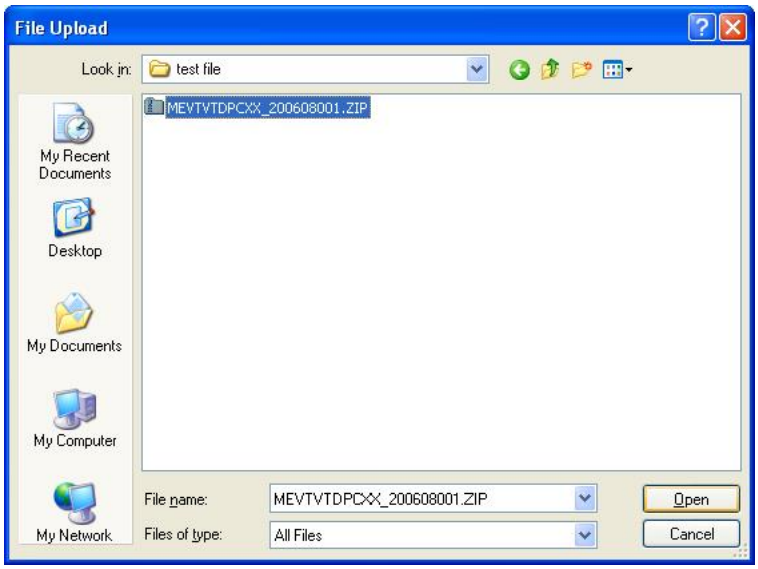


2. After clicking the UPLOAD A SINGLE FILE button, designate the type of file — production or test — that you plan to upload. (Since most payers have entered production with Onpoint's system, the default selection is a production file. If in the testing phase, simply use the drop-down option to change the file type.)

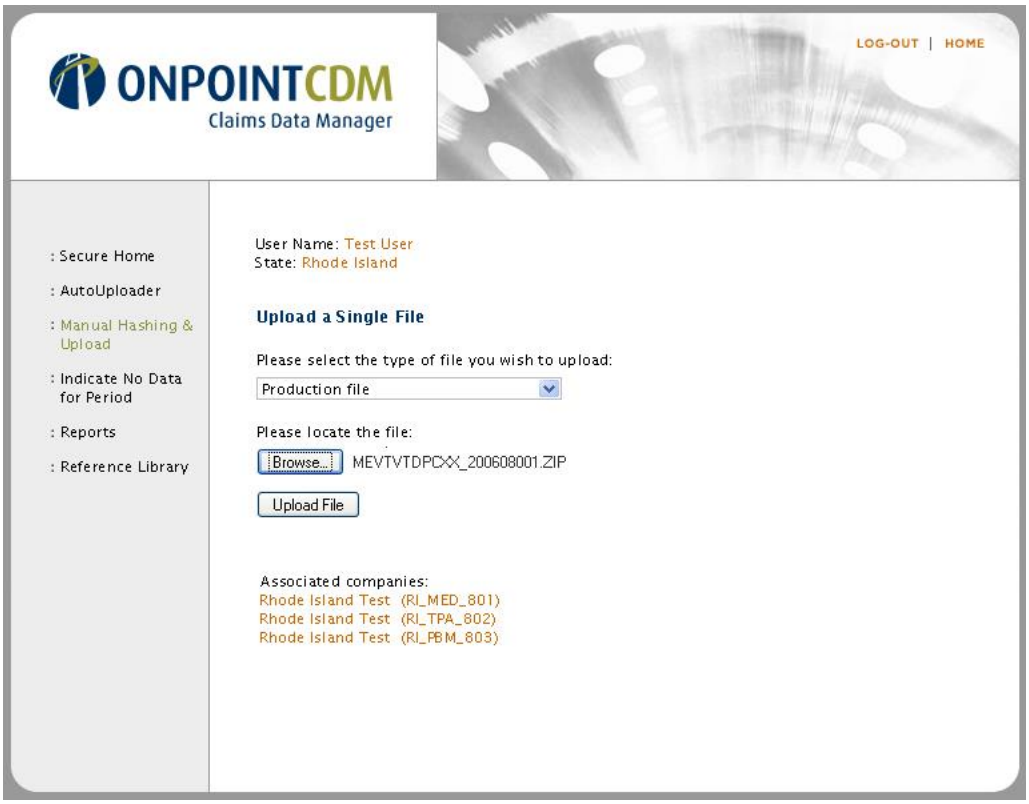


3. Next, click the BROWSE button to locate the file within your local system that you plan to upload. Do so by using the FILE UPLOAD pop-up dialog box and clicking OPEN.

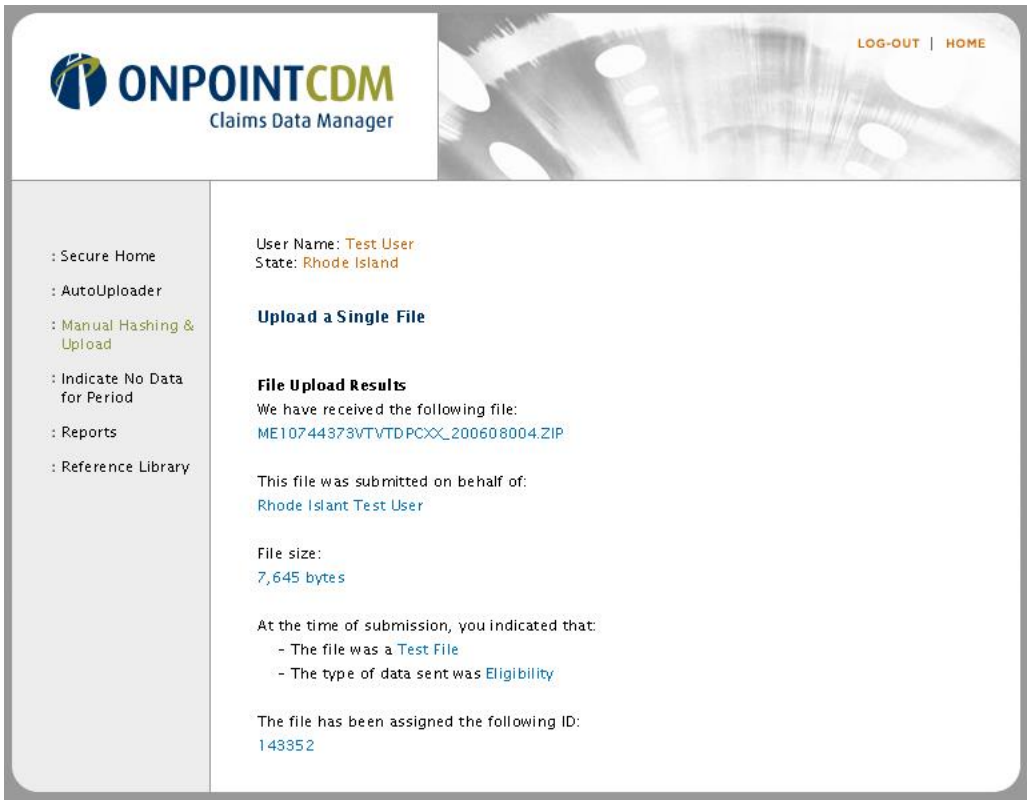




4. After verifying the correct file selection by examining the displayed file name to the right of the BROWSE button, click the UPLOAD FILE button to begin transmission to Onpoint.



5. Once your file has been submitted to Onpoint CDM, a response file will notify you of the upload results, providing documentation that can be used to track your submission.

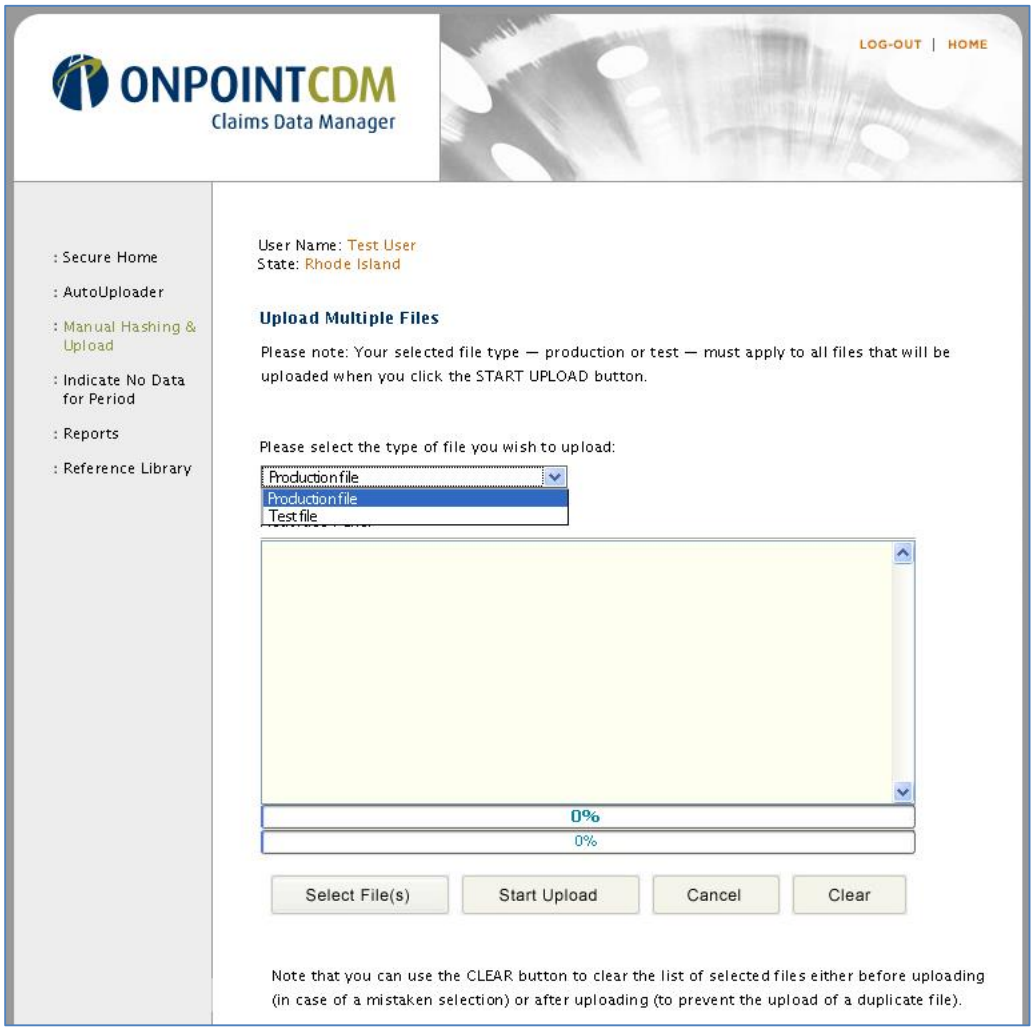


Uploading Multiple Files

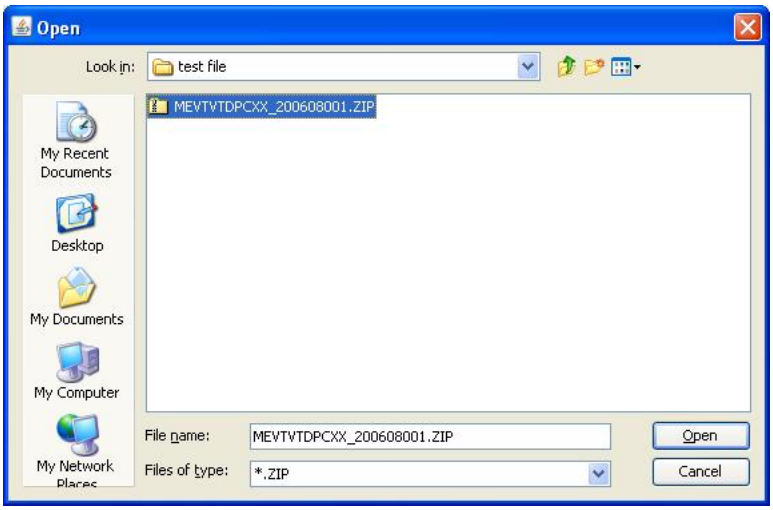
1. Manually uploading multiple files follows a similar path. After manually hashing your data, click instead on the UPLOAD MULTIPLE FILES button.

2. Depending on your browser's cache file and session storage, Java may need to reload. If so, you will see the animated Java icon with a progress bar (below).

3. Once the Java applet has loaded, use the drop-down menu to identify whether your files are production or test files. (Note that all files submitted during a manual upload must be of the same type.) You may use the multiple file uploader to submit files for more than one state at the same time, and you may select as many files as you wish to upload at one time.



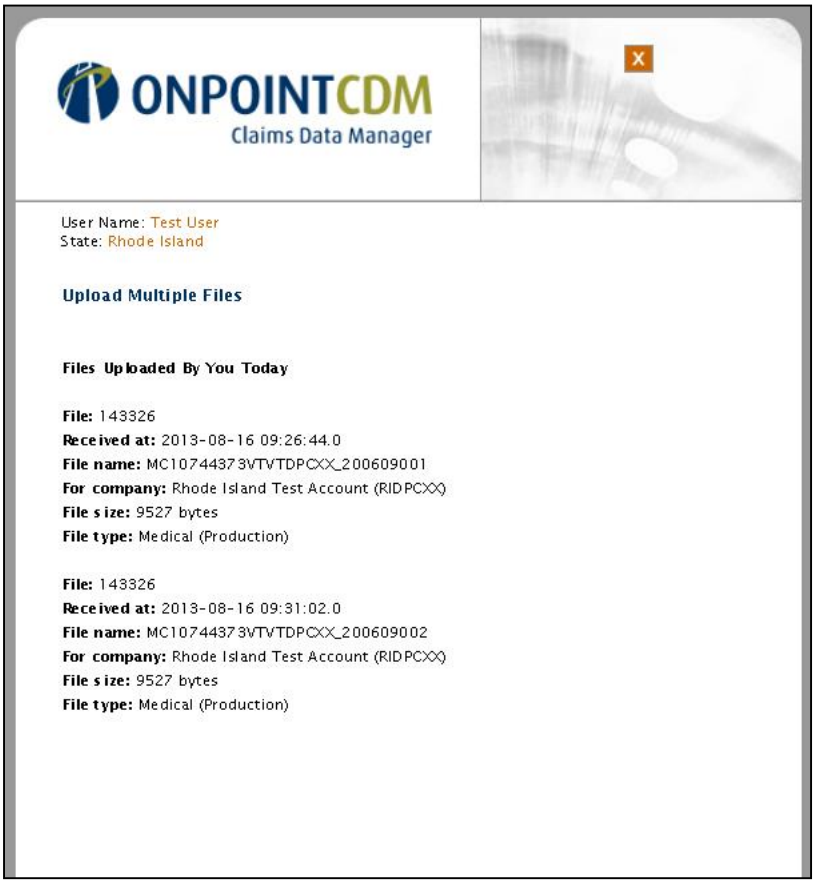
4. Click on the SELECT FILES(S) button at the bottom of the screen and browse to find the hashed files to be uploaded. Verify your file selection by checking the session's Activity Panel in the center of the screen.



5. After selecting the files that you wish to upload, click the START UPLOAD button. Note that you can use the CLEAR button to clear the list of selected files either before uploading (in case of a mistaken selection) or after uploading (to prevent the upload of a duplicate file).

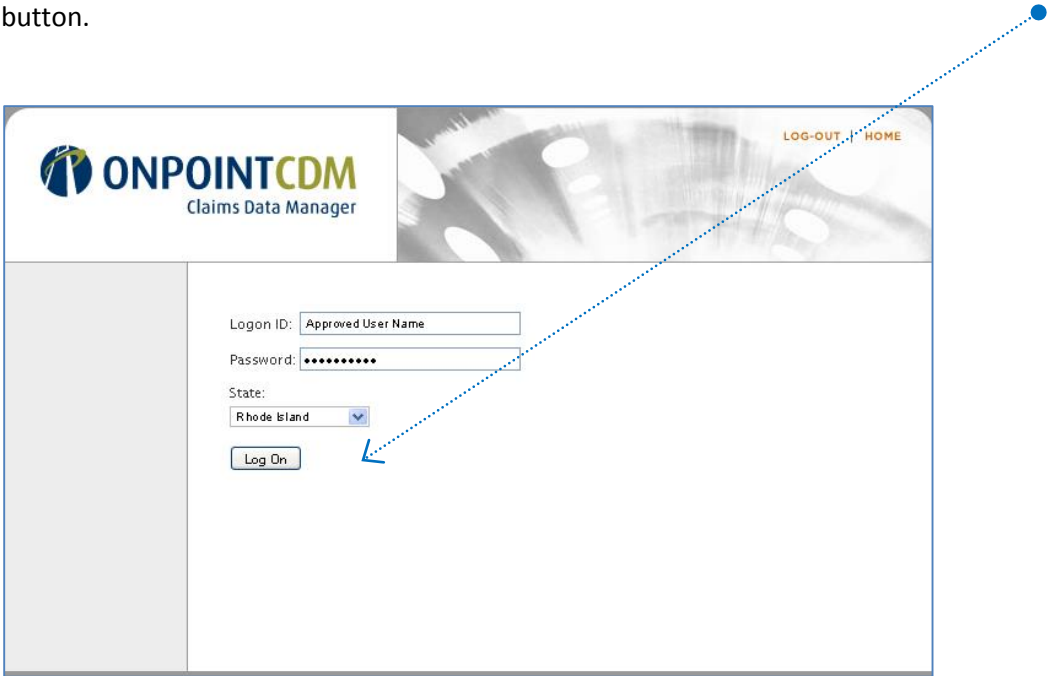
6. While your files are uploading, the upper progress bar shows the percentage complete for the file currently being uploaded. The lower progress bar shows the percentage of files that have completed the upload process. You can click CANCEL if you wish to stop the upload. When all of your files have finished uploading, your screen will show a status message for each one.

7. Additionally, when your files have finished uploading, a window or tab will open with a report on all of the files that you have uploaded today.



Monitoring Your Submissions

Credentialed users can log in to Onpoint CDM anytime to monitor the status of their submissions, including up-to-date reporting on stage, status, reasons for file failure, and resubmission deadlines. Gaining access begins at the Onpoint CDM home page. Simply click the LOG-IN option from the page's upper-right corner. Next, enter your Onpoint-assigned Logon ID and Password, select RHODE ISLAND from the drop-down list of states, and click the LOG ON button.



Upon being verified by the system, you will be presented with the secure portal's user options with access to hashing, upload, and reporting tools based on your authorized permissions.

Supporting Payers

Onpoint CDM's data quality validations can be a complex and rigorous test for submitters, which is why we will work hand in hand with your technical staff to understand and meet Rhode Island's established data layouts, quality and completeness thresholds, and compliance processes.

Onpoint's data intake specialists are the human face of Onpoint CDM, distinguishing us from other vendors in service to submitters. We don't simply fail a submission and abandon submitters to resolve issues on their own; we help you find the solutions that both you and the State need. Our ultimate goal is to arrive at a solution that is efficient and programmable for the submitter while not compromising the timeliness and quality of the submitted data.

Onpoint CDM includes automated alerts and hands-on support — on the phone, by email, via webinar tools, etc. — to help resolve any issues as soon as they arise. We tackle these issues through two key tools: submission tracking and status updates.

Submission & Status Tracking

Throughout the entire data flow, Onpoint CDM monitors each submission from start to finish — and enables submitters to do the same. Onpoint CDM provides authorized data reporters with a series of tracking tools, including an updated log of each submission's status, frequency reports, and validation reports.

When your submission passes all phases — or at any failure prior to final review — Onpoint CDM will send you an email alert. Submissions that fail any threshold check trigger an auto-generated failure notice, which is created instantly at the time of failure and refers submitters to an online report documenting the failure. Submissions that fail a data quality check trigger a review by Onpoint's data intake team, who notify the submitter, identify the data problem, provide examples of the records failing the validation, and enumerate the necessary next steps. For more complex problems, intake staff also work with payers to suggest the probable cause and propose the likely fix. This process generally takes less than 48 hours following file processing. See Table 4 below for a summary of common stage and status categories.

All failure notices alert submitters to any required resubmission and include details regarding the data type, data period, and due date. Resubmission due dates are tracked by Onpoint CDM, which captures sufficient information to identify the submitter, the submission, the date due, the date received, the date entered, the submission stage, the submission status, and any additional comments, allowing our intake staff to track and report on compliance and resubmissions.

Table 4. Data Stage & Status Categories

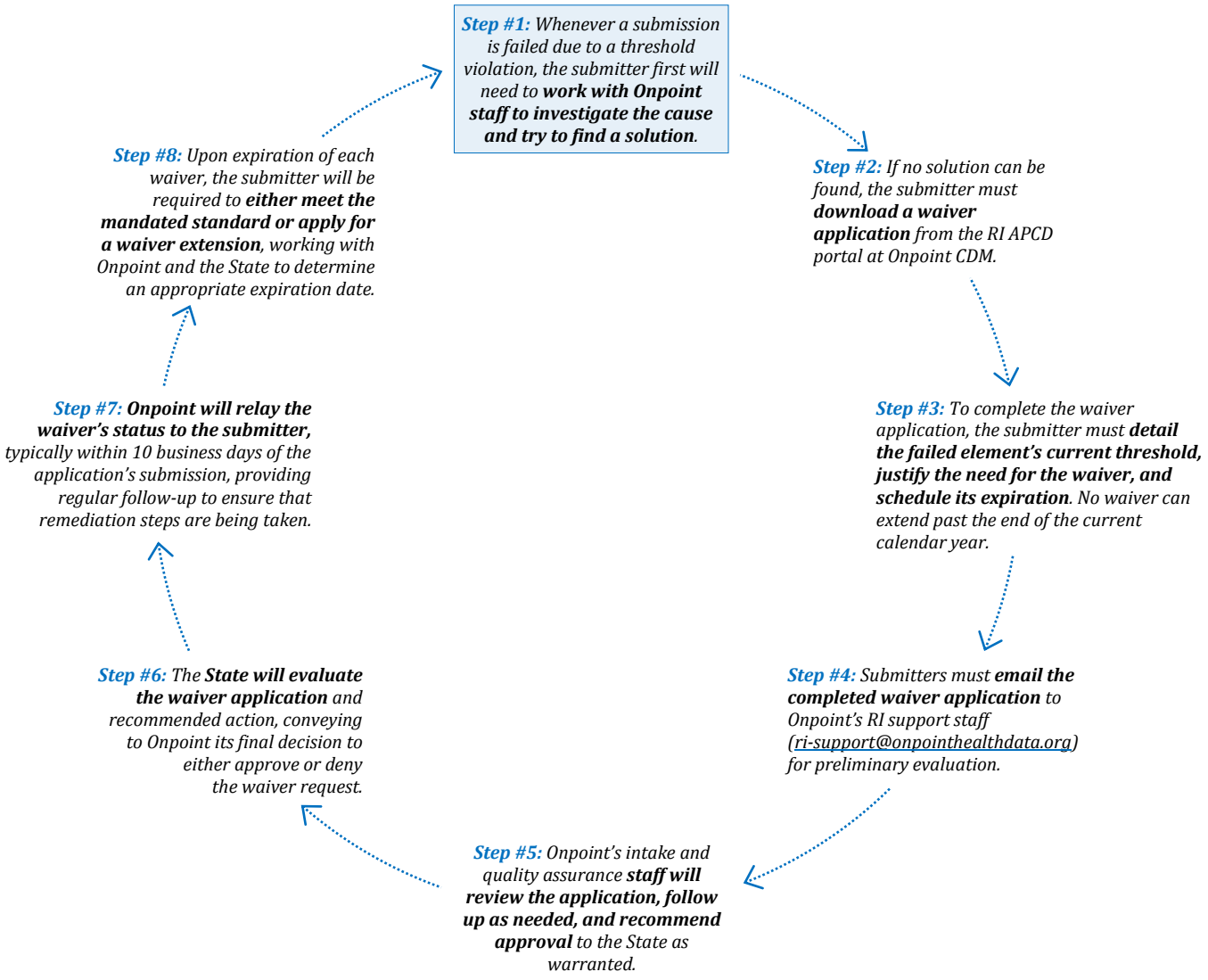
Stage	Status	Description	Typical Follow-Up Action Required
PRELIM	**REJECTED**	File has been rejected in the preliminary stage since a preceding version has been extracted	Reason for resubmission
PRELIM	**FAIL**	File has failed the preliminary stage for not meeting field requirements	Resubmission
LOAD	**FAIL**	File has failed the load stage for not meeting the default threshold on particular fields	Resubmission or request for a waiver to the threshold
DELETE	**DONE**	File has been replaced and deleted	None
DQ	**FAIL**	File has failed the data quality validations	Resubmission to correct failing validations
DQ	**HOLD**	File has some questionable data quality validations that are failing	Resubmission or explanation on failing validations
DQ	**REVIEW**	File has entered data quality review	Manual review by Onpoint's staff
DQ	**PASS**	File has passed the data quality validations	None
REPLACED	**FAIL**	Failed file has been replaced	None
REPLACED	**PASS**	Passed file has been replaced	None
TRANSMIT	**INHOUSE**	File has been received in house and is in the queue for processing	None

Requesting a Variance from the State's Standards

Throughout the course of capturing data for the RI APCD, it may be necessary to make exceptions to the State's mandated data thresholds — most commonly when a payer's system does not collect a required element or has special considerations based on the population that they serve. When these situations arise, Onpoint CDM enables the state to authorize payer-specific overrides and variances. Approved variances have a built-in expiration date, requiring payers to reapply and justify any continuing exception on a regular basis.

Rhode Island submitters wishing to apply for a variance may download an application form at Onpoint CDM's section for the RI APCD (www.onpointcdm.org). Completed applications must be returned to Onpoint for pre-processing followed by official review and consideration by the State. An overview of the process follows in Figure 7:

Figure 7. An Overview of the Variance Process



General File Specifications

Basic Rules

- **Header and trailer records.** Each submission regardless of type — eligibility, medical claims, pharmacy claims, and provider — must begin with a header record and end with a trailer record (example header and trailer records for a test eligibility submission of 4,350 records for June 2012 are included below).
- **Submitting multiple months at once.** You may submit multiple complete months of data with one pair of header and trailer records by indicating the earliest year and month in HD005 and TR005 and the latest year and month in HD006 and TR006. Note that each month of data will be evaluated for completeness in its own right and will pass or fail as if it were submitted as a single month of data. If a submitter provides a single file with six months of data for January through June and all months except May pass all checks, May will be rejected and the submitter will be asked to correct and resend only May data. No partially complete months are allowed.
- **Indicating missing data.** When two or more asterisks appear together, there is no data for the field. For example, in the Eligibility File example below, the lack of data between the asterisks highlighted in yellow indicate fields that are unavailable for reporting.

Header

Enrollment data (before hashing)

Trailer

```
HD*RIC0000Z**ME*201206*201206*4350

RIC0000Z*PS*2012*06*CTZ1245889*18*M*19520708*PROVIDENCE*RI*55311*Y*N*3*****CROSBY*FRANKLIN**CROSBY*FRANKLIN**ME
RIC0000Z*PS*2012*06*CTZ1245889*01*F*19550328*PROVIDENCE*RI*55311*Y*N*3******CROSBY*FRANKLIN**CROSBY*LUCY**ME
RIC0000Z*PS*2012*06*CTZ003456F*18*F*19800326*CRANSTON*RI*55985*Y*N*3******PLATT*AMELIA*J*PLATT*AMELIA*J*ME
RIC0000Z*PS*2012*06*CTZ003456F*19*F*20060603*CRANSTON*RI*55985*Y*N*3******PLATT*AMELIA*J*PLATT*ANN*T*ME
RIC0000Z*PS*2012*06**18*M*19630407*WARWICK*RI*56359*Y*N*3******OROURKE*JAMES**OROURKE*JAMES**ME
RIC0000Z*PR*2012*06**18*M*19750504*RICHMOND*RI*55042*Y*N*3******LAMOREAU*JOHN**LAMOREAU*JOHN**ME
.........

TR*RIC0000Z**ME*201206*201206*20120924
```

- **No punctuation.** Punctuation should not be included in the reporting of any names, including the names of drugs. For example, a last name of O'Rourke should be reported as "OROURKE".
- **No decimal points.** Decimal points should not be included in the reporting of financial fields. For example, a dollar amount of $120.56 should be reported as "12056".
- **Date formats.** Dates, unless otherwise specified, should be reported using the 8-digit format of CCYYMMDD. For example, January 18, 1972, should be reported as "19720118".
- **Review the online FAQs.** Please refer to the FAQs section at Onpoint CDM's website — www.onpointcdm.org — for additional information and updates regarding the population of data fields.

Eligibility File

The Basics

Key References R23-17.17-RIAPCD §1.21 and §4.3.c

Covered Parties All

Required Frequency Either monthly or quarterly (in adherence to calendar-year quarters; for example, Q1 data should be submitted to Onpoint prior to May 31)

Specific Deadline Within 10 business days of receipt of Unique Member Identifiers from the Lockbox Vendor (§5.2.c.4.i)

Important Notes

- One record must be submitted for each member who had coverage during the period reported in the header and trailer records.
- Submissions must cover full months of data; partial months must not be reported.
- Full data for every member who had coverage during the period reported and has a reported Member Opt-Out Status (RF018) of either I (included) or U (unknown) must be included in the submitted eligibility file.
- Each member who had coverage during the period reported but instead has a reported Member Opt-Out Status (RF018) of O (opted out) must have only the following fields included in the submitted eligibility file: Submitter Code (ME001), Year (ME004), Month (ME005), Unique Member Identifier (ME010A), Member Opt-Out Status (ME010D), and Record Type (ME899); all other fields for this member must be reported as null.

Columns Included in the Eligibility File

Indicates the element's required position within the submission file	Indicates the element's reference number	Indicates the element's name	Indicates whether or not the element's true value has been rendered permanently non-recoverable by one-way hashing prior to submission to Onpoint	Indicates whether the type of data for the element is a date, decimal, integer, or text	Indicates the maximum length allowed for this element	Provides a general description of the data element, including valid codes for elements whose acceptable codes vary from industry standards and for elements that lack a national standard altogether. Values appended with superscript text in blue (e.g., + 01/01/2012) note the effective date of newly valid values; those with strikethrough text (i.e., ~~strikethrough~~) are no longer valid and have their expiration dates appended in red superscript text (e.g., x 12/31/2011).	Indicates the element's X12 reference standard	Indicates the percent of submitted records for which this element must have a valid code	Indicates the type of records to be used to calculate the threshold percent for submission. Note: Denominators are comprised of records for only those members with an opt-out status of I (included) or U (unknown) unless the field is shaded gold. For gold-shaded fields, denominators also include records for members with an opt-out status of O (opted out) to enable QA review.
↓	↓	↓	↓	↓	↓	↓	↓	↓	↓
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	X12 REF	THRESH.	DENOM.

File Layout & Specifications

ELIGIBILITY FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	X12 REF	THRESH.	DENOM.
1	HD001	Record Type	N	Text	2	This field must be coded HD to indicate the start of the header record.	Administrative element	100%	All
2	HD002	Submitter Code	N	Text	8	This field must contain the submitter code assigned to you by Onpoint Health Data.	Administrative element	100%	All
3	HD003	Placeholder	N	Text	30	This field must be coded as null; it is reserved for header consistency across all clients using Onpoint Health Data's APCD services.	Administrative element	0%	All
4	HD004	Type of File	N	Text	2	This field must be coded ME to indicate submission of eligibility data.	Administrative element	100%	All
5	HD005	Period Beginning Date	N	Integer	6	Use this field to report the earliest eligibility year/month included in the submission in CCYYMM format. Submissions with records containing an eligibility period (ME004, ME005) before this date will fail.	Administrative element	100%	All
6	HD006	Period Ending Date	N	Integer	6	Use this field to report the latest eligibility year/month included in the submission in CCYYMM format. Submissions with records containing an eligibility period (ME004, ME005) after this date will fail.	Administrative element	100%	All
7	HD007	Record Count	N	Integer	10	Use this field to report the total number of records in the submission, excluding the header and trailer records. If the number of records within the submission does not equal the number reported in this field, the submission will fail.	Administrative element	100%	All
8	HD008	Comments	N	Text	80	This field may be used by the submitter to document a file name, system source, or other administrative device to assist with their internal tracking of the submission.	Administrative element	0%	All
1	ME001	Submitter Code	N	Text	8	Use this field to report your Onpoint-assigned submitter code for the data submitter. Note that the first two characters of the submitter code are used to indicate the reporting state and the third character designates the type of submitter. For Rhode Island's APCD collection, valid prefixes include: RIC..... Commercial carrier RIG ..... Governmental agency RIT..... Third-party administrator **Notes:** A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter.	Administrative element	100%	All
2	ME002	NAIC	N	Text	5	Use this field to report, at a record level, the code as assigned by the NAIC that uniquely identifies the applicable insurance plan. If no NAIC number has been assigned, report as "0".	271/2100A/NM1/NI/09	100%	All

ELIGIBILITY FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	X12 REF	THRESH.	DENOM.
3	ME003	Insurance Type / Product Code	N	Text	2	Use this field to report the member's type of insurance or insurance product. **Notes:** The value reported for this field should be reported consistently in the "Insurance Type / Product Code" field in both the medical claims (MC003) and pharmacy claims (PC003) data. To ensure reporting consistency between submitters, all Medicare Advantage plans should use the code "HN" to denote a Health Maintenance Organization (HMO) – Medicare Risk. Valid codes are maintained by the Accredited Standards Committee (ASC) and are available in the ASC X12 transaction set.	271/2110C/EB/ /04, 271/2110D/EB/ /04	100%	All
4	ME004	Year	N	Integer	4	Use this field to report the year of eligibility using a 4-digit format of CCYY (e.g., January 1972, would be coded as "1972").	N/A	100%	All
5	ME005	Month	N	Text	2	Use this field to report the month of eligibility using a 2-digit format of MM (e.g., January would be coded as "01").	N/A	100%	All
6	ME005A	Days Eligible	N	Integer	3	Use this field to report the number of days for which the member was eligible during this reporting period.	N/A	99.9%	All
7	ME006	Insured Group or Policy Number	N	Text	50	Use this field to report the group or policy number. **Notes:** The value reported for this field should be reported consistently in the "Insured Group or Policy Number" field in both the medical claims (MC006) and pharmacy claims (PC006) data. This is not the number that uniquely identifies the subscriber. If a policy is sold to an individual as a non-group policy, then both the Insured Group or Policy Number (ME006) and Group Name (ME037) should be reported with a value of "IND". This principle pertains to all claim types: commercial, Medicaid, and Medicare.	271/2100C/REF/1L/02, 271/2100C/REF/IG/02, 271/2100C/REF/6P/02, 271/2100D/REF/1L/02, 271/2100D/REF/IG/02, 271/2100D/REF/6P/02	99.5%	All
8	ME007	Coverage Level Code	N	Text	3	Use this field to report the benefit level of coverage. **Notes:** Valid codes are maintained by the Accredited Standards Committee (ASC) and are available in the ASC X12 transaction set.	271/2110C/EB/ /02, 271/2110D/EB/ /02	99.9%	All
9	ME008	Subscriber Social Security Number	Y	Text	9	Use this field to report the subscriber's 9-digit Social Security number. **Notes:** The value reported for this field should be reported consistently in the "Subscriber Social Security Number" field in both the medical claims (MC007) and pharmacy claims (PC007) data. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	271/2100C/REF/SY/02	99.9%	All
10	ME009	Plan-Specific Contract Number	Y	Text	80	Use this field to report the submitter-assigned contract number for the subscriber. **Notes:** The value reported for this field should be reported consistently in the "Plan-Specific Contract Number" field in both the medical claims (MC008) and pharmacy claims (PC008) data. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	271/2100C/NM1/MI/09	99.9%	All

ELIGIBILITY FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	X12 REF	THRESH.	DENOM.
11	ME010	Member Suffix or Sequence Number	N	Text	20	Use this field to report the unique number of the member within the contract.	N/A	50%	All
12	ME010A	Unique Member Identifier	N	String	32	Use this field to report the Unique Member Identifier assigned by the Lockbox Vendor. **Notes:** The value for this field will be supplied in the Response File from the Lockbox Vendor using the field RF017. The value reported for this field should be reported consistently in the Unique Member Identifier field in both the medical claims (MC010A) and pharmacy claims (PC010A) data.	Administrative element	100%	All
13	ME010B	Unique Member Identifier (Legacy)	N	String	32	Use this field to report the Unique Member Identifier (Legacy) previously assigned by the Lockbox Vendor. **Notes:** The value for this field will be supplied in the Response File from the Lockbox Vendor using the field RF020. This legacy ID has been replaced by the Unique Member Identifier reported above in ME010A. This change is due to the merging or splitting of the member's previously assigned Unique Member Identifier as identified by the code reported in the Response File from the Lockbox Vendor using the field RF019 (and below in ME010C).	Administrative element	0%	All
14	ME010C	Unique Member Identifier Merge/Split Indicator	N	Text	1	Use this field to report a code that indicates whether a legacy ID was created because a member's ID was merged with another ID (for a member identified by the Lockbox Vendor as being reported duplicatively) or split into a different ID (for a member identified by the Lockbox Vendor as incorrectly previously grouped under a single Unique Member ID). The only valid codes for this field are: M ..... Merged S ..... Split **Notes:** The value for this field will be supplied in the Response File from the Lockbox Vendor using the field RF019.	Administrative element	100%	ME010B is populated

ELIGIBILITY FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	X12 REF	THRESH.	DENOM.
15	ME010D	Member Opt-Out Status	N	Text	1	Use this field to indicate that a member has elected to opt out of having their data submitted to the APCD as provided to you in the Lockbox Vendor's Response File using field RF018. The only valid codes for this field are: I..... Included O ..... Omitted U ..... Unknown **Notes:** The value for this field will be supplied in the Response File from the Lockbox Vendor using the field RF018. Even though you may have submitted a value of I for this field to the Lockbox Vendor, indicating inclusion in the APCD, the member may have requested to opt out via another insurer or the Opt-Out Portal, therefore, therefore requiring a value of O to be returned to all insurers providing coverage for the same individual. If the value reported in the Member Opt-Out Status field is O, the only reportable data fields for this record are Submitter Code (ME001), Year (ME004), Month (ME005), Unique Member Identifier (ME010A), and Member Opt-Out Status (ME010D) and Record Type (ME899); all other fields must be reported as null.	Administrative element	100%	All
16	ME011	Member Social Security Number	Y	Text	9	Use this field to report the member's 9-digit Social Security number. **Notes:** The value reported for this field should be consistently reported in the "Member Social Security Number" field in both the medical claims (MC010) and pharmacy claims (PC010) data. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	271/2100C/REF/SY/02, 271/2100D/REF/SY/02	75%	All
17	ME012	Member Relationship	N	Text	2	Use this field to report the member's relationship to the subscriber or the insured. **Notes:** The value reported for this field should be consistently reported in the "Member Relationship" field in both the medical claims (MC011) and pharmacy claims (PC011) data. Valid codes are maintained by the Accredited Standards Committee (ASC) and are available in the ASC X12 transaction set.	271/2100C/INS/Y/02, 271/2100D/INS/N/02	100%	All
18	ME013	Member Gender	N	Text	1	Use this field to report the member's gender. The only valid codes for this field are: F ..... Female M ..... Male U ..... Unknown **Notes:** The value reported for this field should be consistently reported in the "Member Gender" field in both the medical claims (MC012) and pharmacy claims (PC012) data.	271/2100C/DMG/ /03, 271/2100D/DMG/ /03	100%	All

ELIGIBILITY FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	X12 REF	THRESH.	DENOM.
19	ME014	Member Date of Birth	Y	Date	8	Use this field to report the member's date of birth using an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118"). **Notes:** The value reported for this field should be consistently reported in the "Member Date of Birth" field in both the medical claims (MC013) and pharmacy claims (PC013) data. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Immediately prior to hashing this field, Onpoint's hashing application calculates a member's age in months based on the Member Date of Birth field (ME014, MC013, PC013). The Member Date of Birth field is then hashed and both the hashed value and the value-added Age in Months element are submitted to the APCD — the hashed value to allow for quality assurance review, the de-identified Age in Months to enable analytic use of the APCD.	271/2100C/DMG/D8/02, 271/2100D/DMG/D8/02	99.5%	All
20	ME015	Member City	N	Text	30	Use this field to report the name of the member's city of residence.	271/2100C/N4/ /01, 271/2100D/N4/ /01	99.5%	All
21	ME016	Member State or Province	N	Text	2	Use this field to report the member's state or province using the two-character abbreviation code defined by the U.S. Postal Service (for U.S. states) and Canada Post (for Canadian provinces).	271/2100C/N4/ /02, 271/2100D/N4/ /02	99.5%	All
22	ME017	Member ZIP/Postal Code	N	Text	9	Use this field to report the ZIP/postal code of the member's residence. **Notes:** For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code). Do not code dashes or spaces within ZIP/postal codes.	271/2100C/N4/ /03, 271/2100D/N4/ /03	99.5%	All
23	ME018	Medical Coverage	N	Text	1	Use this field to report whether or not the member had medical coverage during the reported period. The only valid codes for this field are: Y..... Yes N ..... No	Administrative element	100%	All
24	ME019	Prescription Drug Coverage	N	Text	1	Use this field to report whether or not the member had prescription drug coverage during the reported period. The only valid codes for this field are: Y..... Yes N ..... No	Administrative element	100%	All
25	ME021	Race - 1	N	Text	6	Use this field to report the member's primary race. The only valid codes for this field are: R1..... American Indian/Alaska Native R2..... Asian R3..... Black/African American R4..... Native Hawaiian or other Pacific Islander R5..... White R9..... Other Race UNKNOW ..... Unknown / Not specified **Notes:** The code "UNKNOW" (Unknown / not specified) should be used only when a member answers unknown or refuses to answer. If data has not been collected, leave as null.	N/A	3%	All

ELIGIBILITY FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	X12 REF	THRESH.	DENOM.
26	ME022	Race - 2	N	Text	6	Use this field to report the member's secondary race. The only valid codes for this field are: R1..... American Indian/Alaska Native R2..... Asian R3..... Black/African American R4..... Native Hawaiian or other Pacific Islander R5..... White R9..... Other Race UNKNOW ..... Unknown / Not specified **Notes:** The code "UNKNOW" (Unknown / not specified) should be used only when a member answers unknown or refuses to answer. If data has not been collected, leave as null.	N/A	0%	All
27	ME023	Race - Other	N	Text	15	Use this field to report a member's self-disclosed race when ME021 or ME022 is reported as R9 (Other Race). **Notes:** Leave null if not applicable.	N/A	99%	ME021 or ME022 = R9
28	ME024	Hispanic Indicator	N	Text	1	Use this field to report whether or not a member has identified as Hispanic. The only valid codes for this field are: Y..... Yes N ..... No U ..... Unknown **Notes:** If the data has not been collected, leave as null.	N/A	3%	All

ELIGIBILITY FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	X12 REF	THRESH.	DENOM.
29	ME025	Ethnicity - 1	N	Text	6	Use this field to report the member's primary ethnicity. The only valid codes for this field are: 2182-4..... Cuban 2184-0..... Dominican 2148-5..... Mexican, Mexican American, Chicano 2180-8..... Puerto Rican 2161-8..... Salvadoran 2155-0..... Central American (not otherwise specified) 2165-9..... South American (not otherwise specified) 2060-2..... African 2058-6..... African American AMERCN..... American 2028-9..... Asian 2029-7..... Asian Indian BRAZIL..... Brazilian 2033-9..... Cambodian CVERDN..... Cape Verdean CARIBI ..... Caribbean Island 2034-7..... Chinese 2169-1..... Columbian 2108-9..... European 2036-2..... Filipino 2157-6..... Guatemalan 2071-9..... Haitian 2158-4..... Honduran 2039-6..... Japanese 2040-4..... Korean 2041-2..... Laotian 2118-8..... Middle Eastern PORTUG ..... Portuguese EASTEU..... Eastern European RUSSIA ..... Russian 2047-9..... Vietnamese OTHER..... Other ethnicity UNKNOW ..... Unknown / Not specified **Notes:** The code "UNKNOW" (Unknown / Not specified) should be used only when a member answers unknown or refuses to answer. If data has not been collected, leave as null.	N/A	3%	All

ELIGIBILITY FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	X12 REF	THRESH.	DENOM.
30	ME026	Ethnicity - 2	N	Text	6	Use this field to report the member's secondary ethnicity. The only valid codes for this field are: 2182-4..... Cuban 2184-0..... Dominican 2148-5..... Mexican, Mexican American, Chicano 2180-8..... Puerto Rican 2161-8..... Salvadoran 2155-0..... Central American (not otherwise specified) 2165-9..... South American (not otherwise specified) 2060-2..... African 2058-6..... African American AMERCN..... American 2028-9..... Asian 2029-7..... Asian Indian BRAZIL..... Brazilian 2033-9..... Cambodian CVERDN..... Cape Verdean CARIBI ..... Caribbean Island 2034-7..... Chinese 2169-1..... Columbian 2108-9..... European 2036-2..... Filipino 2157-6..... Guatemalan 2071-9..... Haitian 2158-4..... Honduran 2039-6..... Japanese 2040-4..... Korean 2041-2..... Laotian 2118-8..... Middle Eastern PORTUG ..... Portuguese EASTEU..... Eastern European RUSSIA ..... Russian 2047-9..... Vietnamese OTHER..... Other ethnicity UNKNOW ..... Unknown / Not specified **Notes:** The code "UNKNOW" (Unknown / Not specified) should be used only when a member answers unknown or refuses to answer. If data has not been collected, leave as null.	N/A	0%	All
31	ME027	Ethnicity - Other	N	Text	20	Use this field to report a member's self-disclosed ethnicity when either ME025 or ME026 is reported as OTHER (Other ethnicity). **Notes:** Leave null if not applicable.	N/A	99.9%	ME025 or ME026 = OTHER

ELIGIBILITY FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	X12 REF	THRESH.	DENOM.
32	ME028	Primary Insurance Indicator	N	Text	1	Use this field to report whether or not this coverage is primary. The only valid codes for this field are: Y..... Yes N ..... No P..... Partial (for Medicaid use only; includes CNOM, EFT, etc.)	N/A	99.9%	All
33	ME029	Coverage Type	N	Text	3	Use this field to report the type of coverage, distinguishing self-funded plans from commercially insured plans. The only valid codes for this field are: ASW ..... Self-funded plans that are administered by a third-party administrator, where the employer has purchased stop-loss or group excess insurance coverage ASO ..... Self-funded plans that are administered by a third-party administrator, where the employer has not purchased stop-loss or group excess insurance coverage STN..... Short-term, non-renewable health insurance UND ..... Plans underwritten by the insurer OTH..... Any other plan	N/A	99.9%	All
34	ME030	Market Category Code	N	Text	4	Use this field to report the type of policy sold by the insurer. The only valid codes for this field are: IND..... Policies sold and issued directly to individuals (i.e., a non-group policy) FCH ..... Policies sold and issued directly to individuals on a franchise basis GCV ..... Policies sold and issued directly to individuals as group conversion policies GS1..... Policies sold and issued directly to employers having exactly one employee GS2..... Policies sold and issued directly to employers having between two and nine employees GS3..... Policies sold and issued directly to employers having 10–25 employees GS4..... Policies sold and issued directly to employers having 26–50 employees GS5..... Policies sold and issued directly to employers having 1–50 employees GLG0 ..... Policies sold and issued directly to employers having 51 or more employees GLG1 ..... Policies sold and issued directly to employers having 51–~~99~~100 employees GLG2 ..... Policies sold and issued directly to employers having ~~100 or more~~ 101–250 employees GLG3 ..... Policies sold and issued directly to employers having 251–500 employees GLG4 ..... Policies sold and issued directly to employers having 501 or more employees GSA ..... Policies sold and issued directly to small employers through a qualified association trust OTH..... Policies sold to other types of entities	N/A	99.9%	All
35	ME031	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A	N/A
36	ME032	PCMH Assigned Flag	N	Text	1	Use this field to report whether or not the member has an approved medical home for this coverage period. The only valid codes for this field are: Y..... Yes N ..... No U ..... Unknown	Administrative element	100%	All

ELIGIBILITY FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	X12 REF	THRESH.	DENOM.
37	ME033	PCMH Number	N	Text	30	Use this field to report the submitter-assigned number for the medical home when ME032 is reported as Y. **Notes:** Leave null if not applicable.	Administrative Element	90%	ME032 = Y
38	ME034	PCMH Tax ID	N	Text	9	Use this field to report the federal taxpayer's identification number for the medical home when ME032 is reported as Y. **Notes:** Leave null if not applicable.	Administrative Element	90%	ME032 = Y
39	ME035	PCMH NPI	N	Text	10	Use this field to report the National Provider Identifier (NPI) for the medical home when ME032 is reported as Y. **Notes:** Leave null if not applicable.	Administrative Element	10%	ME032 = Y
40	ME036	PCMH Name	N	Text	60	Use this field to report the full name of the medical home when ME032 is reported as Y. **Notes:** If an individual, report in the format of last name, first name, and middle initial with no punctuation (e.g., John J. Doe would be reported as "DOEJOHNJ"). Leave null if not applicable.	Administrative Element	90%	ME032 = Y
41	ME037	Group Name	N	Text	60	Use this field to report the name of the group that covers the member. **Notes:** If a policy is sold to an individual as a non-group policy, then both the Insured Group or Policy Number (ME006) and Group Name (ME037) should be reported with a value of "IND". This principle pertains to all claim types: commercial, Medicaid, and Medicare.	834/2100D/NM1/36/03	90%	All
42	ME050	Assigned Primary Care Provider Flag	N	Text	1	Use this field to report whether or not the member identified a primary care provider at the time of enrollment. The only valid codes for this field are: Y ..... Yes N ..... No U ..... Unknown	Administrative element	100%	All
43	ME051	Assigned Primary Care Provider Plan ID	N	Text	50	Use this field to report the submitter-assigned or legacy provider plan ID for the member's primary care provider. **Note:** The provider data reported in the eligibility, claims, and provider files are used to create a Provider Master Index that is used to match the data across all file types. It is expected that a provider's identifiers (e.g., plan-assigned ID, NPI, etc.) will be reported consistently by a submitter across file types as this is the payer-assigned provider ID (ME051, MC024, PC048A, PV006).	834/2310/NM1/P3/SV/09	99%	ME050 = Y
44	ME052	Assigned Primary Care Provider NPI	N	Text	10	Use this field to report the National Provider Identifier (NPI) for the member's assigned primary care provider.	834/2310/NM1/P3/XX/09	99%	ME050 = Y
45	ME053	Assigned Primary Care Provider Last Name	N	Text	60	Use this field to report the last name of the member's assigned primary care provider.	834/2310/NM1/P3/03	99%	ME050 = Y
46	ME054	Assigned Primary Care Provider First Name	N	Text	35	Use this field to report the first name of the member's assigned primary care provider.	834/2310/NM1/P3/04	99%	ME050 = Y

ELIGIBILITY FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	X12 REF	THRESH.	DENOM.
47	ME055	Assigned Primary Care Provider Middle Initial	N	Text	1	Use this field to report the middle initial of the member's assigned primary care provider.	834/2310/NM1/P3/05	5%	ME050 = Y
48	ME056	Assigned Primary Care Provider Street Address 1	N	Text	55	Use this field to report the first line of the street address for the member's assigned primary care provider.	834/2310/N3/ /01	99%	ME050 = Y
49	ME057	Assigned Primary Care Provider Street Address 2	N	Text	55	Use this field to report the second line of the street address for the member's assigned primary care provider (if needed).	834/2310/N3/ /02	0%	ME050 = Y
50	ME058	Assigned Primary Care Provider City	N	Text	30	Use this field to report the city of the member's assigned primary care provider.	834/2310/N4/ /01	99%	ME050 = Y
51	ME059	Assigned Primary Care Provider State or Province	N	Text	2	Use this field to report the state or province of the member's assigned primary care provider using the two-character abbreviation defined by the U.S. Postal Service (for U.S. states) and Canada Post (for Canadian provinces).	834/2310/N4/ /02	99%	ME050 = Y
52	ME060	Assigned Primary Care Provider ZIP/Postal Code	N	Text	9	Use this field to report the ZIP/postal code of the member's assigned primary care provider. **Notes:** For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code). Do not code dashes or spaces within ZIP/postal codes.	834/2310/N4/ /03	99%	ME050 = Y
53	ME070	Purchased Through Exchange Indicator	N	Text	1	Use this field to indicate whether or not the product was purchased through the Rhode Island Health Benefits Exchange. The only valid codes for this field are: Y..... Yes, purchased through the Exchange N ..... No, not purchased through the Exchange	N/A	100%	All
54	ME071	Exchange Market Type	N	Text	2	Use this field to report the type of policy sold by the insurer through the Exchange. The only valid codes for this field are: IN ..... Individual SG ..... Small group SH..... SHOP	N/A	99%	ME070 = Y
55	ME072	HIOS ID	N	Text	17	Use this field to report the member's type of insurance or insurance product provided through the Exchange.	N/A	99%	ME070 = Y
56	ME073	Exchange Metallic Tier	N	Text	1	Use this field to report the metallic tier that designates the level of the member's Exchange product. The only valid codes for this field are: 1..... Bronze 2..... Silver 3..... Gold 4..... Platinum 5..... Catastrophic 0..... Unknown / Not Applicable	N/A	99%	ME070 = Y
57	ME080	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A	N/A
58	ME081	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A	N/A
59	ME082	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A	N/A

ELIGIBILITY FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	X12 REF	THRESH.	DENOM.
60	ME083	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A	N/A
61	ME084	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A	N/A
62	ME101	Subscriber Last Name	Y	Text	60	Use this field to report the subscriber's last name. **Notes:** The value reported for this field should be consistently reported in the "Subscriber Last Name" field in both the medical claims (MC101) and pharmacy claims (PC101) data. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	271/2100C/NM1/ /03	100%	All
63	ME102	Subscriber First Name	Y	Text	35	Use this field to report the subscriber's first name. **Notes:** The value reported for this field should be consistently reported in the "Subscriber First Name" field in both the medical claims (MC102) and pharmacy claims (PC102) data. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	271/2100C/NM1/ /04	100%	All
64	ME103	Subscriber Middle Initial	Y	Text	1	Use this field to report the subscriber's middle initial. **Notes:** The value reported for this field should be consistently reported in the "Subscriber Middle Initial" field in both the medical claims (MC103) and pharmacy claims (PC103) data. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	271/2100C/NM1/ / 05	50%	All
65	ME104	Member Last Name	Y	Text	60	Use this field to report the member's last name. **Notes:** The value reported for this field should be consistently reported in the "Member Last Name" field in both the medical claims (MC104) and pharmacy claims (PC104) data. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	271/2100C/NM1/ /03, 271/2100D/NM1/ /03	100%	All
66	ME105	Member First Name	Y	Text	35	Use this field to report the member's first name. **Notes:** The value reported for this field should be consistently reported in the "Member First Name" field in both the medical claims (MC105) and pharmacy claims (PC105) data. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	271/2100C/NM1/ /04, 271/2100D/NM1/ /04	100%	All
67	ME106	Member Middle Initial	Y	Text	1	Use this field to report the member's middle initial. **Notes:** The value reported for this field should be consistently reported in the "Member Middle Initial" field in both the medical claims (MC106) and pharmacy claims (PC106) data. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	271/2100C/NM1/ /05, 271/2100D/NM1/ /05	50%	All

ELIGIBILITY FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	X12 REF	THRESH.	DENOM.
68	ME201	Aid Category	N	Text	2	For Medicaid members only, use this field to report the member's Medicaid aid category based on service date.	N/A	99%	Medicaid
69	ME202	Dual Eligibility Code	N	Text	2	For Medicaid and Medicare members only, use this field to report whether or not a member had both Medicaid and Medicare coverage (i.e., dual coverage) for the reported membership month.	N/A	99%	Medicaid & Medicare
70	ME203	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A	N/A
71	ME205	Long-Term Care (LTC) Coverage Flag	N	Text	1	For Medicaid members only, use this field to report the level of care provided to a member who had long-term care coverage for the reported membership month.	N/A	99%	Medicaid
72	ME206	Attributed Income Level Code	N	Text	1	For Medicaid members only, use this field to report the member's attributed income level for the reported membership month. These codes are based on aid categories and tie back to a member's specific eligibility, which may cause overlap in code values.	N/A	99%	Medicaid
73	ME212	Third-Party Liability Flag	N	Text	1	For Medicaid members only, use this field to indicate that the member was covered by commercial insurance as well. The only valid codes for this field are: Y..... Yes N ..... No	N/A	99%	Medicaid
74	ME213	Medicaid Program Code	N	Text	2	Use this field to report the Medicaid program in which the member was enrolled for the reported month.	N/A	99%	Medicaid
75	ME401	Date of Death	N	Date	8	Use this field to report the member's date of death using an 8-digit format of CCYYMMDD (e.g., January 1972 would be coded as "197201").	N/A	0%	Medicaid & Medicare
76	ME402	Risk Score	N	Decimal	22,3	For Medicare members only, use this field to report the member's most recent risk score. Notes: Always report with three decimal places. Do not code the decimal place when reporting this field to Onpoint.	N/A	0%	Medicare
77	ME404	Hospice Status Indicator	N	Text	2	For Medicare members only, use this field to report whether or not a patient was enrolled in hospice.	N/A	0%	Medicare
78	ME405	Medicare Advantage Indicator	N	Text	2	For Medicare members only, use this field to report whether or not the member is a participant in a group health organization (GHO).	N/A	99%	Medicare
79	ME406	Medicare Status Indicator	N	Text	2	For Medicare members only, use this field to report the member's Medicare status with relationship to Aged, ESRD (End Stage Renal Disease), and Disability.	N/A	99%	Medicare
80	ME407	Monthly Reason For Entitlement	N	Text	2	For Medicare members only, use this field to report whether the member qualified for Medicare for a specific reported eligibility month as Aged, Disabled, ESRD (End Stage Renal Disease), or Disabled and ESRD.	N/A	99%	Medicare
81	ME408	Original Reason For Entitlement	N	Text	2	For Medicare members only, use this field to report the reason for the beneficiary's original entitlement to Medicare benefits.	N/A	99%	Medicare
82	ME899	Record Type	N	Text	2	Use this field to report the constant value of "ME" to denote a member eligibility record.	N/A	100%	All
1	TR001	Record Type	N	Text	2	This field must be coded TR to indicate the start of the trailer record.	Administrative Element	100%	All

ELIGIBILITY FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	X12 REF	THRESH.	DENOM.
2	TR002	Submitter Code	N	Text	8	This field must contain the submitter code assigned to you by Onpoint Health Data.	Administrative Element	100%	All
3	TR003	Placeholder	N/A	Text	30	This field must be coded as null; it is reserved for trailer consistency across all clients using Onpoint CDM.	N/A	N/A	N/A
4	TR004	Type of File	N	Text	2	This field must be coded ME to indicate submission of eligibility data.	Administrative Element	100%	All
5	TR005	Period Beginning Date	N	Integer	6	Use this field to report the earliest eligibility year/month included in the submission in CCYYMM format. Submissions with records containing an eligibility period (ME004, ME005) before this date will fail.	Administrative Element	100%	All
6	TR006	Period Ending Date	N	Integer	6	Use this field to report the latest eligibility year/month included in the submission in CCYYMM format. Submissions with records containing an eligibility period (ME004, ME005) after this date will fail.	Administrative Element	100%	All
7	TR007	Date Processed	N	Date	8	Use this field to report the date on which the file was created in CCYYMMDD format.	Administrative Element	0%	All

Medical Claims

The Basics

Key References R23-17.17-RIAPCD §1.19 and §4.3.a

Covered Parties All

Required Frequency Either monthly or quarterly (in adherence to calendar-year quarters; for example, Q1 data should be submitted to Onpoint prior to May 31)

Specific Deadline Within 10 business days of receipt of Unique Member Identifiers from the Lockbox Vendor (§5.2.c.4.i)

Important Notes

- Medical claims submissions must include all claims adjudicated during the reported time period.
- All lines of partially denied claims are to be reported. Only fully denied claims are to be excluded.
- One record must be submitted for each service adjudicated during the period reported in the header and trailer records.
- Submissions must cover full months of data; partial months must not be reported.
- Every member who had coverage during the period reported and has a reported Member Opt-Out Status (RF018) of either I (included) or U (unknown) must be included in the submitted medical claims file.
- Every member who had coverage during the period reported but instead has a reported Member Opt-Out Status (RF018) of O (opted out) must have no claims data reported in this file.

Columns Included in the Medical Claims File

COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	MAPPINGS			THRESH.	DENOM.
							UB-04 REF	CMS 1500 REF	X12 REF		
Indicates the element's required position within the submission file	Indicates the element's reference number	Indicates the element's name	Indicates whether or not the element's true value has been rendered permanently non-recoverable by one-way hashing prior to submission to Onpoint	Indicates whether the type of data for the element is a date, decimal, integer, or text	Indicates the maximum length allowed for this element	codes for elements whose acceptable codes vary from industry standards and for elements that lack a national standard altogether. Values appended with superscript text in blue (e.g., + 01/01/2012) note the effective date of newly valid values; those with strikethrough text (i.e., ~~strikethrough~~) are no longer valid and have their expiration dates appended in red superscript text (e.g., x 12/31/2011).	Indicates the element's relevant reference standard across national coding systems			Indicates the percent of submitted records for which this element must have a valid code	Indicates the type of records to be used to calculate the threshold percent for submission. Note: Denominators are comprised of records for only those members with an opt-out status of I (included) or U (unknown) unless the field is shaded gold. For gold-shaded fields, denominators also include records for members with an opt-out status of O (opted out) to enable QA review.

File Layout & Specifications

MEDICAL CLAIMS FILE TO ONPOINT											
							MAPPINGS				
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	UB-04 REF	CMS 1500 REF	X12 REF	THRESH.	DENOM.
1	HD001	Record Type	N	Text	2	This field must be coded HD to indicate the start of the header record.	Administrative element	Administrative element	Administrative element	100%	All
2	HD002	Submitter Code	N	Text	8	This field must contain the submitter code assigned to you by Onpoint Health Data.	Administrative element	Administrative element	Administrative element	100%	All
3	HD003	Placeholder	N	Text	30	This field must be coded as null; it is reserved for header consistency across all clients using Onpoint Health Data's APCD services.	Administrative element	Administrative element	Administrative element	0%	All
4	HD004	Type of File	N	Text	2	This field must be coded MC to indicate submission of medical claims data.	Administrative element	Administrative element	Administrative element	100%	All
5	HD005	Period Beginning Date	N	Integer	6	Use this field to report the earliest payment year/month included in the submission in CCYYMM format. Submissions with records containing a Payment Date / Settlement Date (MC017) outside of the date range indicated in this file's header and trailer records will fail.	Administrative element	Administrative element	Administrative element	100%	All
6	HD006	Period Ending Date	N	Integer	6	Use this field to report the latest payment year/month included in the submission in CCYYMM format. Submissions with records containing a Payment Date / Settlement Date (MC017) outside of the date range indicated in this file's header and trailer records will fail.	Administrative element	Administrative element	Administrative element	100%	All
7	HD007	Record Count	N	Integer	10	Use this field to report the total number of records in the submission, excluding the header and trailer records. If the number of records within the submission does not equal the number reported in this field, the submission will fail.	Administrative element	Administrative element	Administrative element	100%	All
8	HD008	Comments	N	Text	80	This field may be used by the submitter to document a file name, system source, or other administrative device to assist with their internal tracking of the submission.	Administrative element	Administrative element	Administrative element	0%	All

MEDICAL CLAIMS FILE TO ONPOINT

COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	MAPPINGS			THRESH.	DENOM.
							UB-04 REF	CMS 1500 REF	X12 REF		
1	MC001	Submitter Code	N	Text	8	Use this field to report your Onpoint-assigned submitter code for the data submitter. Note that the first two characters of the submitter code are used to indicate the reporting state and the third character designates the type of submitter. For Rhode Island's APCD collection, valid prefixes include: RIC .....Commercial carrier RIG .....Governmental agency RIT.....Third-party administrator **Notes:** A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter.	Administrative element	Administrative element	Administrative element	100%	All
2	MC002	NAIC	N	Text	5	Use this field to report, at a record level, the code as assigned by the NAIC that uniquely identifies the applicable insurance plan. If no NAIC number has been assigned, report as "0".	N/A	N/A	835/1000A/REF/NF/02	100%	All
3	MC003	Insurance Type / Product Code	N	Text	2	Use this field to report the member's type of insurance or insurance product. **Notes:** The value reported for this field should be consistent with the value reported in ME003 ("Insurance Type / Product Code") in the eligibility file. To ensure reporting consistency between submitters, all Medicare Advantage plans should use the code "HN" to denote a Health Maintenance Organization (HMO) – Medicare Risk. Valid codes are maintained by the Accredited Standards Committee (ASC) and are available in the ASC X12 transaction set.	N/A	N/A	271/2110C/EB/ /04, 271/2110D/EB/ /04	100%	All

MEDICAL CLAIMS FILE TO ONPOINT

COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	MAPPINGS			THRESH.	DENOM.
							UB-04 REF	CMS 1500 REF	X12 REF		
4	MC004	Payer Claim Control Number	N	Text	50	Use this field to report the claim number used by the data submitter to internally track the claim. **Notes:** In general, the claim number is associated with all service lines of the claim. It must apply to the entire claim and be unique within the data submitter's system. The value reported in this field should remain consistent over time. If reporting multiple versions of the same claim, this number should remain the same; use MC005A (Version Number) to report multiple versions of the same claim subject to subsequent changes/adjustments.	N/A	N/A	835/2100/CLP/ /07	99.9%	All
5	MC004A	Claim Submitter's Identifier	N	Text	38	Use this field to report the claim number used by the healthcare provider (e.g., the doctor, hospital, etc.) to track a claim from creation through payment.	3A	26	837/2300/CLM/ /01	90%	All
6	MC005	Line Counter	N	Integer	4	Use this field to report the line number for this service. **Notes:** The line counter should begin with 1 and be incremented by 1 for each additional service line of a claim.	N/A	N/A	837/2400/LX/ /01	99.5%	All
7	MC005A	Version Number	N	Integer	4	Use this field to report the version number of the claim service record. **Notes:** The version number should begin with 0 and be incremented by 1 for each subsequent version of that service line. If versioning is not used to report adjusted claims, report claims with a Version Number of zero (0).	Administrative element	Administrative element	Administrative element	99.5%	All
8	MC006	Insured Group or Policy Number	N	Text	50	Use this field to report the group or policy number. **Notes:** This is not the number that uniquely identifies the subscriber. The value reported for this field should be consistent with the value reported in the Insured Group or Policy Number fields across all file types (ME006, MC006, PC006). If a policy is sold to an individual as a non-group policy, then this field should be reported with a value of "IND". This principle pertains to all claim types: commercial, Medicaid, and Medicare.	62 (A-C)	11C	837/2000B/SBR/ /03	99.5%	All

MEDICAL CLAIMS FILE TO ONPOINT											
							MAPPINGS				
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	UB-04 REF	CMS 1500 REF	X12 REF	THRESH.	DENOM.
9	MC007	Subscriber Social Security Number	Y	Text	9	Use this field to report the subscriber's 9-digit Social Security number. **Notes:** The value reported for this field should be consistent with the value reported in ME008 ("Subscriber Social Security Number") in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	N/A	N/A	835/2100/NM1/FI/09	99.9%	All
10	MC008	Plan-Specific Contract Number	Y	Text	80	Use this field to report the submitter-assigned contract number for the subscriber. **Notes:** The value reported for this field should be consistent with the value reported in ME009 ("Plan-Specific Contract Number") in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	60 (A-C)	1a	835/2100/NM1/MI/09	99.9%	All
11	MC009	Member Suffix or Sequence Number	N	Text	20	Use this field to report the unique number of the member within the contract.	N/A	N/A	N/A	50%	All
12	MC010	Member Social Security Number	Y	Text	9	Use this field to report the member's 9-digit Social Security number. **Notes:** The value reported for this field should be consistent with the value reported in ME011 ("Member Social Security Number") in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	N/A	N/A	835/2100/NM1/34/09	75%	All
13	MC010A	Unique Member Identifier	N	String	32	Use this field to report the Unique Member Identifier assigned by the Lockbox Vendor in the Response File's field RF017. **Notes:** The value reported for this field should be reported identically to the "Unique Member Identifier" field in the eligibility file (ME010A).	Administrative element	Administrative element	Administrative element	100%	All

MEDICAL CLAIMS FILE TO ONPOINT

COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	MAPPINGS			THRESH.	DENOM.
							UB-04 REF	CMS 1500 REF	X12 REF		
14	MC011	Member Relationship	N	Text	2	Use this field to report the member's relationship to the subscriber or the insured. **Notes:** The value reported for this field should be consistent with the value reported in ME012 ("Member Relationship") in the eligibility file. Valid codes are maintained by the Accredited Standards Committee (ASC) and are available in the ASC X12 transaction set.	59 (A-C)	6	837/2000B/SBR/ /02 837/2000C/PAT/ /01	100%	All
15	MC012	Member Gender	N	Text	1	Use this field to report the member's gender. The only valid codes for this field are: F.....Female M .....Male U .....Unknown **Notes:** The value reported for this field should be consistent with the value reported in ME013 ("Member Gender") in the eligibility file.	11	3	837/2010BA/DMG/ /03, 837/2010CA/DMG/ /03	100%	All
16	MC013	Member Date of Birth	Y	Date	8	Use this field to report the member's date of birth using an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118"). **Notes:** The value reported for this field should be consistent with the value reported in ME014 ("Member Date of Birth") in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Immediately prior to hashing this field, Onpoint's hashing application calculates a member's age in months based on the Member Date of Birth field (ME014, MC013, PC013). The Member Date of Birth field is then hashed and both the hashed value and the value-added Age in Months element are submitted to the APCD — the hashed value to allow for quality assurance review, the de-identified Age in Months to enable analytic use of the APCD.	10	3	837/2010BA/DMG/D8/02 837/2010CA/DMG/D8/02	99.5%	All
17	MC014	Member City	N	Text	30	Use this field to report the name of the member's city of residence.	09 (b)	5	837/2010BA/N4/ /01 837/2010CA/N4/ /01	99.5%	All
18	MC015	Member State or Province	N	Text	2	Use this field to report the member's state or province using the two-character abbreviation code defined by the U.S. Postal Service(for U.S. states) and Canada Post (for Canadian provinces).	09 (c)	5	837/2010BA/N4/ /02 837/2010CA/N4/ /02	99.5%	All

MEDICAL CLAIMS FILE TO ONPOINT

COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	MAPPINGS			THRESH.	DENOM.
							UB-04 REF	CMS 1500 REF	X12 REF		
19	MC016	Member ZIP/Postal Code	N	Text	9	Use this field to report the ZIP/postal code associated with the member's residence. **Notes:** For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code). Do not code dashes or spaces within ZIP/postal codes.	09 (d)	5	837/2010BA/N4/ /03 837/2010CA/N4/ /03	99.5%	All
20	MC017	Payment Date / Settlement Date	N	Date	8	Use this field to report the date on which the record was approved for payment using an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118"). **Notes:** This date generally is referred to as the paid date. When BPR04 is "NON" for nonpayment, report the remittance date instead.	N/A	N/A	835/Header Financial Information/BPR/ /16	100%	All
21	MC018	Admission Date	N	Date	8	Use this field to report the date of the inpatient admission using an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	12	18	*Institutional* 837/2300/DTP/435/DT/03 *Professional* 837/2300/DTP/435/D8/03	95%	Institutional inpatient / Professional with place of service as inpatient hospital
22	MC019	Admission Hour	N	Text	2	Use this field to report the hour — in the format of military time (i.e., 00 through 23) — during which the member was admitted for inpatient care.	13	N/A	*Institutional* 837/2300/DTP/435/03	50%	Institutional inpatient
23	MC020	Admission Type	N	Text	1	Use this field to report the type of admission for the inpatient hospital claim. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	14	N/A	*Institutional* 837/2300/CL1/ /01	90%	Institutional inpatient
24	MC021	Admission Source	N	Text	1	Use this field to report the source of admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	15	N/A	*Institutional* 837/2300/CL1/ /02	90%	Institutional inpatient
25	MC022	Discharge Hour	N	Text	2	Use this field to report the hour — in the format of military time (i.e., 00 through 23) — during which the member was discharged from inpatient care.	16	N/A	*Institutional* 837/2300/DTP/096/03	50%	Institutional inpatient
26	MC023	Discharge Status	N	Text	2	Use this field to report the status for the patient discharged from an inpatient stay. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	17	N/A	*Institutional* 837/2300/CL1/ /03	90%	Institutional inpatient

MEDICAL CLAIMS FILE TO ONPOINT

COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	MAPPINGS			THRESH.	DENOM.
							UB-04 REF	CMS 1500 REF	X12 REF		
27	MC024	Rendering Provider Plan ID	N	Text	50	Use this field to report the submitter-assigned or legacy provider plan ID for the rendering provider. **Note:** The provider data reported in the eligibility, claims, and provider files are used to create a Provider Master Index that is used to match the data across all file types. It is expected that a provider's identifiers (e.g., plan-assigned ID, NPI, etc.) will be reported consistently by a submitter across file types as this is the payer-assigned provider ID (ME051, MC024, PC048A, PV006).	57	24J	835/2100/REF/1A/02, 835/2100/REF/1B/02, 835/2100/REF/1C/02, 835/2100/REF/1D/02, 835/2100/REF/G2/02, 835/2100/NM1/BD/09, 835/2100/NM1/PC/09, 835/2100/NM1/MC/09, 835/2100/NM1/BS/09	90%	All
28	MC025	Rendering Provider Tax ID Number	N	Text	9	Use this field to report the federal taxpayer identification number for the rendering provider. **Notes:** If the tax ID number is an individual's Social Security number, report this field as null.	5	N/A	835/2100/NM1/FI/09	90%	Institutional
29	MC026	Rendering Provider NPI	N	Text	10	Use this field to report the National Provider Identifier (NPI) for the rendering provider or entity.	56	24J	*Institutional* 837/2010AA/NMI/XX/09 *Professional* 837/2420A/NMI/XX/09, 837/2310B/NM1/XX/09	90%	All
30	MC027	Entity Type Qualifier	N	Text	1	Use this field to report whether the rendering provider was an individual practitioner or a business entity. **Notes:** Valid codes are maintained by the Accredited Standards Committee (ASC) and are available in the ASC X12 transaction set.	N/A	N/A	*Institutional* 837/2010AA/NM1/85/02 *Professional* 837/2420A/NM1/82/02, 837/2310B/NM1/82/02	90%	All
31	MC027A	Network Indicator	N	Text	1	Use this field to report whether the rendering provider was in or out of the network. The only valid codes for this field are: O .....Out of network I.....In network N .....Not applicable U .....Unknown	N/A	N/A	N/A	100%	All
32	MC028	Rendering Provider First Name	N	Text	35	Use this field to report the rendering provider's first name. **Notes:** Set to null if the provider is a facility or an organization.	N/A	31	*Professional* 837/2420A/NM1/82/04, 837/2310B/NM1/82/04	75%	Professional
33	MC029	Rendering Provider Middle Initial	N	Text	1	Use this field to report the rendering provider's middle initial. **Notes:** Set to null if the provider is a facility or an organization.	N/A	31	*Professional* 837/2420A/NM1/82/05, 837/2310B/NM1/82/05	0.5%	Professional

MEDICAL CLAIMS FILE TO ONPOINT

COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	MAPPINGS			THRESH.	DENOM.
							UB-04 REF	CMS 1500 REF	X12 REF		
34	MC030	Rendering Provider Last Name or Organization Name	N	Text	60	Use this field to report the last name of the rendering provider if an individual or the full name if the provider is a facility or an organization.	1	31	*Institutional* 837/2010AA/NM1/85/2/03 *Professional* 837/2420A/NM1/82/03, 837/2310B/NM1/82/03	99.5%	All
35	MC031	Rendering Provider Suffix	N	Text	10	Use this field to report any generational identifiers associated with the rendering provider's name (e.g., JR, SR, III). **Notes:** Do not code punctuation and do not code the rendering provider's credentials (e.g., MD, LCSW) in this field. Set to null if the provider is a facility or an organization.	N/A	31	*Professional* 837/2420A/NM1/82/07, 837/2310B/NM1/82/07	0%	Professional
36	MC032	Rendering Provider Taxonomy Code	N	Text	10	Use this field to report the rendering provider's taxonomy code.	N/A	24J Qualifier ZZ	*Institutional* 837/2000A/PRV/PXC/03 *Professional* 837/2310B/PRV/PXC/03	99.5%	All
37	MC033	Rendered Service Location - City	N	Text	30	Use this field to report the city where the service was rendered. **Notes:** When not available (e.g., ambulance services), report the organization or provider's location city.	1	32	*Institutional* 837/2010AA/N4/ /01 *Professional* 837/2420C/N4/ /01, 837/2310C/N4/ /01	90%	All
38	MC034	Rendered Service Location - State or Province	N	Text	2	Use this field to report the state or province where the service was rendered using the two-character abbreviation defined by the U.S. Postal Service (for U.S. states) and Canada Post (for Canadian provinces). **Notes:** When not available (e.g., ambulance services), report the organization or provider's location state or province.	1	32	*Institutional* 837/2010AA/N4/ /02 *Professional* 837/2420C/N4//02, 837/2310C/N4/ /02	90%	All
39	MC035	Rendered Service Location - ZIP/Postal Code	N	Text	9	Use this field to report the ZIP/postal code where the service was rendered. **Notes:** For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code). Do not code dashes or spaces within ZIP/postal codes. When not available (e.g., ambulance services), report the organization or provider's location ZIP/postal code.	1	32	*Institutional* 837/2010AA/N4/ /03 *Professional* 837/2420C/N4/ /03, 837/2310C/N4/ /03	90%	All
40	MC036	Type of Bill	N	Text	3	Use this field to report the code for the type of bill. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual. This field is required for institutional claims and must be set to null for professional claims.	4	N/A	*Institutional* 837/2300/CLM/ /05-1 and 837/2300/CLM/ /05-3	99%	Institutional

MEDICAL CLAIMS FILE TO ONPOINT

COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	MAPPINGS			THRESH.	DENOM.
							UB-04 REF	CMS 1500 REF	X12 REF		
41	MC037	Place of Service	N	Text	2	Use this field to report the place of service code as reported on a professional claim. **Notes:** This field is required for professional claims and must be set to null for institutional claims.	N/A	24B	*Professional* 837/2300/CLM/ /05-1	99%	Professional
42	MC038	Claim Status	N	Text	2	Use this field to report the status of the claim line — whether paid as primary, paid as secondary, denied, etc. **Notes:** Valid codes are maintained by the Accredited Standards Committee (ASC) and are available in the ASC X12 transaction set.	N/A	N/A	835/2100/CLP/ /02	99.5%	All
43	MC039	Admitting Diagnosis	N	Text	7	Use this field to report the ICD diagnosis code indicating the reason for the inpatient admission. **Notes:** Do not include the decimal point when coding this field.	69	N/A	*Institutional* 837/2300/HI/BJ/01-2, 837/2300/HI/ABJ/01-2	90%	Institutional inpatient
44	MC039A	ICD Version Indicator	N	Text	1	Use this field to declare the version of ICD reported on this service line. The only valid codes for this field are: 9.....ICD-9 0.....ICD-10 **Notes:** The version indicator should be consistent for the entire claim and for all ICD diagnosis and procedure codes.	66	CMS 1500 v02/12 field locator 21	N/A	100%	All
45	MC040	External Cause of Injury (ECI) Code - 1	N	Text	7	Use this field to report the first injury, poisoning, or adverse effect using an ICD diagnosis code. **Notes:** Do not include the decimal point when coding this field.	72a	N/A	*Institutional* 837/2300/HI/BN/01-2, 837/2300/HI/ABN/01-2	1%	Institutional
46	MC040A	External Cause of Injury (ECI) Code - 2	N	Text	7	Use this field to report the second injury, poisoning, or adverse effect using an ICD diagnosis code. **Notes:** Do not include the decimal point when coding this field.	72b	N/A	*Institutional* 837/2300/HI/BN/02-2, 837/2300/HI/ABN/02-2	0%	Institutional
47	MC040B	External Cause of Injury (ECI) Code - 3	N	Text	7	Use this field to report the third injury, poisoning, or adverse effect using an ICD diagnosis code. **Notes:** Do not include the decimal point when coding this field.	72c	N/A	*Institutional* 837/2300/HI/BN/03-2, 837/2300/HI/ABN/03-2	0%	Institutional

MEDICAL CLAIMS FILE TO ONPOINT											
							MAPPINGS				
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	UB-04 REF	CMS 1500 REF	X12 REF	THRESH.	DENOM.
48	MC041	Principal Diagnosis	N	Text	7	Use this field to report the ICD diagnosis for the principal diagnosis. **Notes:** Do not include the decimal point when coding this field.	67	CMS 1500 Version 08/05 21.1, CMS 1500 Version 02/12 21.A	837/2300/HI/BK/01-2, 837/2300/HI/ABK/01-2	95%	All
49	MC042	Other Diagnosis - 1	N	Text	7	Use this field to report the ICD diagnosis code for the first secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67A	CMS 1500 Version 08/05 21.2, CMS 1500 Version 02/12 21.B	*Institutional* 837/2300/HI/BF/01-2, 837/2300/HI/ABF/01-2 *Professional* 837/2300/HI/BF/02-2, 837/2300/HI/ABF/02-2	50%	All
50	MC043	Other Diagnosis - 2	N	Text	7	Use this field to report the ICD diagnosis code for the second secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67B	CMS 1500 Version 08/05 21.3, CMS 1500 Version 02/12 21.C	*Institutional* 837/2300/HI/BF/02-2, 837/2300/HI/ABF/02-2 *Professional* 837/2300/HI/BF/03-2, 837/2300/HI/ABF/03-2	20%	All
51	MC044	Other Diagnosis - 3	N	Text	7	Use this field to report the ICD diagnosis code for the third secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67C	CMS 1500 Version 08/05, 21.4 CMS D500 Version 02/12 21.d	*Institutional* 837/2300/HI/BF/03-2, 837/2300/HI/ABF/03-2 *Professional* 837/2300/HI/BF/04-2, 837/2300/HI/ABF/04-2	5%	All
52	MC045	Other Diagnosis - 4	N	Text	7	Use this field to report the ICD diagnosis code for the fourth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67D	CMS 1500 Version 02/12 21.E	*Institutional* 837/2300/HI/BF/04-2, 837/2300/HI/ABF/04-2 *Professional* 837/2300/HI/BF/05-2, 837/2300/HI/ABF/05-2	.05%	All
53	MC046	Other Diagnosis - 5	N	Text	7	Use this field to report the ICD diagnosis code for the fifth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67E	CMS 1500 Version 02/12 21.F	*Institutional* 837/2300/HI/BF/05-2, 837/2300/HI/ABF/05-2 *Professional* 837/2300/HI/BF/06-2, 837/2300/HI/ABF/06-2	0%	All
54	MC047	Other Diagnosis - 6	N	Text	7	Use this field to report the ICD diagnosis code for the sixth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67F	CMS 1500 Version 02/12 21.G	*Institutional* 837/2300/HI/BF/06-2, 837/2300/HI/ABF/06-2 *Professional* 837/2300/HI/BF/07-2, 837/2300/HI/ABF/07-2	0%	All

MEDICAL CLAIMS FILE TO ONPOINT

COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	MAPPINGS			THRESH.	DENOM.
							UB-04 REF	CMS 1500 REF	X12 REF		
55	MC048	Other Diagnosis - 7	N	Text	7	Use this field to report the ICD diagnosis code for the seventh secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67G	CMS 1500 Version 02/12 21.H	*Institutional* 837/2300/HI/BF/07-2, 837/2300/HI/ABF/07-2 *Professional* 837/2300/HI/BF/08-2, 837/2300/HI/ABF/08-2	0%	All
56	MC049	Other Diagnosis - 8	N	Text	7	Use this field to report the ICD diagnosis code for the eighth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67H	CMS 1500 Version 02/12 21.I	*Institutional* 837/2300/HI/BF/08-2, 837/2300/HI/ABF/08-2 *Professional* 837/2300/HI/BF/09-2, 837/2300/HI/ABF/09-2	0%	All
57	MC050	Other Diagnosis - 9	N	Text	7	Use this field to report the ICD diagnosis code for the ninth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67I	CMS 1500 Version 02/12 21.J	*Institutional* 837/2300/HI/BF/09-2, 837/2300/HI/ABF/09-2 *Professional* 837/2300/HI/BF/10-2, 837/2300/HI/ABF/10-2	0%	All
58	MC051	Other Diagnosis - 10	N	Text	7	Use this field to report the ICD diagnosis code for the tenth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67J	CMS 1500 Version 02/12 21.K	*Institutional* 837/2300/HI/BF/10-2, 837/2300/HI/ABF/10-2 *Professional* 837/2300/HI/BF/11-2, 837/2300/HI/ABF/11-2	0%	All
59	MC052	Other Diagnosis - 11	N	Text	7	Use this field to report the ICD diagnosis code for the eleventh secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67K	CMS 1500 Version 02/12 21.L	*Institutional* 837/2300/HI/BF/11-2, 837/2300/HI/ABF/11-2 *Professional* 837/2300/HI/BF/12-2, 837/2300/HI/ABF/12-2	0%	All
60	MC053	Other Diagnosis - 12	N	Text	7	Use this field to report the ICD diagnosis code for the twelfth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67L	N/A	*Institutional* 837/2300/HI/BF/12-2, 837/2300/HI/ABF/12-2	0%	All
61	MC054	Revenue Code	N	Text	4	Use this field to report the revenue code for institutional claims. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual. Code using leading zeroes to ensure a full complement of four digits. Leave this field null for professional claims.	42	N/A	835/2110/SVC/NU/01-2 835/2110/SVC/ /04	99.9%	Institutional

MEDICAL CLAIMS FILE TO ONPOINT											
							MAPPINGS				
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	UB-04 REF	CMS 1500 REF	X12 REF	THRESH.	DENOM.
62	MC055	Procedure Code	N	Text	5	Use this field to report the HCPCS, CPT, or HIPPS code for the service rendered.	44	24.D	835/2110/SVC/HC/01-2, 835/2110/SVC/HP/01-2	80%	All
63	MC056	Procedure Modifier - 1	N	Text	2	Use this field to report the first modifier indicating that a service or procedure has been altered by some specific circumstance but has not been changed in its definition or code.	44	24.D	835/2110/SVC/HC/01-3	10%	All
64	MC057	Procedure Modifier - 2	N	Text	2	Use this field to report the second modifier indicating that a service or procedure has been altered by some specific circumstance but has not been changed in its definition or code.	44	24.D	835/2110/SVC/HC/01-4	2%	All
65	MC057A	Procedure Modifier - 3	N	Text	2	Use this field to report the third modifier indicating that a service or procedure has been altered by some specific circumstance but has not been changed in its definition or code.	44	224.D	835/2110/SVC/HC/01-5	0%	All
66	MC057B	Procedure Modifier - 4	N	Text	2	Use this field to report the fourth modifier indicating that a service or procedure has been altered by some specific circumstance but has not been changed in its definition or code.	44	24.D	835/2110/SVC/HC/01-6	0%	All
67	MC058	Principal ICD Procedure Code	N	Text	7	Use this field to report the principal ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	74	N/A	*Institutional* 837/2300/HI/BR/01-2 837/2300/HI/BBR/01-2	55%	Institutional inpatient hospital
68	MC058A	Other ICD Procedure Code - 1	N	Text	7	Use this field to report the second ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	74a	N/A	*Institutional* 837/2300/HI/BQ/01-2 837/2300/HI/BBQ/01-2	30%	Institutional inpatient hospital
69	MC058B	Other ICD Procedure Code - 2	N	Text	7	Use this field to report the third ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	74b	N/A	*Institutional* 837/2300/HI/BQ/02-2 837/2300/HI/BBQ/02-2	15%	Institutional inpatient hospital

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COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	MAPPINGS			THRESH.	DENOM.
							UB-04 REF	CMS 1500 REF	X12 REF		
70	MC058C	Other ICD Procedure Code - 3	N	Text	7	Use this field to report the fourth ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	74c	N/A	*Institutional* 837/2300/HI/BQ/03-2 837/2300/HI/BBQ/03-2	10%	Institutional inpatient hospital
71	MC058D	Other ICD Procedure Code - 4	N	Text	7	Use this field to report the fifth ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	74d	N/A	*Institutional* 837/2300/HI/BQ/04-2 837/2300/HI/BBQ/04-2	5%	Institutional inpatient hospital
72	MC058E	Other ICD Procedure Code - 5	N	Text	7	Use this field to report the sixth ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	74e	N/A	*Institutional* 837/2300/HI/BQ/05-2 837/2300/HI/BBQ/05-2	0%	Institutional inpatient hospital
73	MC058F	Other ICD Procedure Code - 6	N	Text	7	Use this field to report the seventh ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BQ/06-2 837/2300/HI/BBQ/06-2	0%	Institutional inpatient hospital
74	MC058G	Other ICD Procedure Code - 7	N	Text	7	Use this field to report the eighth ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BQ/07-2 837/2300/HI/BBQ/07-2	0%	Institutional inpatient hospital

MEDICAL CLAIMS FILE TO ONPOINT

COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	MAPPINGS			THRESH.	DENOM.
							UB-04 REF	CMS 1500 REF	X12 REF		
75	MC058H	Other ICD Procedure Code - 8	N	Text	7	Use this field to report the ninth ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BQ/08-2 837/2300/HI/BBQ/08-2	0%	Institutional inpatient hospital
76	MC058I	Other ICD Procedure Code - 9	N	Text	7	Use this field to report the tenth ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BQ/09-2 837/2300/HI/BBQ/09-2	0%	Institutional inpatient hospital
77	MC058J	Other ICD Procedure Code - 10	N	Text	7	Use this field to report the eleventh ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BQ/10-2 837/2300/HI/BBQ/10-2	0%	Institutional inpatient hospital
78	MC058K	Other ICD Procedure Code - 11	N	Text	7	Use this field to report the twelfth ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BQ/11-2 837/2300/HI/BBQ/11-2	0%	Institutional inpatient hospital
79	MC058L	Other ICD Procedure Code - 12	N	Text	7	Use this field to report the thirteenth ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BQ/12-2 837/2300/HI/BBQ/12-2	0%	Institutional inpatient hospital

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COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	MAPPINGS			THRESH.	DENOM.
							UB-04 REF	CMS 1500 REF	X12 REF		
80	MC058M	Other ICD Procedure Code - 13	N	Text	7	Use this field to report the fourteenth ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BQ/13-2 837/2300/HI/BBQ/13-2	0%	Institutional inpatient hospital
81	MC058N	Other ICD Procedure Code - 14	N	Text	7	Use this field to report the fifteenth ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BQ/14-2 837/2300/HI/BBQ/14-2	0%	Institutional inpatient hospital
82	MC058O	Other ICD Procedure Code - 15	N	Text	7	Use this field to report the sixteenth ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BQ/15-2 837/2300/HI/BBQ/15-2	0%	Institutional inpatient hospital
83	MC058P	Other ICD Procedure Code - 16	N	Text	7	Use this field to report the seventeenth ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BQ/16-2 837/2300/HI/BBQ/16-2	0%	Institutional inpatient hospital
84	MC058Q	Other ICD Procedure Code - 17	N	Text	7	Use this field to report the eighteenth ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BQ/17-2 837/2300/HI/BBQ/17-2	0%	Institutional inpatient hospital

MEDICAL CLAIMS FILE TO ONPOINT											
							MAPPINGS				
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	UB-04 REF	CMS 1500 REF	X12 REF	THRESH.	DENOM.
85	MC058R	Other ICD Procedure Code - 18	N	Text	7	Use this field to report the nineteenth ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BQ/18-2 837/2300/HI/BBQ/18-2	0%	Institutional inpatient hospital
86	MC058S	Other ICD Procedure Code - 19	N	Text	7	Use this field to report the twentieth ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BQ/19-2 837/2300/HI/BBQ/19-2	0%	Institutional inpatient hospital
87	MC058T	Other ICD Procedure Code - 20	N	Text	7	Use this field to report the twenty-first ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BQ/20-2 837/2300/HI/BBQ/20-2	0%	Institutional inpatient hospital
88	MC058U	Other ICD Procedure Code - 21	N	Text	7	Use this field to report the twenty-second ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BQ/21-2 837/2300/HI/BBQ/21-2	0%	Institutional inpatient hospital
89	MC058V	Other ICD Procedure Code - 22	N	Text	7	Use this field to report the twenty-third ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BQ/22-2 837/2300/HI/BBQ/22-2	0%	Institutional inpatient hospital

MEDICAL CLAIMS FILE TO ONPOINT											
							MAPPINGS				
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	UB-04 REF	CMS 1500 REF	X12 REF	THRESH.	DENOM.
90	MC058W	Other ICD Procedure Code - 23	N	Text	7	Use this field to report the twenty-fourth ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BQ/23-2 837/2300/HI/BBQ/23-2	0%	Institutional inpatient hospital
91	MC058X	Other ICD Procedure Code - 24	N	Text	7	Use this field to report the twenty-fifth ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BQ/24-2 837/2300/HI/BBQ/24-2	0%	Institutional inpatient hospital
92	MC059	Date of Service (From)	N	Date	8	Use this field to report the first date of service for this service line using an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as “19720118”). **Notes:** Dates subsequent to the Paid Date are not acceptable.	45	24 A	835/2110/DTM/472/02, 835/2110/DTM/150/02	99.5%	All
93	MC060	Date of Service (Through)	N	Date	8	Use this field to report the last date of service for this service line using an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as “19720118”). **Notes:** Dates subsequent to the Date of Service (From) and the Paid Date are not acceptable.	N/A	24 A	835/2110/DTM/472/02, 835/2110/DTM/151/02	99.5%	All
94	MC061	Quantity	N	Decimal	10,2	Use this field to report a count of services performed. **Notes:** This field may be negative. When coding this field, always report with two decimal places. If the actual value includes three decimal places, round to two. Do not include the decimal point when coding this field.	46	24 G	835/2110/SVC/ /05	99.5%	All
95	MC062	Charge Amount	N	Decimal	10,2	Use this field to report the total charges for the service. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	47	24 F	835/2110/SVC/ /02	99.5%	All

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COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	MAPPINGS			THRESH.	DENOM.
							UB-04 REF	CMS 1500 REF	X12 REF		
96	MC063	Paid Amount	N	Decimal	10,2	Use this field to report the total dollar amount paid to the provider, including all health plan payments and excluding all member payments and withholds from providers. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	N/A	N/A	835/2110/SVC/ /03	99.5%	All
97	MC063A	Payment Indicator	N	Text	1	Use this field to report whether the payment is reported on the header or line. The only valid codes for this field are: H .....Header (global payment) L.....Line (fee-for-service) U .....Unavailable information **Notes:** If "H", populate all lines included in the global payment with an "H". Note that some claims may have a combination of lines paid at the Header and Line level and so may have both "H" and "L" records reported. If "L", populate each line as necessary. As payers' systems are updated to store this information, it should be reported to the APCD.	Administrative Element	Administrative Element	Administrative element	100%	All
98	MC064A	Payment Arrangement Indicator	N	Text	1	Use this field to report the payment arrangement under which this claim has been processed. The actual amount paid should be reported in the Paid Amount field (MC063); the fee-for-service equivalent, if available, should be reported in the Fee-for-Service Equivalent field (MC064B). The only valid codes for this field are: C.....Capitation B .....Bundled payment paid to other provider (e.g., ACO) V .....Virtual bundled payment paid by the submitter directly to each provider who rendered services M .....Managed care withholds N .....Not applicable / Not available	N/A	N/A	N/A	99.5%	All

MEDICAL CLAIMS FILE TO ONPOINT

COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	MAPPINGS			THRESH.	DENOM.
							UB-04 REF	CMS 1500 REF	X12 REF		
99	MC064B	Fee-for-Service Equivalent	N	Decimal	10,2	Use this field to report the fee-for-service equivalent that would have been paid by the healthcare claims processor for a specific service if the service had not been capitated or paid under a bundled or managed care withhold payment arrangement. This field should contain the sum of the monies that would have been paid to the provider had funds not been withheld under a managed care withhold arrangement (i.e., the sum of the actual amount paid to the provider (Paid Amount; MC063) plus the amount withheld.) **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	N/A	N/A	N/A	99.5%	All
100	MC065	Copay Amount	N	Decimal	10,2	Use this field to report the preset, fixed dollar amount payable by a member, often on a per visit/service basis. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	N/A	N/A	835/2110/CAS/PR/3-03	99.5%	All
101	MC066	Coinsurance Amount	N	Decimal	10,2	Use this field to report the dollar amount that a member must pay toward the cost of a covered service, which is often a percentage of total cost. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	N/A	N/A	835/2110/CAS/PR/2-03	99.5%	All
102	MC067	Deductible Amount	N	Decimal	10,2	Use this field to report the dollar amount that a member must pay before the health plan benefits will begin to reimburse for services. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	N/A	N/A	835/2110/CAS/PR/1-03	99.5%	All

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COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	MAPPINGS			THRESH.	DENOM.
							UB-04 REF	CMS 1500 REF	X12 REF		
103	MC068	Medical Record Number	N	Text	20	Use this field to report the member's medical record number.	3B	N/A	837/2300/REF/EA/02	90%	All
104	MC069	Discharge Date	N	Date	8	Use this field to report the discharge date of the patient from inpatient care using an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	6	18	*Institutional* 837/2300/DTP/RD8/04 *Professional* 837/2300/DTP/D8/03	95%	Institutional inpatient / Professional with place of service as inpatient hospital
105	MC070	Rendering Provider Country	N	Text	30	Use this field to report the name of the country where the service was rendered. **Notes:** Please code only a two-digit response — "US" — to indicate the United States.	N/A	N/A	837/2310C/N4/07	100%	All
106	MC071	DRG	N	Text	7	Use this field to report the Diagnosis-Related Group (DRG) if available.	N/A	N/A	837/2300/HI/DR/01-2	0%	Institutional inpatient hospital
107	MC072	DRG Version	N	Text	4	Use this field to declare the version of Diagnosis-Related Group (DRG) reported in MC071. The only valid codes for this field are: **If using ICD-9 codes:** MS9.....Medicare DRG (CMS-DRG & MS-DRG) R9.....Refined DRGs (R-DRG) AP9 .....All Patient DRGs (AP-DRG) S9.....Severity DRGs (S-DRG) APS9.....All Patient, Severity-Adjusted DRGs (APS-DRG) APR9 .....All Patient Refined DRGs (APR-DRG) IR9.....International-Refined DRGs (IR-DRG) **If using ICD-10 codes:** MS0.....Medicare DRG (CMS-DRG & MS-DRG) R0.....Refined DRGs (R-DRG) AP0 .....All Patient DRGs (AP-DRG) S0.....Severity DRGs (S-DRG) APS0.....All Patient, Severity-Adjusted DRGs (APS-DRG) APR0 .....All Patient Refined DRGs (APR-DRG) IR0.....International-Refined DRGs (IR-DRG)	Administrative Element	Administrative Element	Administrative element	0%	Institutional inpatient hospital
108	MC073	APC	N	Text	5	Use this field to report the Ambulatory Payment Classification (APC) if available.	N/A	N/A	835/2110/REF/APC/02	0%	Institutional outpatient hospital

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							MAPPINGS				
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	UB-04 REF	CMS 1500 REF	X12 REF	THRESH.	DENOM.
109	MC074	APC Version	N	Text	2	Use this field to declare the version of the Ambulatory Payment Classification (APC) reported in MC073.	Administrative Element	Administrative Element	Administrative element	0%	Institutional outpatient hospital
110	MC075	National Drug Code	N	Text	11	Use this field to report the National Drug Code (NDC) assigned by the U.S. Food and Drug Administration (FDA).	43	24	837/2410/LIN/N4/03	0%	All
111	MC076	Billing Provider Plan ID	N	Text	50	Use this field to report the submitter-assigned billing provider number. **Notes:** This should be the identifier used by the submitter for internal reasons and should not routinely change.	57	33b	837/2010BB/REF/G2/02	90%	All
112	MC077	Billing Provider NPI	N	Text	10	Use this field to report the National Provider Identifier (NPI) for the billing provider.	56	33a	837/2010AA/NM1/XX/09	99%	All
113	MC078	Billing Provider Last Name or Organization Name	N	Text	60	Use this field to report the last name of the billing provider if an individual or the full name if an organization.	1	33	837/2010AA/NM1/ /03	99.5%	All
114	MC080	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
115	MC081	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
116	MC082	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
117	MC083	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
118	MC084	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
119	MC101	Subscriber Last Name	Y	Text	60	Use this field to report the subscriber's last name. **Notes:** The value reported for this field should be consistent with the value reported in ME101 ("Subscriber Last Name") in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	58(A-C)	4	837/2010BA/NM1/ /03	100%	All
120	MC102	Subscriber First Name	Y	Text	35	Use this field to report the subscriber's first name. **Notes:** The value reported for this field should be consistent with the value reported in ME102 ("Subscriber First Name") in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	58(A-C)	4	837/2010BA/NM1/ /04	100%	All

MEDICAL CLAIMS FILE TO ONPOINT											
							MAPPINGS				
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	UB-04 REF	CMS 1500 REF	X12 REF	THRESH.	DENOM.
121	MC103	Subscriber Middle Initial	Y	Text	1	Use this field to report the subscriber's middle initial. **Notes:** The value reported for this field should be consistent with the value reported in ME103 ("Subscriber Middle Initial") in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	58(A-C)	4	837/2010BA/NM1/ /05	50%	All
122	MC104	Member Last Name	Y	Text	60	Use this field to report the member's last name. **Notes:** If the member is the subscriber, report the subscriber's last name again in this field. The value reported for this field should be consistent with the value reported in ME104 ("Member Last Name") in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	8a	2	837/2010CA/NM1/ /03, 837/2010BA/NM1/ /03	100%	All
123	MC105	Member First Name	Y	Text	35	Use this field to report the member's first name. **Notes:** If the member is the subscriber, report the subscriber's first name again in this field. The value reported for this field should be consistent with the value reported in ME105 ("Member First Name") in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	8a	2	837/2010CA/NM1/ /04, 837/2010BA/NM1/ /04	100%	All

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COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	MAPPINGS			THRESH.	DENOM.
							UB-04 REF	CMS 1500 REF	X12 REF		
124	MC106	Member Middle Initial	Y	Text	1	Use this field to report the member's middle initial. **Notes:** If the member is the subscriber, report the subscriber's middle initial again in this field. The value reported for this field should be consistent with the value reported in ME106 ("Member Middle Initial") in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	8a	2	837/2010CA/NM1/ /05, 837/2010BA/NM1/ /05	50%	All
125	MC201	Aid Category	N	Text	2	For Medicaid claims only, use this field to report the member's Medicaid aid category based on service date.	N/A	N/A	N/A	99%	Medicaid
126	MC212	Category Of Service	N	Text	4	For Medicaid claims only, use this field to report the member's Medicaid category of service.	N/A	N/A	N/A	99%	Medicaid
127	MC215	Fund Source Code	N	Text	2	For Medicaid claims only, use this field to report the Medicaid funding source.	N/A	N/A	N/A	99%	Medicaid
128	MC401	Other Diagnosis - 13	N	Text	7	Use this field to report the ICD diagnosis code for the thirteenth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67M	N/A	*Institutional* 837/2300/HI/BF/13-2, 837/2300/HI/ABF/13-2	0%	Institutional
129	MC402	Other Diagnosis - 14	N	Text	7	Use this field to report the ICD diagnosis code for the fourteenth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67N	N/A	*Institutional* 837/2300/HI/BF/14-2, 837/2300/HI/ABF/14-2	0%	Institutional
130	MC403	Other Diagnosis - 15	N	Text	7	Use this field to report the ICD diagnosis code for the fifteenth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67O	N/A	*Institutional* 837/2300/HI/BF/15-2, 837/2300/HI/ABF/15-2	0%	Institutional
131	MC404	Other Diagnosis - 16	N	Text	7	Use this field to report the ICD diagnosis code for the sixteenth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67P	N/A	*Institutional* 837/2300/HI/BF/16-2, 837/2300/HI/ABF/16-2	0%	Institutional

MEDICAL CLAIMS FILE TO ONPOINT											
							MAPPINGS				
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	UB-04 REF	CMS 1500 REF	X12 REF	THRESH.	DENOM.
132	MC405	Other Diagnosis - 17	N	Text	7	Use this field to report the ICD diagnosis code for the seventeenth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67Q	N/A	*Institutional* 837/2300/HI/BF/17-2, 837/2300/HI/ABF/17-2	0%	Institutional
133	MC406	Other Diagnosis - 18	N	Text	7	Use this field to report the ICD diagnosis code for the eighteenth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BF/18-2, 837/2300/HI/ABF/18-2	0%	Institutional
134	MC407	Other Diagnosis - 19	N	Text	7	Use this field to report the ICD diagnosis code for the nineteenth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BF/19-2, 837/2300/HI/ABF/19-2	0%	Institutional
135	MC408	Other Diagnosis - 20	N	Text	7	Use this field to report the ICD diagnosis code for the twentieth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BF/20-2, 837/2300/HI/ABF/20-2	0%	Institutional
136	MC409	Other Diagnosis - 21	N	Text	7	Use this field to report the ICD diagnosis code for the twenty-first secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BF/21-2, 837/2300/HI/ABF/21-2	0%	Institutional
137	MC410	Other Diagnosis - 22	N	Text	7	Use this field to report the ICD diagnosis code for the twenty-second secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BF/22-2, 837/2300/HI/ABF/22-2	0%	Institutional
138	MC411	Other Diagnosis - 23	N	Text	7	Use this field to report the ICD diagnosis code for the twenty-third secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BF/23-2, 837/2300/HI/ABF/23-2	0%	Institutional
139	MC412	Other Diagnosis - 24	N	Text	7	Use this field to report the ICD diagnosis code for the twenty-fourth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	N/A	N/A	*Institutional* 837/2300/HI/BF/24-2, 837/2300/HI/ABF/24-2	0%	Institutional

MEDICAL CLAIMS FILE TO ONPOINT											
							MAPPINGS				
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	UB-04 REF	CMS 1500 REF	X12 REF	THRESH.	DENOM.
140	MC413	Present on Admission - External Cause of Injury (ECI) Code - 1	N	Text	1	Use this field to report whether or not the first external cause of injury code was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	72a	N/A	*Institutional* 837/2300/HI/BN/01-9, 837/2300/HI/ABN/01-9	1%	Institutional inpatient
141	MC413A	Present on Admission - External Cause of Injury (ECI) Code - 2	N	Text	1	Use this field to report whether or not the second external cause of injury code was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	72b	N/A	*Institutional* 837/2300/HI/BN/02-9, 837/2300/HI/ABN/02-9	0%	Institutional inpatient
142	MC413B	Present on Admission - External Cause of Injury (ECI) Code - 3	N	Text	1	Use this field to report whether or not the third external cause of injury code was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	72c	N/A	*Institutional* 837/2300/HI/BN/03-9, 837/2300/HI/ABN/03-9	0%	Institutional inpatient
143	MC414	Present on Admission - Principal Diagnosis Code	N	Text	1	Use this field to report whether or not the primary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	67	N/A	*Institutional* 837/2300/HI/BK/01-9 837/2300/HI/ABK/01-9	95%	Institutional inpatient
144	MC415	Present on Admission - Other Diagnosis - 1	N	Text	1	Use this field to report whether or not the first secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	67A	N/A	*Institutional* 837/2300/HI/BF/01-9 837/2300/HI/ABF/01-9	50%	Institutional inpatient
145	MC416	Present on Admission - Other Diagnosis - 2	N	Text	1	Use this field to report whether or not the second secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	67B	N/A	*Institutional* 837/2300/HI/BF/02-9 837/2300/HI/ABF/02-9	20%	Institutional inpatient
146	MC417	Present on Admission - Other Diagnosis - 3	N	Text	1	Use this field to report whether or not the third secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	67C	N/A	*Institutional* 837/2300/HI/BF/03-9 837/2300/HI/ABF/03-9	5%	Institutional inpatient

MEDICAL CLAIMS FILE TO ONPOINT											
							MAPPINGS				
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	UB-04 REF	CMS 1500 REF	X12 REF	THRESH.	DENOM.
147	MC418	Present on Admission - Other Diagnosis - 4	N	Text	1	Use this field to report whether or not the fourth secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	67D	N/A	*Institutional* 837/2300/HI/BF/04-9 837/2300/HI/ABF/04-9	.05%	Institutional inpatient
148	MC419	Present on Admission - Other Diagnosis - 5	N	Text	1	Use this field to report whether or not the fifth secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	67E	N/A	*Institutional* 837/2300/HI/BF/05-9 837/2300/HI/ABF/05-9	0%	Institutional inpatient
149	MC420	Present on Admission - Other Diagnosis - 6	N	Text	1	Use this field to report whether or not the sixth secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	67F	N/A	Institutional 837/2300/HI/BF/06-9 837/2300/HI/ABF/06-9	0%	Institutional inpatient
150	MC421	Present on Admission - Other Diagnosis - 7	N	Text	1	Use this field to report whether or not the seventh secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	67G	N/A	*Institutional* 837/2300/HI/BF/07-9 837/2300/HI/ABF/07-9	0%	Institutional inpatient
151	MC422	Present on Admission - Other Diagnosis - 8	N	Text	1	Use this field to report whether or not the eighth secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	67H	N/A	*Institutional* 837/2300/HI/BF/08-9 837/2300/HI/ABF/08-9	0%	Institutional inpatient
152	MC423	Present on Admission - Other Diagnosis - 9	N	Text	1	Use this field to report whether or not the ninth secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	67I	N/A	*Institutional* 837/2300/HI/BF/09-9 837/2300/HI/ABF/09-9	0%	Institutional inpatient
153	MC424	Present on Admission - Other Diagnosis - 10	N	Text	1	Use this field to report whether or not the tenth secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	67J	N/A	*Institutional* 837/2300/HI/BF/10-9 837/2300/HI/ABF/10-9	0%	Institutional inpatient

MEDICAL CLAIMS FILE TO ONPOINT											
							MAPPINGS				
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	UB-04 REF	CMS 1500 REF	X12 REF	THRESH.	DENOM.
154	MC425	Present on Admission - Other Diagnosis - 11	N	Text	1	Use this field to report whether or not the eleventh secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	67K	N/A	*Institutional* 837/2300/HI/BF/11-9 837/2300/HI/ABF/11-9	0%	Institutional inpatient
155	MC426	Present on Admission - Other Diagnosis - 12	N	Text	1	Use this field to report whether or not the twelfth secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	67L	N/A	*Institutional* 837/2300/HI/BF/12-9 837/2300/HI/ABF/12-9	0%	Institutional inpatient
156	MC427	Present on Admission - Other Diagnosis - 13	N	Text	1	Use this field to report whether or not the thirteenth secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	67M	N/A	*Institutional* 837/2300/HI/BF/13-9 837/2300/HI/ABF/13-9	0%	Institutional inpatient
157	MC428	Present on Admission - Other Diagnosis - 14	N	Text	1	Use this field to report whether or not the fourteenth secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	67N	N/A	*Institutional* 837/2300/HI/BF/14-9 837/2300/HI/ABF/14-9	0%	Institutional inpatient
158	MC429	Present on Admission - Other Diagnosis - 15	N	Text	1	Use this field to report whether or not the fifteenth secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	67O	N/A	*Institutional* 837/2300/HI/BF/15-9 837/2300/HI/ABF/15-9	0%	Institutional inpatient
159	MC430	Present on Admission - Other Diagnosis - 16	N	Text	1	Use this field to report whether or not the sixteenth secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	67P	N/A	*Institutional* 837/2300/HI/BF/16-9 837/2300/HI/ABF/16-9	0%	Institutional inpatient
160	MC431	Present on Admission - Other Diagnosis - 17	N	Text	1	Use this field to report whether or not the seventeenth secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	67Q	N/A	*Institutional* 837/2300/HI/BF/17-9 837/2300/HI/ABF/17-9	0%	Institutional inpatient

MEDICAL CLAIMS FILE TO ONPOINT											
							MAPPINGS				
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	UB-04 REF	CMS 1500 REF	X12 REF	THRESH.	DENOM.
161	MC432	Present on Admission - Other Diagnosis - 18	N	Text	1	Use this field to report whether or not the eighteenth secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	N/A	N/A	*Institutional* 837/2300/HI/BF/18-9 837/2300/HI/ABF/18-9	0%	Institutional inpatient
162	MC433	Present on Admission - Other Diagnosis - 19	N	Text	1	Use this field to report whether or not the nineteenth secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	N/A	N/A	*Institutional* 837/2300/HI/BF/19-9 837/2300/HI/ABF/19-9	0%	Institutional inpatient
163	MC434	Present on Admission - Other Diagnosis - 20	N	Text	1	Use this field to report whether or not the twentieth secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	N/A	N/A	*Institutional* 837/2300/HI/BF/20-9 837/2300/HI/ABF/20-9	0%	Institutional inpatient
164	MC435	Present on Admission - Other Diagnosis - 21	N	Text	1	Use this field to report whether or not the twenty-first secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	N/A	N/A	*Institutional* 837/2300/HI/BF/21-9 837/2300/HI/ABF/21-9	0%	Institutional inpatient
165	MC436	Present on Admission - Other Diagnosis - 22	N	Text	1	Use this field to report whether or not the twenty-second secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	N/A	N/A	*Institutional* 837/2300/HI/BF/22-9 837/2300/HI/ABF/22-9	0%	Institutional inpatient
166	MC437	Present on Admission - Other Diagnosis - 23	N	Text	1	Use this field to report whether or not the twenty-third secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	N/A	N/A	*Institutional* 837/2300/HI/BF/23-9 837/2300/HI/ABF/23-9	0%	Institutional inpatient
167	MC438	Present on Admission - Other Diagnosis - 24	N	Text	1	Use this field to report whether or not the twenty-fourth secondary diagnosis was present on admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	N/A	N/A	*Institutional* 837/2300/HI/BF/24-9 837/2300/HI/ABF/24-9	0%	Institutional inpatient

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COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	MAPPINGS			THRESH.	DENOM.
							UB-04 REF	CMS 1500 REF	X12 REF		
168	MC439	DRG Outlier Payment Amount	N	Decimal	12,2	For Medicare claims only, use this field to report the additional payment amount approved by the Peer Review Organization due to an outlier situation for a beneficiary's stay under the prospective payment system, which has been classified into a specific diagnosis related group. Notes: When reporting this field, always report with two decimal places. Do not code the decimal point when reporting to Onpoint.	N/A	N/A	N/A	20%	Medicare
169	MC440	Submitter-Supplied Claim Type	N	Text	2	For Medicaid and Medicare claims only, use this field to indicate the type of claim using the payer's classification system.	N/A	N/A	N/A	99%	Medicaid & Medicare
170	MC441	Claim Utilization Day Count	N	Integer	6	For Medicare claims only, use this field to report the number of covered days of care that are chargeable to Medicare facility utilization that includes full days, coinsurance days, and lifetime reserve days.	39-41	N/A	*Institutional* 837/2300/HI/BE/01-24	0%	Medicare
171	MC445	Non-Payment Reason Code	N	Text	2	For Medicare claims only, use this field to report the reason that no payment was made for services on an institutional claim.	N/A	N/A	N/A	0%	Medicare
172	MC446	Primary Payer Code	N	Text	2	For Medicare claims only, use this field to specify a federal non-Medicare program or other source that has primary responsibility for the payment of the Medicare beneficiary's medical bills relating to the line item service on the non-institutional claim.	N/A	N/A	N/A	0%	Medicare
173	MC447	Line Processing Indicator	N	Text	2	For a non-institutional Medicare claim only, use this field to report to whom payment was made or if the claim was denied.	N/A	N/A	N/A	0%	Medicare
174	MC448	Claim Coinsurance Days	N	Integer	22	For Medicare claims only, use this field to report the count of the total number of coinsurance days involved with the beneficiary's stay in a facility.	39-41	N/A	*Institutional* 837/2300/HI/BE/01-24	0%	Medicare
175	MC449	Claim Final Bill Code	N	Integer	22	For Medicare claims only, use this field to report the type of claim record being processed with respect to payment (e.g., debit/credit indicator; interim/final indicator; etc.).	N/A	N/A	N/A	0%	Medicare
176	MC451	Claim MCO Paid Switch	N	Text	2	For Medicare claims only, use this field to report whether or not a managed care organization (MCO) has paid the provider for an institutional claim.	N/A	N/A	N/A	0%	Medicare
177	MC452	Noncovered Charge Amount	N	Decimal	10,2	For Medicare claims only, use this field to report the charge amount related to a revenue center code for services that are not covered by Medicare.	48	N/A	*Institutional* 837/2400/SV2//07	0%	Medicare
178	MC454	Type of Service Code	N	Text	2	Use this field to report the type of service for this line item on a professional claim.	N/A	N/A	N/A	0%	Medicare

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COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	MAPPINGS			THRESH.	DENOM.
							UB-04 REF	CMS 1500 REF	X12 REF		
179	MC456	Attending Provider Last Name	N	Text	60	Use this field to report the last name of the attending provider on an institutional claim.	76	N/A	*Institutional* 827/2310A/NM1/71/03	0%	Medicare
180	MC457	Attending Provider First Name	N	Text	35	Use this field to report the first name of the attending provider on an institutional claim.	76	N/A	*Institutional* 827/2310A/NM1/71/04	0%	Medicare
181	MC458	Attending Provider Middle Initial	N	Text	1	Use this field to report the middle initial of the attending provider on an institutional claim.	76	N/A	*Institutional* 827/2310A/NM1/71/05	0%	Medicare
182	MC459	Attending Provider NPI	N	Text	10	Use this field to report the NPI of the attending provider on an institutional claim.	76	N/A	*Institutional* 827/2310A/NM1/71/09	0%	Medicare
183	MC460	Operating Provider Last Name	N	Text	60	Use this field to report the last name of the operating provider on an institutional claim.	77	N/A	*Institutional* 827/2310B/NM1/72/03	0%	Medicare
184	MC460A	Operating Provider First Name	N	Text	35	Use this field to report the first name of the operating provider on an institutional claim.	77	N/A	*Institutional* 827/2310B/NM1/72/04	0%	Medicare
185	MC460B	Operating Provider Middle Initial	N	Text	1	Use this field to report the middle initial of the operating provider on an institutional claim.	77	N/A	*Institutional* 827/2310B/NM1/72/05	0%	Medicare
186	MC461	Operating Provider NPI	N	Text	10	Use this field to report the NPI of the operating provider on an institutional claim.	77	N/A	*Institutional* 827/2310B/NM1/72/09	0%	Medicare
187	MC462	Other Provider NPI	N	Text	10	Use this field to report the NPI of the other provider on an institutional claim.	78-79	N/A	*Institutional* 827/2310C/NM1/ZZ/09	0%	Medicare
188	MC463	Ordering Provider NPI	N	Text	10	Use this field to report the NPI of the ordering provider on an institutional claim.	78-79	N/A	N/A	0%	Medicare
189	MC464	Referring Provider NPI	N	Text	10	Use this field to report the NPI of the referring provider.	78-79	N/A	*Institutional* 827/2310F/NM1/DN/09	0%	Medicare
190	MC465	Date Performed - ICD Primary Procedure Code	N	Date	8	Use this field to report the date on which the primary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	74	N/A	*Institutional* 837/2300/HI/BR/01-4 837/2300/HI/BBR/01-4	55%	Institutional inpatient hospital
191	MC466	Date Performed - Other ICD Procedure Code - 1	N	Date	8	Use this field to report the date on which the first secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	74a	N/A	*Institutional* 837/2300/HI/BQ/01-4 837/2300/HI/BBQ/01-4	30%	Institutional inpatient hospital

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COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	UB-04 REF	CMS 1500 REF	X12 REF	THRESH.	DENOM.
192	MC467	Date Performed - Other ICD Procedure Code - 2	N	Date	8	Use this field to report the date on which the second secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	74b	N/A	*Institutional* 837/2300/HI/BQ/02-4 837/2300/HI/BBQ/02-4	15%	Institutional inpatient hospital
193	MC468	Date Performed - Other ICD Procedure Code - 3	N	Date	8	Use this field to report the date on which the third secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	74c	N/A	*Institutional* 837/2300/HI/BQ/03-4 837/2300/HI/BBQ/03-4	10%	Institutional inpatient hospital
194	MC469	Date Performed - Other ICD Procedure Code - 4	N	Date	8	Use this field to report the date on which the fourth secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	74d	N/A	*Institutional* 837/2300/HI/BQ/04-4 837/2300/HI/BBQ/04-4	5%	Institutional inpatient hospital
195	MC470	Date Performed - Other ICD Procedure Code - 5	N	Date	8	Use this field to report the date on which the fifth secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	74e	N/A	*Institutional* 837/2300/HI/BQ/05-4 837/2300/HI/BBQ/05-4	0%	Institutional inpatient hospital
196	MC471	Date Performed - Other ICD Procedure Code - 6	N	Date	8	Use this field to report the date on which the sixth secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	N/A	N/A	*Institutional* 837/2300/HI/BQ/06-4 837/2300/HI/BBQ/06-4	0%	Institutional inpatient hospital
197	MC472	Date Performed - Other ICD Procedure Code - 7	N	Date	8	Use this field to report the date on which the seventh secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	N/A	N/A	*Institutional* 837/2300/HI/BQ/07-4 837/2300/HI/BBQ/07-4	0%	Institutional inpatient hospital
198	MC473	Date Performed - Other ICD Procedure Code - 8	N	Date	8	Use this field to report the date on which the eighth secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	N/A	N/A	*Institutional* 837/2300/HI/BQ/08-4 837/2300/HI/BBQ/08-4	0%	Institutional inpatient hospital

MEDICAL CLAIMS FILE TO ONPOINT											
							MAPPINGS				
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	UB-04 REF	CMS 1500 REF	X12 REF	THRESH.	DENOM.
199	MC474	Date Performed - Other ICD Procedure Code - 9	N	Date	8	Use this field to report the date on which the ninth secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	N/A	N/A	*Institutional* 837/2300/HI/BQ/09-4 837/2300/HI/BBQ/09-4	0%	Institutional inpatient hospital
200	MC475	Date Performed - Other ICD Procedure Code - 10	N	Date	8	Use this field to report the date on which the tenth secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	N/A	N/A	*Institutional* 837/2300/HI/BQ/10-4 837/2300/HI/BBQ/10-4	0%	Institutional inpatient hospital
201	MC476	Date Performed - Other ICD Procedure Code - 11	N	Date	8	Use this field to report the date on which the eleventh secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	N/A	N/A	*Institutional* 837/2300/HI/BQ/11-4 837/2300/HI/BBQ/11-4	0%	Institutional inpatient hospital
202	MC477	Date Performed - Other ICD Procedure Code - 12	N	Date	8	Use this field to report the date on which the twelfth secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	N/A	N/A	*Institutional* 837/2300/HI/BQ/12-4 837/2300/HI/BBQ/12-4	0%	Institutional inpatient hospital
203	MC478	Date Performed - Other ICD Procedure Code - 13	N	Date	8	Use this field to report the date on which the thirteenth secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	N/A	N/A	*Institutional* 837/2300/HI/BQ/13-4 837/2300/HI/BBQ/13-4	0%	Institutional inpatient hospital
204	MC479	Date Performed - Other ICD Procedure Code - 14	N	Date	8	Use this field to report the date on which the fourteenth secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	N/A	N/A	*Institutional* 837/2300/HI/BQ/14-4 837/2300/HI/BBQ/14-4	0%	Institutional inpatient hospital
205	MC480	Date Performed - Other ICD Procedure Code - 15	N	Date	8	Use this field to report the date on which the fifteenth secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	N/A	N/A	*Institutional* 837/2300/HI/BQ/15-4 837/2300/HI/BBQ/15-4	0%	Institutional inpatient hospital

MEDICAL CLAIMS FILE TO ONPOINT											
							MAPPINGS				
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	UB-04 REF	CMS 1500 REF	X12 REF	THRESH.	DENOM.
206	MC481	Date Performed - Other ICD Procedure Code - 16	N	Date	8	Use this field to report the date on which the sixteenth secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	N/A	N/A	*Institutional* 837/2300/HI/BQ/16-4 837/2300/HI/BBQ/16-4	0%	Institutional inpatient hospital
207	MC482	Date Performed - Other ICD Procedure Code - 17	N	Date	8	Use this field to report the date on which the seventeenth secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	N/A	N/A	*Institutional* 837/2300/HI/BQ/17-4 837/2300/HI/BBQ/17-4	0%	Institutional inpatient hospital
208	MC483	Date Performed - Other ICD Procedure Code - 18	N	Date	8	Use this field to report the date on which the eighteenth secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	N/A	N/A	*Institutional* 837/2300/HI/BQ/18-4 837/2300/HI/BBQ/18-4	0%	Institutional inpatient hospital
209	MC484	Date Performed - Other ICD Procedure Code - 19	N	Date	8	Use this field to report the date on which the nineteenth secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	N/A	N/A	*Institutional* 837/2300/HI/BQ/19-4 837/2300/HI/BBQ/19-4	0%	Institutional inpatient hospital
210	MC485	Date Performed - Other ICD Procedure Code - 20	N	Date	8	Use this field to report the date on which the twentieth secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	N/A	N/A	*Institutional* 837/2300/HI/BQ/20-4 837/2300/HI/BBQ/20-4	0%	Institutional inpatient hospital
211	MC486	Date Performed - Other ICD Procedure Code - 21	N	Date	8	Use this field to report the date on which the twenty-first secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	N/A	N/A	*Institutional* 837/2300/HI/BQ/21-4 837/2300/HI/BBQ/21-4	0%	Institutional inpatient hospital
212	MC487	Date Performed - Other ICD Procedure Code - 22	N	Date	8	Use this field to report the date on which the twenty-second secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	N/A	N/A	*Institutional* 837/2300/HI/BQ/22-4 837/2300/HI/BBQ/22-4	0%	Institutional inpatient hospital

MEDICAL CLAIMS FILE TO ONPOINT											
							MAPPINGS				
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	UB-04 REF	CMS 1500 REF	X12 REF	THRESH.	DENOM.
213	MC488	Date Performed - Other ICD Procedure Code - 23	N	Date	8	Use this field to report the date on which the twenty-third secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	N/A	N/A	*Institutional* 837/2300/HI/BQ/23-4 837/2300/HI/BBQ/23-4	0%	Institutional inpatient hospital
214	MC489	Date Performed - Other ICD Procedure Code - 24	N	Date	8	Use this field to report the date on which the twenty-fourth secondary ICD procedure was performed. **Notes:** When coding this field, use an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	N/A	N/A	*Institutional* 837/2300/HI/BQ/24-4 837/2300/HI/BBQ/24-4	0%	Institutional inpatient hospital
215	MC899	Record Type	N	Text	2	Use this field to report the constant value of "MC" to denote a medical claims record.	Administrative Element	Administrative Element	Administrative element	100%	All
1	TR001	Record Type	N	Text	2	This field must be coded TR to indicate the start of the trailer record.	Administrative Element	Administrative Element	Administrative Element	100%	All
2	TR002	Submitter Code	N	Text	8	This field must contain the submitter code assigned to you by Onpoint Health Data.	Administrative Element	Administrative Element	Administrative Element	100%	All
3	TR003	Placeholder	N/A	N/A	N/A	This field must be coded as null; it is reserved for trailer consistency across all clients using Onpoint CDM.	N/A	N/A	N/A	N/A	N/A
4	TR004	Type of File	N	Text	2	This field must be coded MC to indicate submission of medical claims data.	Administrative Element	Administrative Element	Administrative Element	100%	All
5	TR005	Period Beginning Date	N	Integer	6	Use this field to report the earliest payment year/month included in the submission in CCYYMM format. Submissions with records containing a Payment Date / Settlement Date (MC017) outside of the date range indicated in this file's header and trailer records will fail.	Administrative Element	Administrative Element	Administrative Element	100%	All
6	TR006	Period Ending Date	N	Integer	6	Use this field to report the latest payment year/month included in the submission in CCYYMM format. Submissions with records containing a Payment Date / Settlement Date (MC017) outside of the date range indicated in this file's header and trailer records will fail.	Administrative Element	Administrative Element	Administrative Element	100%	All
7	TR007	Date Processed	N	Date	8	Use this field to report the date on which the file was created in CCYYMMDD format.	Administrative Element	Administrative Element	Administrative Element	0%	All

Pharmacy Claims

The Basics

Key References R23-17.17-RIAPCD §1.25 and §4.3.b

Covered Parties All

Required Frequency Either monthly or quarterly (in adherence to calendar-year quarters; for example, Q1 data should be submitted to Onpoint prior to May 31)

Specific Deadline Within 10 business days of receipt of Unique Member Identifiers from the Lockbox Vendor (§5.2.c.4.i)

Important Notes

- All lines of partially denied claims are to be reported. Only fully denied claims are to be excluded.
- One record must be submitted for each service adjudicated during the period reported in the header and trailer records.
- Submissions must cover full months of data; partial months must not be reported.
- Every member who had coverage during the period reported and has a reported Member Opt-Out Status (RF018) of either I (included) or U (unknown) must be included in the submitted medical claims file.
- Every member who had coverage during the period reported but instead has a reported Member Opt-Out Status (RF018) of O (opted out) must have no claims data reported in this file.

Columns Included in the Pharmacy Claims File

Indicates the element's required position within the submission file	Indicates the element's reference number	Indicates the element's name	Indicates whether or not the element's true value has been rendered permanently non-recoverable by one-way hashing prior to submission to Onpoint	Indicates whether the type of data for the element is a date, decimal, integer, or text	Indicates the maximum length allowed for this element	Provides a general description of the data element, including valid codes vary from industry standards and for elements that lack a national standard altogether. Values appended with superscript text in blue (e.g., [+] 01/01/2012) note the effective date of newly valid values; those with strikethrough text (i.e., ~~strikethrough~~) are no longer valid and have their expiration dates appended in red superscript text (e.g., [x] 12/31/2011).	Indicates the element's NCPDP reference standard	Indicates the percent of submitted records for which this element must have a valid code	Indicates the type of records to be used to calculate the threshold percent for submission. Note: Denominators are comprised of records for only those members with an opt-out status of I (included) or U (unknown) unless the field is shaded gold. For gold-shaded fields, denominators also include records for members with an opt-out status of O (opted out) to enable QA review.
↓	↓	↓	↓	↓	↓	↓	↓	↓	↓
COL. #	**ID**	**NAME**	**HASHED?**	**TYPE**	**MAX. LENGTH**	**DESCRIPTION**	**NCPDP REFERENCE**	**THRESH.**	**DENOM.**

File Layout & Specifications

PHARMACY CLAIMS FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	NCPDP REFERENCE	THRESH.	DENOM.
1	HD001	Record Type	N	Text	2	This field must be coded HD to indicate the start of the header record.	Administrative element	100%	All
2	HD002	Submitter Code	N	Text	8	This field must contain the submitter code assigned to you by Onpoint Health Data.	Administrative element	100%	All
3	HD003	Placeholder	N	Text	30	This field must be coded as null; it is reserved for header consistency across all clients using Onpoint Health Data's APCD services.	Administrative element	0%	All
4	HD004	Type of File	N	Text	2	This field must be coded PC to indicate submission of pharmacy claims data.	Administrative element	100%	All
5	HD005	Period Beginning Date	N	Integer	6	Use this field to report the earliest date service approved year/month included in the submission in CCYYMM format. Submissions with records containing a Payment Date / Settlement Date value (PC017) outside of the date range indicated in this file's header and trailer records will fail.	Administrative element	100%	All
6	HD006	Period Ending Date	N	Integer	6	Use this field to report the latest date service approved year/month included in the submission in CCYYMM format. Submissions with records containing a Payment Date / Settlement Date value (PC017) outside of the date range indicated in this file's header and trailer records will fail.	Administrative element	100%	All
7	HD007	Record Count	N	Integer	10	Use this field to report the total number of records in the submission, excluding the header and trailer records. If the number of records within the submission does not equal the number reported in this field, the submission will fail.	Administrative element	100%	All
8	HD008	Comments	N	Text	80	This field may be used by the submitter to document a file name, system source, or other administrative device to assist with their internal tracking of the submission.	Administrative element	0%	All
1	PC001	Submitter Code	N	Text	8	Use this field to report your Onpoint-assigned submitter code for the data submitter. Note that the first two characters of the submitter code are used to indicate the reporting state and the third character designates the type of submitter. For Rhode Island's APCD collection, valid prefixes include: RIC .....Commercial carrier RIG .....Governmental agency RIT.....Third-party administrator **Notes:** A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter.	Administrative element	100%	All
2	PC002	NAIC	N	Text	5	Use this field to report, at a record level, the code as assigned by the NAIC that uniquely identifies the applicable insurance plan. If no NAIC number has been assigned, report as "0".	Administrative element	100%	All

PHARMACY CLAIMS FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	NCPDP REFERENCE	THRESH.	DENOM.
3	PC003	Insurance Type / Product Code	N	Text	2	Use this field to report the member's type of insurance or insurance product. **Notes:** The value reported for this field should be consistent with the value reported in ME003 ("Insurance Type / Product Code") in the eligibility file. To ensure reporting consistency between submitters, all Medicare Advantage plans should use the code "HN" to denote a Health Maintenance Organization (HMO) – Medicare Risk. Valid codes are maintained by the Accredited Standards Committee (ASC) and are available in the ASC X12 transaction set.	271/2110C/EB/ /04, 271/2110D/EB/ /04	100%	All
4	PC004	Payer Claim Control Number	N	Text	50	Use this field to report the claim number used by the data submitter to internally track the claim. **Notes:** In general, the claim number is associated with all service lines of the claim. It must apply to the entire claim and be unique within the data submitter's system. The value reported in this field should remain consistent over time. If reporting multiple versions of the same claim, this number should remain the same; use PC005A (Version Number) to report multiple versions of the same claim subject to subsequent changes/adjustments.	993-A7	99.9%	All
5	PC004A	Claim Submitter's Identifier	N	Text	38	Use this field to report the claim number used by the pharmacy to track a claim from creation through payment.	880-K5	90%	All
6	PC005	Line Counter	N	Integer	4	Use this field to report the line number for this service. **Notes:** The line counter should begin with 1 and be incremented by 1 for each additional service line of a claim.	Administrative element	99.5%	All
7	PC005A	Version Number	N	Integer	4	Use this field to report the version number of the claim service record. **Notes:** The version number should begin with 0 and be incremented by 1 for each subsequent version of that service line. If versioning is not used to report adjusted claims, report claims with a Version Number of zero (0).	Administrative element	99.5%	All
8	PC006	Insured Group or Policy Number	N	Text	50	Use this field to report the group or policy number. **Notes:** This is not the number that uniquely identifies the subscriber. The value reported for this field should be consistent with the value reported in the Insured Group or Policy Number fields across all file types (ME006, MC006, PC006). If a policy is sold to an individual as a non-group policy, then this field should be reported with a value of "IND". This principle pertains to all claim types: commercial, Medicaid, and Medicare.	301-C1	99.5%	All

PHARMACY CLAIMS FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	NCPDP REFERENCE	THRESH.	DENOM.
9	PC007	Subscriber Social Security Number	Y	Text	9	Use this field to report the subscriber's 9-digit Social Security number. **Notes:** The value reported for this field should be consistent with the value reported in ME008 ("Subscriber Social Security Number") in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	N/A	99.9%	All
10	PC008	Plan-Specific Contract Number	Y	Text	80	Use this field to report the submitter-assigned contract number for the subscriber. **Notes:** The value reported for this field should be consistent with the value reported in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	302-C2	99.9%	All
11	PC009	Member Suffix or Sequence Number	N	Text	20	Use this field to report the unique number of the member within the contract.	N/A	50%	All
12	PC010	Member Social Security Number	Y	Text	9	Use this field to report the member's 9-digit Social Security number. **Notes:** The value reported for this field should be consistent with the value reported in ME011 ("Member Social Security Number") in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	N/A	75%	All
13	PC010A	Unique Member Identifier	N	String	32	Use this field to report the Unique Member Identifier assigned by the Lockbox Vendor in the Response File's field RF017. **Notes:** The value reported for this field should be reported identically to the "Unique Member Identifier" field in the eligibility file (ME010A).	Administrative element	100%	All
14	PC011	Member Relationship	N	Text	2	Use this field to report the member's relationship to the subscriber or the insured. **Notes:** The value reported for this field should be consistent with the value reported in ME012 ("Member Relationship") in the eligibility file. Valid codes are maintained by the National Council for Prescription Drug Programs (NCPDP) and are available in the NCPDP standards set.	306-C6	100%	All

PHARMACY CLAIMS FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	NCPDP REFERENCE	THRESH.	DENOM.
15	PC012	Member Gender	N	Text	1	Use this field to report the member's gender. **Notes:** The value reported for this field should be consistent with the value reported in ME013 ("Member Gender") in the eligibility file. Valid codes are maintained by the National Council for Prescription Drug Programs (NCPDP) and are available in the NCPDP standards set. Please note that an additional gender code has been added for this field to accommodate a non-NCPDP value of O (Other).	305-C5	100%	All
16	PC013	Member Date of Birth	Y	Date	8	Use this field to report the member's date of birth using an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118"). **Notes:** The value reported for this field should be consistent with the value reported in ME014 ("Member Date of Birth") in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Immediately prior to hashing this field, Onpoint's hashing application calculates a member's age in months based on the Member Date of Birth field (ME014, MC013, PC013). The Member Date of Birth field is then hashed and both the hashed value and the value-added Age in Months element are submitted to the APCD — the hashed value to allow for quality assurance review, the de-identified Age in Months to enable analytic use of the APCD.	304-C4	99.5%	All
17	PC014	Member City	N	Text	30	Use this field to report the name of the member's city of residence.	323-CN	99.5%	All
18	PC015	Member State or Province	N	Text	2	Use this field to report the member's state or province using the two-character abbreviation code defined by the U.S. Postal Service(for U.S. states) and Canada Post (for Canadian provinces).	324-CO	99.5%	All
19	PC016	Member ZIP/Postal Code	N	Text	9	Use this field to report the ZIP/postal code associated with the member's residence. **Notes:** For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code). Do not code dashes or spaces within ZIP/postal codes.	325-CP	99.5%	All
20	PC017	Payment Date / Settlement Date	N	Date	8	Use this field to report the date on which the record was approved for payment using an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118"). **Notes:** This is generally referred to as the paid date and reported with a CCYYMMDD format. When BPR04 is "NON" for nonpayment, include remittance date.	216	100%	All
21	PC018	Pharmacy Number	N	Text	30	Use this field to report the payer-assigned pharmacy number.	201-B1	90%	All
22	PC019	Pharmacy Tax ID Number	N	Text	9	Use this field to report the pharmacy's federal taxpayer's identification number.	N/A	10%	All
23	PC020	Pharmacy Name	N	Text	30	Use this field to report the name of the pharmacy.	833-5P	99.5%	All
24	PC020A	Mail-Order Pharmacy	N	Text	1	Use this field to report whether or not the dispensing pharmacy was a mail-order pharmacy. The only valid codes for this field are: Y.....Yes N .....No U .....Unknown	N/A	99.5%	All

PHARMACY CLAIMS FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	NCPDP REFERENCE	THRESH.	DENOM.
25	PC020B	Out-of-Network Indicator	N	Text	1	Use this field to report whether or not the pharmacy at which the prescription was filled was out of network. The only valid codes for this field are: O .....Out of network I.....In network N .....Not applicable U .....Unknown	N/A	100%	All
26	PC021	National Pharmacy ID Number	N	Text	10	Use this field to report the National Provider Identification (NPI) of the pharmacy.	201-B1	99.5%	All
27	PC022	Pharmacy Location City	N	Text	30	Use this field to report the city where the prescription was filled.	728	99.5%	All
28	PC023	Pharmacy Location State or Province	N	Text	2	Use this field to report the state or province where the prescription was filled using the two-character abbreviation defined by the U.S. Postal Service (for U.S. states) and Canada Post (for Canadian provinces).	729	99.5%	All
29	PC024	Pharmacy ZIP/Postal Code	N	Text	9	Use this field to report the ZIP/postal code where the prescription was filled. **Notes:** For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code). Do not code dashes or spaces within ZIP/postal codes.	730	99.5%	All
30	PC024A	Pharmacy Country	N	Text	30	Use this field to report the name of the country where the prescription was filled. **Notes:** Please code only a two-digit response — "US" — to indicate the United States.	N/A	99.5%	All
31	PC025	Claim Status	N	Text	2	Use this field to report the status of the claim — whether paid as primary, paid as secondary, denied, etc. **Notes:** Valid codes are maintained by the Accredited Standards Committee (ASC) and are available in the ASC X12 transaction set.	835/2100/CLP/ /02	99.5%	All
32	PC026	National Drug Code	N	Text	11	Use this field to report the National Drug Code (NDC) assigned by the U.S. Food and Drug Administration (FDA).	407-D7	99.5%	All
33	PC027	Drug Name	N	Text	80	Use this field to report the text name of the drug. **Notes:** Valid codes are maintained by the National Council for Prescription Drug Programs (NCPDP) and are available in the NCPDP standards set.	516-FG	99.5%	All
34	PC028	New Prescription or Refill	N	Text	2	Use this field to report whether this is a new prescription or refill. The only valid codes for this field are: 00.....New prescription 01–99.....Number of refill(s)	403-D3	99.5%	All
35	PC029	Generic Drug Indicator	N	Text	1	Use this field to report whether the drug is a branded drug or a generic drug. The only valid codes for this field are: N .....No, branded drug Y.....Yes, generic drug U .....Unknown	425-DP	99.5%	All

PHARMACY CLAIMS FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	NCPDP REFERENCE	THRESH.	DENOM.
36	PC030	Dispense as Written Code	N	Integer	1	Use this field to report the instructions given to the pharmacist for filling the prescription. **Notes:** Valid codes are maintained by the National Council for Prescription Drug Programs (NCPDP) and are available in the NCPDP standards set.	408-D8	99.5%	All
37	PC031	Compound Drug Indicator	N	Text	1	Use this field to indicate whether or not the drug is a compound drug. **Notes:** Valid codes are maintained by the National Council for Prescription Drug Programs (NCPDP) and are available in the NCPDP standards set.	406-D6	99.5%	All
38	PC032	Date Prescription Filled	N	Date	8	Use this field to report the date on which the prescription was filled using an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as “19720118”).	401-D1	99.5%	All
39	PC033	Quantity Dispensed	N	Decimal	10,2	Use this field to report the total unit dosage in metric units. **Notes:** This field may contain a negative value. When coding this field, always report with two decimal places. If the actual value included three decimal place, round to two. Do not include the decimal point when coding this field.	442-E7	99.5%	All
40	PC034	Days’ Supply	N	Integer	3	Use this field to report the days’ supply for the prescription based on the metric quantity dispensed. **Notes:** This field may contain a negative value.	405-D5	95%	All
41	PC035	Charge Amount	N	Decimal	10,2	Use this field to report total charges for the prescription as reported by the pharmacy. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	430-DU	99.5%	All
42	PC036	Paid Amount	N	Decimal	10,2	Use this field to report the total dollar amount paid to the provider, including all health plan payments and excluding all member payments and withholds from providers. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	509-F9	99.5%	All
43	PC037	Ingredient Cost / List Price	N	Decimal	10,2	Use this field to report the cost of the drug that was dispensed. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	506-F6	99.5%	All
44	PC038	Postage Amount Claimed	N	Decimal	10,2	Use this field to report the cost of postage included in the Paid Amount field (PC036). **Notes:** Do not include the decimal point when coding this field.	N/A	99.5%	All

PHARMACY CLAIMS FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	NCPDP REFERENCE	THRESH.	DENOM.
45	PC039	Dispensing Fee	N	Decimal	10,2	Use this field to report the amount charged for dispensing the prescription. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	507-F7	99.5%	All
46	PC040	Copay Amount	N	Decimal	10,2	Use this field to report the preset, fixed dollar amount payable by a member, often on a per visit/service basis. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	518-FI	99.5%	All
47	PC041	Coinsurance Amount	N	Decimal	10,2	Use this field to report the dollar amount that a member must pay toward the cost of a covered service. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	572-4U	99.5%	All
48	PC042	Deductible Amount	N	Decimal	10,2	Use this field to report the dollar amount that a member must pay before the health plan benefits will begin to reimburse for services. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	517-FH	99.5%	All
49	PC044	Prescribing Provider First Name	N	Text	35	Use this field to report the first name of the prescribing provider.	N/A	40%	All
50	PC045	Prescribing Provider Middle Initial	N	Text	1	Use this field to report the middle initial of the prescribing provider.	N/A	.5%	All
51	PC046	Prescribing Provider Last Name	N	Text	60	Use this field to report the last name of the prescribing provider.	427-DR	99%	All
52	PC047	Prescribing Provider DEA Number	N	Text	9	Use this field to report the prescribing provider's Drug Enforcement Agency (DEA) number.	421-DL	~~95~~ 85%	All
53	PC047A	Prescribing Provider State License Number	N	Text	20	Use this field to report the prescribing provider's state license number.	421-DL	10%	All
54	PC047B	Prescribing Provider Street Address	N	Text	55	Use this field to report the prescribing provider's street address.	N/A	10%	All
55	PC047C	Prescribing Provider City	N	Text	30	Use this field to report the prescribing provider's city.	N/A	10%	All

PHARMACY CLAIMS FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	NCPDP REFERENCE	THRESH.	DENOM.
56	PC047D	Prescribing Provider State or Province	N	Text	2	Use this field to report the prescribing provider's state using the two-character abbreviation defined by the U.S. Postal Service (for U.S. states) and Canada Post (for Canadian provinces).	267-2N	10%	All
57	PC047E	Prescribing Provider ZIP/Postal Code	N	Text	9	Use this field to report the prescribing provider's ZIP/postal code associated with the prescribing provider's location. **Notes:** For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code). Do not code dashes or spaces within ZIP/postal codes.	268-2P	10%	All
58	PC048	Prescribing Provider NPI	N	Text	10	Use this field to report the prescribing provider's National Provider Identifier (NPI).	421-DL	80%	All
59	PC048A	Prescribing Provider Plan ID	N	Text	15	Use this field to report the payer-supplied ID for the prescribing provider. **Note:** The provider data reported in the eligibility, claims, and provider files are used to create a Provider Master Index that is used to match the data across all file types. It is expected that a provider's identifiers (e.g., plan-assigned ID, NPI, etc.) will be reported consistently by a submitter across file types as this is the payer-assigned provider ID (ME051, MC024, PC048A, PV006).	411-DB	98%	All
60	PC080	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A	N/A
61	PC081	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A	N/A
62	PC082	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A	N/A
63	PC083	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A	N/A
64	PC084	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	PC101	Subscriber Last Name	Y	Text	60	Use this field to report the subscriber's last name. **Notes:** The value reported for this field should be consistent with the value reported in ME101 ("Subscriber Last Name") in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	313-CD	100%	All
66	PC102	Subscriber First Name	Y	Text	35	Use this field to report the subscriber's first name. **Notes:** The value reported for this field should be consistent with the value reported in ME102 ("Subscriber First Name") in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	312-CC	100%	All

PHARMACY CLAIMS FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	NCPDP REFERENCE	THRESH.	DENOM.
67	PC103	Subscriber Middle Initial	Y	Text	1	Use this field to report the subscriber's middle initial. **Notes:** The value reported for this field should be consistent with the value reported in ME103 ("Subscriber Middle Initial") in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	N/A	50%	All
68	PC104	Member Last Name	Y	Text	60	Use this field to report the member's last name. **Notes:** If the member is the subscriber, report the subscriber's last name again in this field. The value reported for this field should be consistent with the value reported in ME104 ("Member Last Name") in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	311-CB	100%	All
69	PC105	Member First Name	Y	Text	35	Use this field to report the member's first name. **Notes:** If the member is the subscriber, report the subscriber's first name again in this field. The value reported for this field should be consistent with the value reported in ME105 ("Member First Name") in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	310-CA	100%	All
70	PC106	Member Middle Initial	Y	Text	1	Use this field to report the member's middle initial. **Notes:** If the member is the subscriber, report the subscriber's middle initial again in this field. The value reported for this field should be consistent with the value reported in ME106 ("Member Middle Initial") in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	N/A	50%	All
71	PC899	Record Type	N	Text	2	Use this field to report the constant value of "PC" to denote a pharmacy claims record.	Administrative element	100%	All
1	TR001	Record Type	N	Text	2	This field must be coded TR to indicate the start of the trailer record.	Administrative element	100%	All
2	TR002	Submitter Code	N	Text	8	This field must contain the submitter code assigned to you by Onpoint Health Data.	Administrative element	100%	All
3	TR003	Placeholder	N/A	N/A	N/A	This field must be coded as null; it is reserved for trailer consistency across all clients using Onpoint CDM.	N/A	N/A	N/A

PHARMACY CLAIMS FILE TO ONPOINT									
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	NCPDP REFERENCE	THRESH.	DENOM.
4	TR004	Type of File	N	Text	2	This field must be coded PC to indicate submission of pharmacy claims data.	Administrative element	100%	All
5	TR005	Period Beginning Date	N	Integer	6	Use this field to report the earliest date service approved year/month included in the submission in CCYYMM format. Submissions with records containing a Payment Date / Settlement Date value (PC017) outside of the date range indicated in this file's header and trailer records will fail.	Administrative element	100%	All
6	TR006	Period Ending Date	N	Integer	6	Use this field to report the latest date service approved year/month included in the submission in CCYYMM format. Submissions with records containing a Payment Date / Settlement Date value (PC017) outside of the date range indicated in this file's header and trailer records will fail.	Administrative element	100%	All
7	TR007	Date Processed	N	Date	8	Use this field to report the date on which the file was created in CCYYMMDD format.	Administrative element	0%	All

Provider File

The Basics

Key References R23-17.17-RIAPCD §4.3.d

Covered Parties All

Required Frequency Either monthly or quarterly in adherence to calendar-year quarters; for example, Q1 data should be submitted to Onpoint prior to May 31

Specific Deadline

- **Testing:** Prior to submission of medical or pharmacy claims to Onpoint
- **Production:** Within 30 calendar days of the calendar year quarter's end

Important Notes

- One record must be submitted for each variation in a provider's information during the period reported in the header and trailer records.
- Submissions must include information for all providers who rendered services reported in your claims data for the quarter.
- The provider file should include all Rhode Island-based providers, providers outside of Rhode Island who have been reported in the claims files (as rendering, billing, and/or prescribing provider), and PCPs reported in the eligibility file.

Columns Included in the Provider File

Indicates the element's required position within the submission file	Indicates the element's reference number	Indicates the element's name	Indicates whether or not the element's true value has been rendered permanently non-recoverable by one-way hashing prior to submission to Onpoint	Indicates whether the type of data for the element is a date, decimal, integer, or text	Indicates the maximum length allowed for this element	Provides a general description of the data element, including valid codes vary from industry standards and for elements that lack a national standard altogether. Values appended with superscript text in blue (e.g., + 01/01/2012) note the effective date of newly valid values; those with strikethrough text (i.e., ~~strikethrough~~) are no longer valid and have their expiration dates appended in red superscript text (e.g., × 12/31/2011).	Indicates the percent of submitted records for which this element must have a valid code as defined by rule	Indicates the type of records to be used to calculate the threshold percent for submission
↓	↓	↓	↓	↓	↓	↓	↓	↓
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	THRESH.	DENOM.

File Layout & Specifications

PROVIDER FILE TO ONPOINT								
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	THRESH.	DENOM.
1	HD001	Record Type	N	Text	2	This field must be coded HD to indicate the start of the header record.	100%	All
2	HD002	Submitter Code	N	Text	8	This field must contain the submitter code assigned to you by Onpoint Health Data.	100%	All
3	HD003	Placeholder	N	Text	30	This field must be coded as null; it is reserved for header consistency across all clients using Onpoint Health Data's APCD services.	0%	All
4	HD004	Type of File	N	Text	2	This field must be coded PV to indicate submission of provider data.	100%	All
5	HD005	Period Beginning Date	N	Integer	6	Use this field to indicate the first month of the reporting period included in the submission in CCYYMM format.	100%	All
6	HD006	Period Ending Date	N	Integer	6	Use this field to report the last month of the reporting period included in the submission in CCYYMM format.	100%	All
7	HD007	Record Count	N	Integer	10	Use this field to report the total number of records in the submission, excluding the header and trailer records. If the number of records within the submission does not equal the number reported in this field, the submission will fail.	100%	All
8	HD008	Comments	N	Text	80	This field may be used by the submitter to document a file name, system source, or other administrative device to assist with their internal tracking of the submission.	100%	0%
1	PV001	Submitter Code	N	Text	8	Use this field to report your Onpoint-assigned submitter code for the data submitter. Note that the first two characters of the submitter code are used to indicate the reporting state and the third character designates the type of submitter. For Rhode Island's APCD collection, valid prefixes include: RIC .....Commercial carrier RIG.....Governmental agency RIT .....Third-party administrator **Notes:** A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter.	100%	All
2	PV002	National Plan ID	N	Text	30	Use this field to report the CMS National Plan ID when implemented by the U.S. Centers for Medicaid & Medicare Services (CMS). Until CMS issues a National Plan ID, report this field as null.	0%	All
3	PV003	Reporting Period Start Date	N	Date	8	Use this field to report the first date of the reporting period for this submission using an 8-digit format of CCYYMMDD (e.g., if reporting for the first quarter of 2012, this field would be coded as "20120101").	100%	All
4	PV004	Reporting Period End Date	N	Date	8	Use this field to report the last date of the reporting period for this submission using an 8-digit format of CCYYMMDD (e.g., if reporting for the first quarter of 2012, this field would be coded as "20120331").	100%	All

PROVIDER FILE TO ONPOINT								
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	THRESH.	DENOM.
5	PV005	Entity Type Qualifier	N	Text	1	Use this field to report the value that defines type of entity associated with the Provider Plan ID reported in PV006. The only valid codes for this field are: 1 ..... **Person:** Physician, clinician, orthodontist, and any individual that is licensed/certified to perform healthcare services 2 ..... **Facility:** Hospital, health center, long-term care, rehabilitation, and any building that is licensed to transact healthcare services 3 ..... **Professional Group:** Collection of licensed/certified healthcare professionals that are practicing healthcare services under the same entity name and Federal Tax Identification Number 4 ..... **Retail Site:** Brick-and-mortar licensed/certified place of transaction that is not solely a healthcare entity (i.e., pharmacies, independent laboratories, vision services) 5 ..... **E-Site:** Internet-based order/logistic system of healthcare services, typically in the form of durable medical equipment, pharmacy, or vision services; address assigned should be the address of the company delivering services or order fulfillment 6 ..... **Financial Parent:** Financial governing body that does not perform healthcare services itself but directs and finances healthcare service entities, usually through a board of directors 7 ..... **Transportation:** Any form of transport that conveys a patient to/from a healthcare provider 0 ..... **Other:** Any type of entity not otherwise defined that performs health care services	100%	All
6	PV006	Provider Plan ID	N	Text	50	Use this field to report the submitter-assigned internal provider ID (e.g., Medicaid ID, Medicare ID, private carrier ID). **Note:** The provider data reported in the eligibility, claims, and provider files are used to create a Provider Master Index that is used to match the data across all file types. It is expected that a provider's identifiers (e.g., plan-assigned ID, NPI, etc.) will be reported consistently by a submitter across file types as this is the payer-assigned provider ID (ME051, MC024, PC048A, PV006).	100%	All
7	PV007	Provider NPI	N	Text	10	Use this field to report the National Provider Identifier (NPI) for the provider.	98%	All
8	PV008	Provider Tax ID	N	Text	9	Use this field to report the federal taxpayer identification number for the provider. **Notes:** If the tax ID number is an individual's Social Security number, report this field as null.	90%	PV005 ≠ 1
9	PV010	Provider DEA Number	N	Text	10	Use this field to report the individual provider's Drug Enforcement Agency (DEA) number.	~~98~~ 50%	Individual provider
10	PV011	Provider License ID	N	Text	20	Use this field to report the provider's state license number.	~~98~~ 40%	All
11	PV013	Provider Taxonomy Code - 1	N	Text	10	Use this field to report the taxonomy code for the provider.	98%	All
12	PV014	Provider Taxonomy Code - 2	N	Text	10	Use this field to report an additional taxonomy code for the provider.	25%	All
13	PV015	Provider Last Name or Organization Name	N	Text	100	Use this field to report the last name of the provider if an individual or the full name if the provider is a facility or an organization.	100%	All
14	PV016	Provider First Name	N	Text	35	Use this field to report the first name of the provider if an individual. **Notes:** Set to null if the provider is a facility or an organization.	98%	Individual provider
15	PV017	Provider Middle Initial	N	Text	1	Use this field to report the middle initial of the provider if an individual. **Notes:** Set to null if the provider is a facility or an organization.	1%	Individual provider

PROVIDER FILE TO ONPOINT

COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	THRESH.	DENOM.
16	PV018	Provider Suffix	N	Text	10	Use this field to report any generational identifiers associated with the provider's name (e.g., JR, SR, III). **Notes:** Do not code punctuation and do not code the provider's credentials (e.g., MD, LCSW) in this field. Set to null if the provider is a facility or an organization.	1%	Individual provider
17	PV019	Entity Name	N	Text	100	Use this field to report the practice or hospital with which the provider is affiliated. Note that a new record should be reported for each affiliation (i.e., if a provider is affiliated with two practices, two records should be reported). If a provider is a sole practitioner and their name is used as the practice name, the provider's name should be reported in this field. If a provider's affiliation is unknown, report with a value of "UNKNOWN". Notes: When reporting this field, omit any punctuation	98%	All
18	PV020	Entity Code	N	Text	2	Use this field to report the value that defines the entity provider type. The only valid codes for this field are: 01 .....Academic Institution 02 .....Adult Foster Care 03 .....Ambulance Services 04 .....Hospital-Based Clinic 05 .....Stand-Alone, Walk-In/Urgent Care Clinic 06 .....Other Clinic 07 .....Community Health Center - General 08 .....Community Health Center - Urgent Care 09 .....Government Agency 10 .....Health Care Corporation 11 .....Home Health Agency 12 .....Acute Hospital 13 .....Chronic Hospital 14 .....Rehabilitation Hospital 15 .....Psychiatric Hospital 16 .....DPH Hospital 17 .....State Hospital 18 .....Veterans' Hospital 19 .....DMH Hospital 20 .....Sub-Acute Hospital 21 .....Licensed Hospital Satellite Emergency Facility 22 .....Hospital Emergency Center 23 .....Nursing Home 24 .....Freestanding Ambulatory Surgery Center 25 .....Hospital-Licensed Ambulatory Surgery Center 26 .....Non-Health Corporation 27 .....School-Based Health Center 28 .....Rest Home 29 .....Licensed Hospital Satellite Facility 30 .....Hospital-Licensed Health Center 31 .....Other Facility 40 .....Physician (PV005 = 1) 50 .....Physician Group (PV005 = 3) 60 .....Nurse (PV005 = 1) 70 .....Clinician (PV005 = 1)	98%	All

PROVIDER FILE TO ONPOINT								
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	THRESH.	DENOM.
						80 .....Technician (PV005 = 1) 90 .....Pharmacy / Site or Mail Order (PV005 = 4 or 5) 99 .....Other Individual or Group (PV005 = 1 or 3)		
19	PV021	Practice Affiliation Date (Start)	N	Date	8	Use this field to report the first date of this provider's affiliation with this practice. **Notes:** When reporting this field, code using an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	98%	PV005 = 1
20	PV022	Practice Affiliation Date (End)	N	Date	8	Use this field to report either (a) the last date of the reporting period or (b) the last date of this provider's affiliation with this practice. If possible, please code as "99991231" for practices that remain affiliated throughout the reporting period to reduce record volume for end users. **Notes:** When reporting this field, code using an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118").	98%	PV005 = 1
21	PV023	Provider Gender	N	Text	1	Use this field to report the gender of the provider if an individual. The only valid codes for this field are: F.....Female M .....Male U .....Unknown **Notes:** Set to null if the provider is a facility or an organization.	98%	Individual provider
22	PV024	Provider Date of Birth	N	Date	8	Use this field to report the provider's date of birth (if an individual) using an 8-digit format of CCYYMMDD (e.g., January 18, 1972, would be coded as "19720118"). **Notes:** Set to null if the provider is a facility or an organization.	~~98~~ 80%	Individual provider
23	PV025	Provider Physical Location - Street Address 1	N	Text	55	Use this field to report the first line of the street address for the physical location where the provider rendered the service (medical claims) or dispensed the prescription (pharmacy claims). **Notes:** A new record must be reported for each physical location reported in the claims file.	99.90%	All
24	PV026	Provider Physical Location - Street Address 2	N	Text	55	Use this field to report the second line of the street address for the physical location where the provider rendered the service (medical claims) or dispensed the prescription (pharmacy claims). **Notes:** A new record must be reported for each physical location reported in the claims file.	10%	All
25	PV027	Provider Physical Location - City	N	Text	30	Use this field to report the city for the physical location where the provider rendered the service (medical claims) or dispensed the prescription (pharmacy claims). **Notes:** A new record must be reported for each physical location reported in the claims file.	99.90%	All
26	PV028	Provider Physical Location - State or Province	N	Text	2	Use this field to report the state or province for the physical location where the provider rendered the service (medical claims) or dispensed the prescription (pharmacy claims) using the two-character abbreviation defined by the U.S. Postal Service (for U.S. states) and Canada Post (for Canadian provinces). **Notes:** A new record must be reported for each physical location reported in the claims file.	99.90%	All

PROVIDER FILE TO ONPOINT								
COL. #	ID	NAME	HASHED?	TYPE	MAX. LENGTH	DESCRIPTION	THRESH.	DENOM.
27	PV029	Provider Physical Location - ZIP/Postal Code	N	Text	9	Use this field to report the ZIP/postal code for the physical location where the provider rendered the service (medical claims) or dispensed the prescription (pharmacy claims). **Notes:** For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code). Do not code dashes or spaces within ZIP/postal codes. A new record must be reported for each physical location reported in the claims file.	99.90%	All
28	PV030	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A
29	PV031	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A
30	PV032	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A
31	PV033	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A
32	PV034	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A
33	PV899	Record Type	N	Text	2	Use this field to report the constant value of "PV" to denote a provider file record.	100%	All
1	TR001	Record Type	N	Text	2	This field must be coded TR to indicate the start of the trailer record.	100%	All
2	TR002	Submitter Code	N	Text	8	This field must contain the submitter code assigned to you by Onpoint Health Data.	100%	All
3	TR003	Placeholder	N/A	N/A	N/A	This field must be coded as null; it is reserved for trailer consistency across all clients using Onpoint CDM.	N/A	N/A
4	TR004	Type of File	N	Text	2	This field must be coded PV to indicate submission of provider data.	100%	All
5	TR005	Period Beginning Date	N	Integer	6	Use this field to indicate the first month of the reporting period included in the submission in CCYYMM format.	100%	All
6	TR006	Period Ending Date	N	Integer	6	Use this field to report the last month of the reporting period included in the submission in CCYYMM format.	100%	All
7	TR007	Date Processed	N	Date	8	Use this field to report the date on which the file was created in CCYYMMDD format.	0%	All

Reaching Onpoint

Onpoint's staff are committed to helping Rhode Island's submitters every step of the way — from helping to explain state requirements to answering general questions to trouble-shooting specific challenges.

In order to process questions as promptly as possible, please be prepared to provide detailed information to help us understand your specific questions and issues. We offer several ways to find support:

207-623-2555 (Eastern)

ri-support@onpointhealthdata.org

www.onpointcdm.org

Onpoint Health Data
Attn: RI APCD Intake Specialist
254 Commercial Street, Suite 257
Portland, ME 04101

One last note: Please remember to refer to the Rhode Island Department of Health's RI APCD website as the authoritative source for state laws and regulations, announcements, calendars, reports, publications, and links of interest. The RI APCD portal at www.onpointcdm.org offers easy access to many of these documents, but focuses primarily on carrier support, including registration and technical information related to file preparation and data submission.

Appendix 1. Change Log

The following log charts key changes since the release of the RI Technical Specifications Manual (Version 1.4). Note that these changes can be found in the document by locating text highlighted in yellow.

Changes from Version 1.4 to Version 1.5			
ID	Name	File	Notes
N/A	N/A	N/A	An updated schedule for ongoing data submissions to the RI APCD has been included as Table 2.
ME030	Market Category Code	Eligibility File (to Onpoint)	The descriptions for Market Category Codes GLG1 and GLG2 have been adjusted slightly to synchronize with federal risk-adjustment reporting needs by changing the cutover between the two codes from 99 to 100. Also, two additional codes have been added — GLG3 and GLG4 — for those submitters who have the ability to report at a finer grain to assist with downstream analytics.
PC047	Prescribing Provider DEA Number	Pharmacy Claims	Due to cross-submitter challenges to reporting this field, the mandated threshold for this field has been lowered from 95% to 85%, effective January 1, 2016, until further notice.
PV010	Provider DEA Number	Provider	Due to cross-submitter challenges to reporting this field, the mandated threshold for this field has been lowered from 98% to 50%, effective January 1, 2016, until further notice.
PV011	Provider License ID	Provider	Due to cross-submitter challenges to reporting this field, the mandated threshold for this field has been lowered from 98% to 40%, effective January 1, 2016, until further notice.
PV024	Provider Date of Birth	Provider	Due to cross-submitter challenges to reporting this field, the mandated threshold for this field has been lowered from 98% to 80%, effective January 1, 2016, until further notice.

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