



NC Medicaid Managed Care

Requirements for Sharing Encounters &
Historical Claims Data to Support
Advanced Medical Homes (AMHs)
Program

Change Log		
Version	Date	Updates/Change Made
1.0	7/1/19	Initial Publication
2.0	10/4/19	<ul style="list-style-type: none"> • Clarified claim type differentiation, file type differentiation, and MCL schedule language • Clarified "File Type" field in all layouts as D- Pipe Delimited, Double Quote Qualified PSV File • Corrected "Country Code" field for consistency across all layouts under Servicing Facility Information (Header tab) to have a maximum length of 3 • Added "Claims Payment Information" field and subfields in header and line section of all layouts • Aligned mapping document language with the file layout changes • Condensed number of embedded files based on updated mapping document language
3.0	9/18/20	<ul style="list-style-type: none"> • Clarified timing for sharing Encounters and Claims with AMHs • Clarified Claims Type and Optional Fields for Pharmacy Claims
4.0	5/17/2023	<ul style="list-style-type: none"> • Updated Claims Transaction example and populating Claim Frequency Code field in Institutional, Professional, and Dental claims file layouts
5.0	8/24/2023	<ul style="list-style-type: none"> • Updated Claim Header Status Code in the Line file to be an optional field in Institutional, Professional, Pharmacy, and Dental claims file layouts
6.0	8/6/2024	<ul style="list-style-type: none"> • Updated File Delivery Frequency for all claims files • Updated Mandatory, Optional, and Situational designations for fields within the Institutional, Professional, and Dental claims file layouts • Removed outdated 837 Companion Guides and replaced with direct link to website
7.0	7/14/2025	<ul style="list-style-type: none"> • Updated Professional, Institutional, Dental, and Pharmacy templates to add specifications around how to handle interpreting data for fields involving dollar amounts.

Requirements for sharing Encounters & Historical Claims data to Support AMH-Program-Version 8.0

8.0	4/27/2026	<ul style="list-style-type: none">• Updated all claims file layout to central location.
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This document is part of a series of policy papers that the Department of Health and Human Services (the Department) to provide additional details to stakeholders regarding the transition of North Carolina Medicaid and NC Health Choice programs to a managed care model. Some topics mentioned in this document may be covered in more detail in other policy papers in the series. For more information on the Department's proposal, stakeholders are encouraged to review the Amended North Carolina Section 1115 Demonstration Waiver Application and previously released policy papers available at dhhs.gov/nc-medicaid-transformation.

While the paper contains information that may be of interest to all those involved in providing care management, the document will be most useful to PHPs, Advanced Medical Homes, information technology vendors, and other entities responsible for receiving and exchanging data.

Input is welcome and appreciated. Send comments to Medicaid.Transformation@dhhs.nc.gov.

I. Introduction

In the previously published resources listed below, the North Carolina Department of Health and Human Services (the Department) outlined the data strategy and specific care management roles, relationships, and requirements for Prepaid Health Plans (PHPs), Advanced Medical Homes (AMH), and Clinically Integrated Networks (CINs).

- [Data Strategy to Support the Advanced Medical Home Program in North Carolina](#), expands on the requirements in the “Data Sharing” section of the Care Management Strategy to provide further information on the data AMH practices will likely need (and the entities responsible for providing it) to perform care coordination and management, population health improvement, and quality management functions for the beneficiaries they serve.
- [Clinically Integrated Networks and Other Partners Support of Advanced Medical Homes Care Management Data Needs](#), provides updated information on specific data formats, timing, transmission methods, and testing approaches in the following areas: beneficiary assignment, transmission of encounter data, care needs screening, risk stratification, comprehensive assessments, care planning, and coordinating beneficiary care.

The Department recognizes that all practices participating in the AMH model, regardless of their tier, will need access to certain types of data to manage the health of individuals enrolled in Medicaid. Compared to AMH Tier 2 and Tier 2, practices in AMH Tier 3 will have enhanced data needs and associated requirements given their elevated care management and other responsibilities.

For PHPs’ transmission of encounters and historical claims data to AMHs and CINs the Department expects that PHPs will adhere to and will not unilaterally deviate from the required specifications described here-in. A PHP may deviate from the required specifications if both the PHP and the data recipient (i.e., AMH, CIN) mutually agree in writing to the proposed changes. Although the Department does not need to review or approve the proposed mutually-agreed-upon changes, the Department expects the PHPs to: (1) document the specifications that have been changed and the effective date of the changes, and (2) transmit the documented changes to the Department. The Department also expects the PHPs and all trading partners to abide by the Department’s Data Governance Policies, which will be published in a separate document and made available on the Department’s website.

II. Background

PHPs will receive claims resulting from member encounters with providers in their networks and will use these claims as a basis for payment according to their contracts with providers.¹ All claims received and adjudicated by the PHP will become “encounter data.” Encounters are records of medically-related services rendered by a PHP provider to a DHB beneficiary enrolled with the capitated PHP on the date of

¹ As per the Department’s contacts with PHPs: “PHP shall collect and submit service-specific encounter data in the standard ANSI ASC X12N 837 and NCPDP Batch format. The PHP shall submit to DHB an electronic record of every encounter between a network provider and a beneficiary. Medical encounters must be submitted within 30 calendar days from the day the medical claim was adjudicated by the PHP or subcontractor. Pharmacy encounters must be submitted within 7 calendar days of the adjudication date. DHB shall conduct validation studies of encounter data, testing for timeliness, accuracy and completeness. The PHP shall report all encounters that occur up to the date of the termination of this Contract.”

service. Encounter data includes both service claim lines paid and claim lines denied, voided claims, interest paid or recovered, penalties paid or recovered, incentive payments paid or recovered, “zero paid” claim lines, cost settlements, sub-capitated service, third party liability denials, claim line adjustments, and other financial activity associated with payment or recoveries made by the PHPs, its delegates or subcontractors.²

Encounters include services provided through either a capitation or fee-for-service (FFS) arrangement by the PHPs. Encounters for all incurred services in the DHB managed care benefit package for which the PHP has made payment must be reported. Referrals to services that are covered by another payer should not be reported. Encounter services include, but are not limited to:

- Hospital services
- Physician visits
- Nursing visits
- Laboratory tests
- Radiology services
- Early and periodic screening, diagnosis, and treatment (EPSDT) services
- Home health services
- Behavioral health services
- Substance abuse services

To support their administrative, care management, and population health responsibilities, Tier 3 AMHs need accurate, timely and complete encounters and historical claims information from PHPs related to the beneficiaries that have been assigned to them. Given AMH Tier 3 practices’ elevated roles in analytics, care management, and care coordination activities, PHPs will be required to share encounter data they have available on a timely basis with AMH Tier 3 practices subject to applicable data security and privacy requirements.³

PHPs are expected to submit medical and pharmacy encounters for all their respective beneficiaries to the Department through 837 X12 Professional, 837 X12 Institutional, 837 X12 Dental, and NCPDP flat files.

In addition to transmitting encounter data to the Tier 3 AMHs on an ongoing basis, the Department expects PHPs to share the initial set of 24 months of beneficiaries’ historic fee-for-service claims data that they receive from the Department as part of transition of care claims extracts. The Department has provided a mapping column in all layouts that maps the historical claims extracts data elements to the Institutional, professional and NCPDP file layouts.

III. Medical Encounters & Historical Claims and Dental Claims: Data Exchange Protocols

File Layout: To streamline information exchange, and reduce costs and administrative burden for all stakeholders, the Department has developed flat file layouts using the standard 837 X12 Professional & Institutional file formats used by healthcare professionals to transit health care claims and encounters, as the baseline. The Department has published companion guides that outlines each data element, its definition and valid values for these file layouts. The Department’s 837 Institutional and professional

² “Encounter Data Submission Guide Version 1.0” released by the Department April 29, 2019.

³ [“Data Strategy to Support the Advanced Medical Home Program in North Carolina”](#) released by the Department July 20, 2018.

companion guides can be found here: [EPS Guidance](#). File layouts can be found [here](#) or on the NC Medicaid website by searching for “Care Management Historic and Ongoing Claims and Encounters file layouts”.

PHPs will receive all Medical claims from NCTracks through the proprietary GDIT medical claims header, line and edit file layouts. Claim type can be identified by checking the values for C-HDR-TY-CD, per below:

- Professional Claims: 'C' 'E' 'L' 'P' 'S' 'T' 'X' '1' '2' '5' '8' 'Y' 'B' 'V' 'O' 'K' '6' '9' 'Y'
- Institutional Claims: 'F' 'G' 'H' 'I' 'N' 'O' '3' 'Z' 'A' 'U' 'Q' 'Z'
- Dental Claims: 'D'

Any non-standard state-derived data fields will not be part of these standard layouts. However, the Department will work with any stakeholders to standardize these fields as requested.

Optional Fields: PHPs have the discretion to populate the following financial-related fields at the header and line levels; they can have null values.

Header-level

1. Total Claim Charge Amount
2. Claim allowed Amount
3. Payers Claim Payment Amount

Line-level

1. Line Item Charge Amount
2. Claim allowed amount
3. Payers Claim Payment Amount
4. Claim Header Status Code

Claim Frequency Code: When PHPs are populating Claim Frequency Code field in the Professional, Institutional and Dental line claims files they should populate this field based on the value in the header file. Claim Frequency code in the line file should match the header file. Claim Frequency Code field can also be blank in the line file.

File Record Count Validation: To ensure that target system received and ingested the same count of records that was sent by the source system, both source and target systems are expected to generate systemic notifications:

- Source system is required to generate an automated email notification with the file records totals once they deliver any file, to the target system. The Department’s governance team will be copied on these notifications, their email address will be provided to the source system separately.
- Target system is required to generate an automated email notification with the total records they processed, to the source system. The Department’s governance team will be copied on these notifications, their email address will be provided to the source system separately.

The Department understands that fully implementing the file count validation requirements by Managed Care Launch could be challenging for some source and target systems. The Department will allow for manual notifications at launch and expects all Source - PHPs and Targets – AMHs and CINs Platform, to fully meet these requirements within 90 days after Managed Care Launch.

The Department also understands that certain source and target systems may be ready to implement exception processing and will be able to validate counts and manage exceptions using exception files like the standard X12 file format for exceptions. They can go ahead and use that approach if the both the Source - PHP and the Targets – AMHs and CINs, mutually agree in writing to implementing that exception approach. Although the Department does not need to review or approve the proposed mutually-agreed-upon change, the Department expects the PHPs to: (1) document the change and (2) notify the Department of the documented changes.

The Department expects the Source - PHPs and Targets – AMHs and CINs to work together to resolve any data quality issues.

AMHs & CINs Onboarding & Testing:

- **1st Release:**
 - The Department expects PHPs to: (1) work with their respective AMHs and CINs and (2) review the file layout, associated requirements, and implementation timeline and testing expectations to ensure Tier 3 AMHs and CINs are ready to consume this data per the requirements and implementation timelines shared by the Department.
 - PHPs must demonstrate successful end-to-end testing of this interface with Tier 3 AMHs and CINs. To meet this requirement, PHPs are required to identify at least two CINs and one AMH Tier 3 provider to participate in end-to-end testing. The Department will transmit the implementation and testing timelines and additional details on testing requirements in a separate document.
- **Ongoing:** As PHPs contract with new Tier 3 AMHs and their respective CINs, they are expected to have an onboarding process that supports establishing and enabling the exchange of information between the PHPs and Tier 3 AMHs and CINs in the required specification with appropriate testing. PHPs will review their onboarding processes and associated testing timelines with DHB.

A. Medical Encounters

Data Scope: Paid and Denied Medical encounters

Data Source: PHPs

Data Target(s): Tier 3 AMH Practices, CINs

File Type: Pipe Delimited, Double Quote Qualified PSV File. The file layout prescribes maximum field lengths for each field. The source system is expected to use that information to ensure the field lengths do not exceed the maximum field length while generating the file. The following coding method is preferred: Pipe.double quote.data.double quote.pipe. Data examples are included below:

```
|"ABCD"|"2019-12-01"|".....
```

The empty fields are expected to be |""| in this format

```
|"ABCD"|"2019-12-01"|"|".....
```

Transmission Type: Secure File Transfer Protocol (sFTP)

File Delivery Frequency & Processing Rules: First full file and ongoing weekly incremental files to be sent every Tuesday

1. PHPs are also expected to submit all managed care encounters to the Department EPS system. If PHPs make any changes to their encounters to resolve any exceptions reported by the EPS system. Those updated encounter records are required to be included in the incremental files that PHPs will be sending to the AMHs/CINs this will ensure data integrity across systems
2. PHPs should share the first Medical Encounter file with AMH/CINs upon 834 confirmation of assignment for that beneficiary.
 - Upon receipt of a beneficiary the PHP should start sending the Medical Encounters file to the AMH up to 30 calendar days prior to the effective begin date and sent no later than 7 business days of the effective date.
 - PHPs should continue to send the Medical Encounter File to an AMH up until the AMH's effective end date
3. Source system should ensure that all new and updated transactions are picked up as part of Incremental file generation. If an encounter goes through multiple adjustments since the creation of last file, all those transactions should be included in the next file
4. Target system can separately request PHPs for a full file for reconciliation purposes, as needed. PHPs are required to work with target system to ensure data integrity between both systems

File Naming Convention: PHPs are expected to follow the below file naming convention
NCMT_<MedicalEncounterClaimData>_<PHPSHORTNAME>_<AMH/CINName>_CCYYMMDD-HHMMSS.TXT

Below are the short names for each PHPs:

- Carolina Complete Health = CCH
- WellCare of North Carolina = WELLC
- UnitedHealthcare = UHC
- BCBS = BCBS
- AmeriHealth Caritas = AMERI

Below are the values that need to be used for MedicalEncounterClaimData:

- Medical Encounter Claim Professional Header = MEDENCCLMPHD
- Medical Encounter Claim Professional Line = MEDENCCLMPLN
- Medical Encounter Claim Institutional Header = MEDENCCLMIHD
- Medical Encounter Claim Institutional Line = MEDENCCLMILN

Full and incremental files will use the same file naming convention. The file layout includes a data field "Full vs Incremental" that needs to be appropriately populated that will allow the target to identify the difference.

B. Historical Fee-for-service (FFS) Medical Claims

Data Scope: 24 months of beneficiaries' historic fee for service paid and denied claims

Data Source: PHPs

Data Target(s): Tier 3 AMHs and CINs.

File Type: Historical Medical claims will use the same file layout and naming convention that will be used for Medical Encounters, please refer to the file type guidance and naming convention under Medical encounters above. The Department will be sending historical fee for service medical claims to the PHPs in a different format; hence, please refer to Column H, labeled as "NC Tracks Field", for respective field mapping in the embedded layouts.

Transmission Type: Secure File Transfer Protocol (sFTP)

File Delivery Frequency & Processing Rules: First full file and ongoing weekly incremental files to be sent every Tuesday

1. For historical FFS claims data, PHPs are required to start with a full file followed by weekly incremental files
2. PHPs should share the first Historical Fee-for-service (FFS) Medical file with AMH/CINs upon 834 confirmation of assignment for that beneficiary.
 - Upon receipt of a beneficiary the PHP should start sending the Historical Fee-for-service (FFS) Medical file to the AMH up to 30 calendar days prior to the effective begin date and sent no later than 7 business days of the effective date.
 - PHPs should continue to send the Historical Fee-for-service (FFS) Medical File to an AMH up until the AMH's effective end date
3. Target system can separately request PHPs for a full file for reconciliation purposes, as needed. PHPs are required to work with target system to ensure data integrity between both systems

C. Historical & Ongoing Fee-for-service (FFS) Dental Claims

Data Scope: 24 months of beneficiaries' historical and ongoing fee for service paid and denied dental claims

Data Source: PHPs

Data Target(s): Tier 3 AMHs and CINs.

File Type: Historical Dental claims will use the Dental file layout, Pipe Delimited, Double Quote Qualified PSV File. The file layout prescribes maximum field lengths for each field. The source system is expected to use that information to ensure the field lengths do not exceed the maximum field length while generating the file. The following coding method is preferred: Pipe.double quote.data.double quote.pipe. Data examples are included below:

|"ABCD"|"2019-12-01"|".....

The empty fields are expected to be |""| in this format

|"ABCD"|"2019-12-01"|"|".....

The Department will be sending historical fee for service dental claims to the PHPs in a different format; hence, please refer to Column H, labeled as "NC Tracks Field", for respective field mapping in the embedded layouts.

Transmission Type: Secure File Transfer Protocol (SFTP)

File Delivery Frequency & Processing Rules: First full file and ongoing weekly incremental files to be sent every Tuesday

1. For historical FFS claims data, PHPs are required to start with a full file followed by weekly incremental files
2. PHPs should share the first Dental Claims File with AMH/CINs upon 834 confirmation of assignment for that beneficiary.
 - a. Upon receipt of a beneficiary the PHP should start sending the Dental Claims file to the AMH up to 30 calendar days prior to the effective begin date and sent no later than 7 business days of the effective date.
 - b. PHPs should continue to send the Dental Claims File to an AMH up until the AMH's effective end date
3. Target system can separately request PHPs for a full file for reconciliation purposes, as needed. PHPs are required to work with target system to ensure data integrity between both systems

File Naming Convention: PHPs are expected to follow the below file naming convention
NCMT_<DentalClaimsData>_<PHPShortName>_<AMH/CINName>_ CCYYMMDD-HHMMSS.TXT

Below are the short names for each PHPs:

- Carolina Complete Health = CCH
- WellCare of North Carolina = WELLC
- UnitedHealthcare = UHC
- BCBS = BCBS
- AmeriHealth Caritas = AMERI

Below are the values that need to be used for DentalClaimsData:

- Dental Header = DENCLMHD
- Professional Line = DENCLMLN

IV. Pharmacy Encounters and Claims: Data Exchange Protocols

File Layout: To streamline information exchange, and reduce costs and administrative burden for all stakeholders, the Department requires use of the standard National Council for Prescription Drug Programs (NCPDP) flat file layout that is used by healthcare professionals to transmit health care pharmacy claims. The Department has published a companion guide that outlines each data element, its definition and valid values for the NCPDP file layout. The companion guide is attached with this document. The NCPDP Batch Standard Implementation Guide and Data Dictionary is available for

NCPDP members to download from the NCPDP website - www.ncpdp.org. File layouts can be found [here](#) or on the NC Medicaid website by searching for “Care Management Historic and Ongoing Claims and Encounters file layouts”.

Based on feedback from CINs, the Department has also developed a simpler flat file layout (File Name: NCMT_CareQualityManagement_AMHEncountersPharmacy_v1.0) – attached below, using the NCPDP batch file companion guide as the baseline. The Department would prefer use of standard National Council for Prescription Drug Programs (NCPDP) flat file layout but would allow implementation of the simpler flat file layout to meet the Managed Care launch timeline. The choice of using the appropriate specification is up to the AMHs/CINs with the expectation that they will mature to the standard National Council for Prescription Drug Programs (NCPDP) flat file layout by June 30th, 2020.

PHPs will receive all Pharmacy claims from NCTracks through the proprietary GDIT pharmacy claims header, line and edit file layouts . Claim type can be identified by checking the values for C-HDR-TY-CD, per below:

- Pharmacy Claims: 'R'

Any non-standard state-derived data fields will not be part of these standard layout. However, state will work with any stakeholders to standardize these fields as requested.



EPS NCPDP
Companion Guide v1..

Optional Fields: PHPs have the discretion to populate the following financial-related fields at the header and line levels; they can have null values.

Header-level

1. Total Claim Charge Amount
2. Claim allowed Amount
3. Payers Claim Payment Amount

Line-level

1. Line Item Charge Amount
2. Claim allowed amount
3. Payers Claim Payment Amount
4. Claim Header Status Code

File Record Count Validation: To ensure that target system received and ingested the same count of records that was sent by the source system, both source and target systems are expected to generate systemic notifications:

- Source system is required to generate an automated email notification with the file records totals once they deliver any file, to the target system. The Department’s governance team will be copied on these notifications, their email address will be provided to the source system separately.

- Target system is required to generate an automated email notification with the total records they processed, to the source system. The Department's governance team will be copied on these notifications, their email address will be provided to the source system separately.

The Department understands that fully implementing the file count validation requirements by Managed Care Launch could be challenging for some source and target systems. The Department will allow for manual notifications at launch and expects all Source - PHPs and Targets – AMHs and CINs to fully meet these requirements within 90 days after Managed Care Launch.

The Department also understands that certain source and target systems may be ready to implement exception processing and will be able to validate counts and manage exceptions using exception files like the standard X12 file format for exceptions. They can go ahead and use that approach if the both the Source - PHP and the Targets – AMHs and CINs mutually agree in writing to implementing that exception approach. Although the Department does not need to review or approve the proposed mutually-agreed-upon change, the Department expects the PHPs to: (1) document the change and (2) notify the Department of the documented changes.

The Department expects the Source - PHPs and Targets – AMHs and CINs to work together to resolve any data quality issues.

AMHs & CINs Onboarding & Testing:

- **1st Release:**
 - The Department expects PHPs to: (1) work with their respective AMHs and CINs and (2) review the file layout, associated requirements, and implementation timeline and testing expectations to ensure Tier 3 AMHs and CINs are ready to consume this data per the requirements and implementation timelines shared by the Department.
 - PHPs must demonstrate successful end-to-end testing of this interface with Tier 3 AMHs and CINs. To meet this requirement, PHPs are required to identify at least two CINs and one AMH Tier 3 provider to participate in end-to-end testing. The Department will transmit the implementation and testing timelines and additional details on testing requirements in a separate document.
- **Ongoing:** As PHPs contract with new Tier 3 AMHs and their respective CINs, they are expected to have an onboarding process that supports establishing and enabling the exchange of information between the PHPs and Tier 3 AMHs and CINs in the required specification with appropriate testing. PHPs will review their onboarding processes and associated testing timelines with DHB.

A. Pharmacy Encounters

Data Scope: Paid and Denied Pharmacy encounters

Data Source: PHPs

Data Target(s): Tier 3 AMHs, CINs

File Type: Pipe Delimited, Double Quote Qualified PSV File. Companion guide includes begin and end position, please disregard that as this is a delimited file. The source system is expected to

ensure that the field lengths do not exceed the field lengths included in the companion guide, while generating the file. The following coding method is preferred: Pipe.double quote.data.double quote.pipe. Data examples are included below:

```
|"ABCD"|"2019-12-01"|".....
```

The empty fields are expected to be |""| in this format

```
|"ABCD"|"2019-12-01"|"|".....
```

Transmission Type: Secure File Transfer Protocol (sFTP)

File Delivery Frequency & Processing Rules: First full file and ongoing weekly incremental files to be sent every Tuesday

1. PHPs are also expected to submit all managed care encounters to the Department EPS system. If PHPs make any changes to their encounters to resolve any exceptions reported by the EPS system. Those updated encounter records are required to be included in the incremental files that PHPs will be sending to the AMHs/CINs and, this will ensure data integrity across systems
2. PHPs should share the first Pharmacy Encounters File with AMH/CINs upon 834 confirmation of assignment for that beneficiary.
 - Upon receipt of a beneficiary the PHP should start sending the Pharmacy Encounters file to the AMH up to 30 calendar days prior to the effective begin date and sent no later than 7 business days of the effective date.
 - PHPs should continue to send the Pharmacy Encounters File to an AMH up until the AMH's effective end date
3. Source system should ensure that all new and updated transactions are picked up as part of Incremental file generation. If an encounter goes through multiple adjustments since the creation of last file, all those transactions should be included in the next file
4. Target system can separately request PHPs for a full file for reconciliation purposes, as needed. PHPs are required to work with target system to ensure data integrity between both systems

File Naming Convention: PHPs are expected to follow the below file naming convention
NCMT_<PharmacyEncounterClaimData>_<PHPShortName>_<AMH/CINName>_CCYYMMDD-HHMMSS.TXT

Below are the short names for each PHPs:

- Carolina Complete Health = CCH
- WellCare of North Carolina = WELLC
- UnitedHealthcare = UHC
- BCBS = BCBS
- AmeriHealth Caritas = AMERI

Below are the values that need to be used for PharmacyEncounterClaimData:

- Pharmacy Header = RXENCHD
- Pharmacy Line = RXENCLN

Full and incremental files will use the same file naming convention. The file layout includes a data field “Full vs Incremental” that needs to be appropriately populated that will allow the target to identify the difference.

Optional Fields: All fields under section 7.7 in NCPDP Companion guide are optional and not required, they can have null values.

B. Historical Fee-for-service (FFS) Pharmacy Claims

Data Scope: 24 months of beneficiaries’ historic fee for service pharmacy paid and denied claims

Data Source: PHPs

Data Target(s): Tier 3 AMHs and CINs.

File Type: Historical Pharmacy claims will use the same file layout and file naming convention that will be used for Pharmacy Encounters, please refer to the file type guidance and naming convention under Pharmacy encounters above. The Department will be sending historical fee for service pharmacy claims to the PHPs in a different format; hence, please refer to Column H, labeled as “NC Tracks Field”, for respective field mapping in the embedded layouts.

Transmission Type: Secure File Transfer Protocol (sFTP)

File Delivery Frequency & Processing Rules: At least weekly – Full file followed by incremental files

1. For historical FFS claims data, PHPs are required to start with a full file followed by weekly incremental files
2. PHPs should share the first Historical Fee-for-service (FFS) Pharmacy Claims File with AMH/CINs upon 834 confirmation of assignment for that beneficiary
 - Upon receipt of a beneficiary the PHP should start sending the Historical Fee-for-service (FFS) Pharmacy Claims file to the AMH up to 30 calendar days prior to the effective begin date and sent no later than 7 business days of the effective date.
 - PHPs should continue to send the Historical Fee-for-service (FFS) Pharmacy Claims File to an AMH up until the AMH’s effective end date
3. Target system can separately request PHPs for a full file for reconciliation purposes, as needed. PHPs are required to work with target system to ensure data integrity between both systems