Massachusetts All Payer Claims Database (MA APCD)

Release 4.0, MA APCD Users Guide

Non-Government Users

CY 2010 - 2014

Center for Health Information and Analysis

Document Revision History

Date	Version Number	Changed/Created by	Requested by:	Change:
October 2015	1.0	Kathryn Scribner	Kevin Walsh	First Draft

Table of Contents

INTRODUCTION

The Center for Health Information and Analysis (CHIA) was created to be the hub for high quality data and analysis for the systematic improvement of health care access and delivery in Massachusetts. Acting as the repository of health care data in Massachusetts, CHIA works to provide meaningful data and analysis for those seeking to improve health care quality, affordability, access, and outcomes.

To this end, the Massachusetts All Payer Claims Database (MA APCD) contributes to a deeper understanding of the Massachusetts health care delivery system by providing access to accurate and detailed claims-level data essential to improving quality, reducing costs, and promoting transparency.

This document provides non-government users[1] with information on the MA APCD Release 4.0 Limited Data Set.

Overview

MA APCD is comprised of medical, pharmacy, and dental claims and information from the member eligibility, provider, and product files which are collected from health insurance payers operating in the Commonwealth of Massachusetts. This information encompasses public and private payers as well as data from insured and self-insured plans.

MA APCD data collection and data release are governed by regulations. These regulations are available on the MA APCD website. (See http://chiamass.gov/regulations/.)

For ease of use, the Center for Health Information and Analysis (CHIA) has created separate chapters for each MA APCD file type available to non-government users:

- Dental Claims (DC),
- Medical Claims (MC),
- Pharmacy Claims (PC),
- Member Eligibility (ME),
- Product File (PR), and
- Provider File (PV).

The figure on page 7 shows an overview of the file types and their content.

[1] As defined by CHIA's data release regulations 957 CMR 5.00

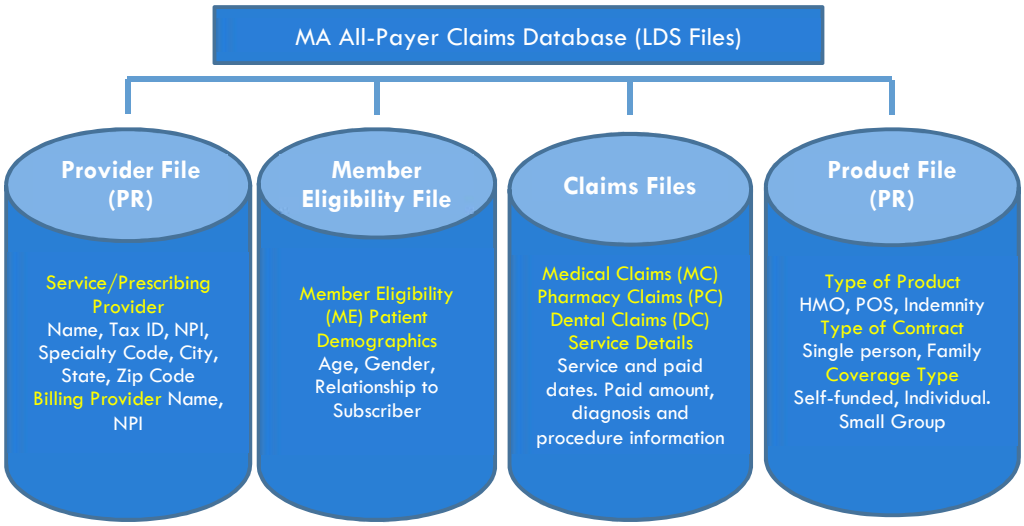

Figure 1. **MA APCD FILE TYPES**

Establishment of the Massachusetts APCD

The first efforts to collect claim-level detail from payers in Massachusetts began in 2006 when the Massachusetts Health Care Quality and Cost Council (HCQCC) was established, pursuant to legislation in 2006, to monitor the Commonwealth's health care system and disseminate cost and quality information to consumers. Initially, data was collected by a third party on behalf of HCQCC under contract. On July 1, 2009, the Division of Health Care Finance and Policy (DHCFP) assumed responsibility for receiving secure file transmissions, creating, maintaining and applying edit criteria, storing the edited data, and creating analytical public use files. By July 2010, Regulations 114.5 CMR 21.00 and 114.5 CMR 22.00 became effective, establishing the APCD in Massachusetts.

Chapter 224 of the Acts of 2012, "An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation," created the Center for Health Information and Analysis (CHIA) which assumed many of the functions – including management of the MA APCD – that were previously performed by the Division of Health Care Finance and Policy (DHCFP).

According to Massachusetts state law, the purpose of the MA APCD is administrative simplification. CHIA collects, stores, and maintains data from payer and provider claims databases. The Center serves as a central location for the information technology infrastructure (hardware, components, servers and personnel) necessary to carry out its mission. All other agencies, authorities, councils, boards and commissions of the commonwealth seeking health care data use CHIA-collected data rather than data directly from health care providers and payers. In *order* to ensure patient data confidentiality, the center does not contract or transfer the operation of the database or its functions to any third-parties, such as nonprofit organization or governmental agencies. However, the Center may enter into an interagency services agreement for transfer and use of the data.

A Preliminary Release of the MA APCD covering dates of service CY 2008-2010 was released in 2012. Release 4.0 covers dates of service CY 2010-2014 (paid through June 30, 2015).

MA APCD Release 4.0 Overview

The MA APCD contains data elements collected from all private and public payers of eligible health care claims for Massachusetts

Highlights of the release include:

- Data is available for dates of service from January 1, 2010 to December 31, 2014 as paid through June 30, 2015. Data submitted to CHIA after June 30, 2015 is not included in the files.
- Release 4.0 contains updated data. (This data includes resubmitted data for dates of service prior to 2014 that CHIA that received in the interim from impacted carriers as part of CHIA's ongoing data validation work.)
- Non-government users may request groups of Level 2 data elements, as curated by CHIA into Limited Data Sets.
- Application of a Master Patient Index using a probabilistic matching algorithm. This allows users to track members as they change payers without the direct identifiers. This preserves patient privacy while increasing analytic value.
- Certain identifying or sensitive data elements are masked in the release in order to protect patient privacy and allow for the linkage of data elements within the same file.
- Some data elements have been derived by CHIA from submission data elements or have been added to the database to aid in versioning and identifying claims (e.g. Unique Record IDs and status flags). Please refer to the MA APCD Release 4.0 Non-Government LDS *Data Elements Reference Tables* for additional details.

DATA COLLECTION AND RELEASE PROCESS

The data collected from the payers for the MA APCD is processed by the Data Compliance and Support team. Data Compliance works with the payers to collect the data on a regular, predetermined, basis and ensure that the data is as complete and accurate as possible. The Data Quality Assurance and Data Standardization and Enhancement teams work to clean and standardize the data to the fullest extent possible. Data Standardization relies on external source codes (see *Appendix A)* from outside government agencies, medical and dental associations, and other vendors to ensure that the data collectors properly utilized codes and lookup tables to make data uniform.

Data Collection and Processing for Release

Third Party Administrators (TPAs)

In instances where more than one entity administers a health plan, the health care payer and third-party administrators are responsible for submitting data according to the specifications and format defined in the Submission Guides. This means that some records may be represented twice – once by the payer, and once by the TPA.

CHIA's objective is to create a comprehensive all payer claims database that includes data from all health care payers and third-party administrators.

Edit Processing

When payers submit their data to CHIA for the MA APCD, an edits process is run on each file in accordance with the MA APCD Submission Guides documentation. The automated edits perform an important data quality check on incoming submissions from payers. They identify whether or not the information is in the expected format (for example, alpha vs. numeric), contains invalid characters (for example, negative values, decimals, future dates) or is missing values (that is, nulls). If these edits detect any issues with a file, they are identified and a report is sent to the payer.

Data elements are grouped into four categories (A, B, C, and Z), which indicate their relative analytic value to CHIA and MA APCD users. Please refer to the MA APCD Release 4.0 Non-Government LDS *Data Elements Reference Tables* to view the Edit Level for each Data Element:

- 'A' level fields must meet their MA APCD threshold percentage in order for a file to pass. There is an allowance for up to a 2% variance within the error margin percentage (depending on the data element). If any 'A' level field falls below this percentage it results in a failed file submission for the payer and the payer's CHIA liaison will work with the payer to correct the submission.
- The other categories (B, C, and Z) are also monitored, but the thresholds are not presently enforced.

More detailed MA APCD Submission Guide File Edit documentation can be found at:

http://chiamass.gov/apcd-data-submission-guides

Claim Versioning Overview

CHIA's standard versioning process includes applying cleaning logic, identifying duplicates, voids/back-outs, replacements/amendments, and setting the highest version flag. Versioning logic has been reviewed and approved by each carrier.

Claim versioning allows CHIA to identify specific attributes in claims that may have multiple versions over time and claim type. This section provides an overview of claim versioning. The Claim Line Type Codes, Highest Paid Version Flag, Highest Version Denied Flag, Highest Version Flag, and Fully Denied Claim Flag are most are most useful for claim versioning.

For file specific information, only *Medical Claims File Versioning* on page 21 and *The purpose of PV002* and Derived PV9 are twofold: to help identify provider data elements associated with provider data, submitted in the claim line, and to identify the details of the Provider Affiliation. This allows linking to the PV file Provider ID. See also *Linking Across File Types* for greater detail on this process.

Pharmacy File Claim Versioning on page 23 are pertinent to this topic.

CHANGES TO CLAIM LINES

The Claim Line Type field determines how a claim line versioning (see Table 1 below).

TABLE 1. CLAIM LINE TYPE CODES

Claim Type Code	Claim Line Type Description	Action/Source
O	Original	
V	Void	Delete Line Referenced / Provider
R	Replacement	Replace line Referenced /Provider
B	Back Out	Delete Line Referenced / Payer
A	Amendment	Replace Line Referenced / Payer

HIGHEST PAID VERSION FLAG

The VERSIONINDICATOR flag helps users and CHIA determine the highest version of a claim line that was "paid," and is derived as part of the standard versioning production logic. This is the version indicator approved by carriers per discussions with CHIA for MA APCD release and financial analysis purposes. Additionally, some carriers provided custom logic for including/excluding claim lines.

The following table defines the Version values for the VERSIONINDICATOR.

TABLE 2. VERSIONINDICATOR FLAG

Value	Meaning
1	Highest Version Paid
0	Not Highest Version Paid
9	Versioning Not Applied

Typically a value of 1 means that the line was directly paid; however, note that depending on Carrier specific logic it is possible that payment for that specific line was actually denied (see the Table 3Highest Version Denied Flag, below). However in such a case, the value 1 indicates that payment was included as part of the payment on another line in the same claim collection.

HIGHEST VERSION DENIED FLAG

The purpose of the HIGHESTVERSIONDENIED flag is to identify claim lines within a claim that have been denied. Values are set according to CHIA's standard versioning production logic. These values are defined in the following table.

TABLE 3. HIGHESTVERSIONDENIED FLAG

Value	Meaning
1	Is Highest Version Denied
0	Is Not Highest Version Denied
9	Highest Version Denied Flag Not Applied

A value of 1 indicates that the claim line was both highest version and payment was denied. For example:

- If HIGHESTVERSIONDENIED =1 and the "VERSIONINDICATOR" = 1, then that means that while this specific claim line was denied, payment for this line was likely included with payment on another line (bundled payment).
- If HIGHESTVERSIONDENIED =1 and "VERSIONINDICATOR" = 0, then that means that this claim line was denied, and that this claim line is the highest version of the claim line.

HIGHEST VERSION FLAG

The HIGHESTVERSIONINDICATOR flag shows claim lines that are the highest version claim line, whether or not the claim line was paid. The following table defines the flag values.

TABLE 4. HIGHESTVERSIONINDICATOR FLAG

Value	Meaning
1	Highest Version Claim Line
0	Not Highest Version Claim Line
9	Versioning Not Applied

FULLY DENIED CLAIM FLAG

The FULLYDENIEDCLAIM flag is a claim level attribute, applied at the claim line level. If all the individual claim lines in the highest version of a claim are denied, then the entire claim is a fully denied claim. The same derived claim level value will be applied to each claim line in the collection.

TABLE 5. FULLYDENIEDCLAIM FLAG

Value	Meaning
1	Fully Denied Claim.
0	Not Fully Denied Claim
9	Versioning Not Applied

The logic for assigning these flags requires sorting the dataset and breaking on OrgId and PCCN (Payer Claim Control Number) where Highest Version indicator = 1. This ensures only a highest version claim will be considered a fully denied claim*. Users should expect to see only highest version claims flagged as fully denied (that is: HIGHESTVERSIONINDICATOR = 1 and FULLYDENIEDCLAIM = 1).

> **Note:** Any claim that is not a highest version claim line related to the final version view will *not* be flagged as a fully denied claim as these claim lines are considered a different claim view, separate from the final claims view. Be aware, however, that these types of claims often have the same PCCN as the highest paid version view.

Variance Process

The Variance Process is a collaborative effort between the payer and CHIA to reach a threshold percentage for any data element which may not meet the MA APCD standard. Payers can request a lower threshold for specific fields, but they must provide a business reason (rationale) and, in some cases, a remediation plan for those elements. CHIA staff reviews each request and follows up with the payer for a variety of reasons, including improving data quality, suggesting alternative threshold rates or by creating plans to reach the threshold over time.

Payers use this process to request certain file type variances (for example. a vision payer requests a variance in submitting pharmacy or dental claim files).

When this process is complete, any submissions from the payer are held to the CHIA standard thresholds and approved variances. The payer receives a report after each submission is processed which compares their data against the required threshold percentages. CHIA holds reviews and discussions with the payer about the files that exceed the threshold percentage. The payer must then provide the corrected data for the submission file.

VARIANCE EXAMPLE

An example of the approved variance would be with the Other Diagnosis fields on the Medical Claim file (data elements MC042 – MC053). To pay claims, it wasn't necessary for a particular carrier to retain more than the Primary or Admitting Diagnosis from claim forms so CHIA allowed historical data to have lower thresholds on these data elements. However, the carrier should develop a remediation plan to start collecting this information going forward, thus eliminating the need for lower thresholds on these fields and improving the quality of the data.

CHIA VARIANCE ANALYSIS BY DATA ELEMENT

CHIA periodically updates variance analyses by data element. A report of such analysis includes the number of payers requesting variances on the indicated data element, the mean of the threshold variance requests, the minimum variance percentage requested, and the maximum variance percentage requested. Users who would like more details about this analysis may contact CHIA at:

apcd.data@state.ma.us

Data Release Process

Restricted Release Files

The Restricted Release File has the following characteristics:

- Each file type is written to a separate asterisk delimited file. Each row in the release file represents one record of the file type. There is an asterisk-delimited field in each row for every data element listed in the MA APCD Release 4.0 Non-Government LDS *Data Elements Reference Tables*.
- Data Elements are delimited as shown in the MA APCD Release 4.0 Non-Government LDS *Data Elements Reference Tables*.
- Empty or null data elements have no spaces or characters between the asterisks.
    - Lookup tables are listed in the intake Submission Guides for each LDS file type. You can find the Guides at:

      http://www.chiamass.gov/apcd-data-submission-guides/
    - External Code Sources support lookup table references in the Submission Guide. See *Appendix A* for additional information.
    - Hashed Elements: For the Data Release, some of the data elements have been hashed to provide confidentiality for Payers, Providers and individuals, while allowing for linkage between claims, files, and lookup tables.

Data Protection/Confidentiality

The Commonwealth of Massachusetts has charged CHIA with protecting the confidentiality of individuals and organizations providing data to the MA APCD. This requirement extends to customers receiving the MA APCD Data Release as well. Please refer to the Data Release regulations located on CHIA's website using the address below:

http://www.chiamass.gov/regulations

MASKED DATA ELEMENTS AND LINKING

In order to comply with confidentiality requirements for MA APCD data, and protect the privacy of individuals and organizations, CHIA has applied masking procedures on certain MA APCD Data Elements prior to release. Masked elements are defined in the MA APCD Release 4.0 Non-Government LDS *Data Elements Reference Tables*.

> **Note:** Masking indicates that a field's contents are replaced in the output extract file (i.e., *masked* output that creates the same random value each time for a specific source value).

NULL VALUES

Null values are excluded from masking to eliminate a possible result of false linking due to masked Null values that appear to match. Any Null value found in masked fields produces an empty (zero length) field in the Release files.

SSN Redaction and Data Standardization

SOCIAL SECURITY NUMBER (SSN) REDACTION

In order to protect against the unintended disclosure of SSN data, certain data elements were subjected to a redaction process.

> Redaction indicates that a field has been scanned and suspected or possible SSN values have been set to null.

SSN redaction was applied against any field or data element that could not otherwise be validated against reference tables.

For a list of data elements that were redacted using the above process, please refer to the MA APCD Release 4.0 Non-Government LDS *Data Elements Reference Tables*.

DATA STANDARDIZATION USING MELISSA DATA

Melissa Data Corp. specializes in global contact data quality and mailing preparation for small businesses and large enterprises that to help improve contact data. CHIA validates demographically-related elements (i.e. Member Zip Code, Service Provider State, etc.) using Melissa Data software for the purpose of standardizing demographic elements to ensure consistent formatting of data fields across the database. For a list of data elements that were standardized using the Melissa Data software application, please refer to the MA APCD Release 4.0 Non-Government LDS *Data Elements Reference Tables*.

Linking Across File Types

DATA HASHING AND FILE LINKING

The Claims tables link to tables using the data elements:

- Linking Plan Provider ID (PV002) + Provider Delegate (Derived PV9) and/or
- Linking Product ID (PR001) + Product Delegate (Derived PR4), respectively.

For instances where there is a risk to identifiable personal information, the values have been hashed using *integer* values that have no identification risks associated with them. This action preserves linkage yet still protects patient confidentiality. See Table 6 for specific references.

Member Entity Identification (EID) Element

CHIA provides a derived element (Member Link EID) that represents a unique Enterprise ID (EID) of an individual member (person entity). This number can be used to link an individual across all filing types - Eligibility, and Claims (Medical, Pharmacy, Dental). See Table 6 for specific references.

TABLE 6. LINKED DATA ELEMENTS BY FILE TYPE

File	Element Code	Data Element Name
DC	DC018	Service Provider Number

File	Element Code	Data Element Name
DC	DC042	Product ID Number
DC	Derived DC11	Member Link EID
MC	MC024	Service Provider Number
MC	MC076	Billing Provider Number
MC	MC079	Product ID Number
MC	MC112	Referring Provider ID
MC	MC125	Attending Provider
MC	MC134	Plan Rendering Provider Identifier
MC	MC135	Provider Location
MC	Derived MC16	Member Link EID
ME	ME036	Health Care Home (PCMH) Number
ME	ME040	Product ID Number
ME	ME046	Member PCP ID
ME	ME124	Attributed PCP Provider ID
ME	Derived ME13	Member Link EID
PC	PC001	Payer
PC	PC043	Prescribing Provider ID
PC	PC056	Product ID Number
PC	PC059	Recipient PCP ID
PC	Derived PC12	Member Link EID
PR	PR001	Product ID
PR	Derived PR4	Product Delegate
PV	PV002	Provider ID
PV	Derived PV9	Provider Delegate
PV	PV054	Medical / Healthcare Home ID
PV	PV056	Provider Affiliation

Data Limitations

Researchers using the MA APCD Release 4.0 data should be aware of the following:

- Due to the variance process, data quality may vary from one payer to another. (See *Variance Process* on page 10 in this document.)
- Claim Files submitted through June 2015 were accepted with relaxed edits. (Refer to the MA APCD Submission Guide for Edit information)
- The release files contain the data submitted to CHIA including valid and invalid values.
- Certain data elements were cleaned when necessary. You can find more detail on cleaning in the *MA APCD Release 4.0 Data Elements Reference Tables*.
- Certain data elements were redacted to protect against disclosure of sensitive information.
- Some Release Data was manipulated to protect patient privacy:
    - Linkage IDs were Hashed to integral values to mask values while retaining linkage,
    - Carrier-specific IDs were hashed,

- Member Birth Year is reported as 999 for all records where the member age was reported as older than 89 years on the date of service.
- Member Birth Year is reported as null for all records where the member was reported as older than 115 years on the date of service.

For more information, see *Linking Across File Types*.

DENTAL CLAIMS (DC) FILE

As part of the Massachusetts All Payer Claims Database (MA APCD), payers are required to submit a Dental Claims File. The Dental Claims File releases claim lines organized by Date of Service To for each requested year. In the event that Date of Service To is unavailable, Submission Month Period will be used to filter data.

Payers are instructed by CHIA to submit any dental claim that is considered paid. The paid amount should be reported as 0 and the corresponding Allowed, Contractual, Deductible Amounts should be calculated accordingly for claims that are paid under a *global payment*, or *capitated payment*, and thus are zero paid.

Below we have provided details on business rules, data definitions, and the potential uses of this data.

DC File Characteristics

Each row in the MA APCD Dental Claims file represents one claim line. If there are multiple services performed and billed on a claim, each of those services are uniquely identified and reported on a line. Line item data provides an understanding of how services are utilized and adjudicated by different payers.

Certain data elements of claim level data are repeated in every row in order to report unique line item processing and maintain a link between line item processing and claim level data.

Dental File Claim Lines

Claim ID

Claims may be isolated by grouping claim lines by the following elements:

Payer Org ID (DC001)/Payer Claim Control Number (DC004)

Denied Claim Lines

Wholly denied claims are not submitted to CHIA. However, if a single procedure is denied within a paid claim that denied line is reported. Denied line items of an adjudicated claim may aid with analysis in the MA APCD in terms of covered benefits and/or eligibility.

Types of Data Collected in the Dental Claims File

Payer-assigned Identifiers

CHIA requires various payer-assigned identifiers for matching logic to other files, i.e., Product File and Member Eligibility. Examples of these fields include DC003, DC006, DC056 and DC057. These fields can be used to aid with the matching algorithm to other files.

Claims Data

CHIA requires line-level detail of all Dental Claims for analysis. The line-level data aids with understanding utilization within products across Payers. Subscriber and Member (Patient) Payer unique identifiers (DC056 and DC057) are included to aid with the matching algorithm.

Non-Massachusetts Residents

CHIA waives the submittal of claims data for employer groups whose employees reside outside of Massachusetts. However, if the payer is contracted with the Group Insurance Commission (GIC) or is regulated by the MA Division of Insurance, then CHIA requires submittal data for non-residents.

Adjudication Data

CHIA requires adjudication-centric data on the file for analysis of Member Eligibility to Product. The elements typically used in an adjudication process are DC017, DC030, DC031, DC037 through DC041, DC045, DC046 and are variations of paper remittances or as defined by HIPAA 835 4010.

Denied Claims

CHIA does not require payers to submit claims rejected in total.

> **Note:** The payer must submit data for partially paid claims.

The Dental Claims Provider ID

Element DC018 (Provider ID) is a critical element in the MA APCD. It links the Provider identified on the Dental Claims file with the corresponding record in the Provider File (PV002) and Provider Delegate (Derived PV9).

The purpose of PV002 and Derived PV9 are twofold: to help identify provider data elements associated with provider data, submitted in the claim line, and to identify the details of the Provider Affiliation. This allows linking to the PV file Provider ID. See also *Linking Across File Types* for greater detail on this process.

MEDICAL CLAIMS (MC) FILE

As part of the MA APCD, payers are required to submit a Medical Claims File. The Medical Claims File consists of all final paid claims from all reporting payers segregated by Date of Service in 2010, 2011, 2012, 2013, and 2014 as paid through June 2015.

The Medical Claim File will be released for each requested year based on Date of Service To for the claim line. In the event that Date of Service To is unavailable, the following will be utilized:

- Discharge Date,
- Date of Service From or Admit Date, or
- Submission Month Period.

Below are details on business rules, data definitions, and the potential uses of this data. For a full list of elements refer to the MA APCD Release 4.0 Non-Government LDS *Data Elements Reference Tabless*.

Payers are instructed by CHIA to submit any medical claim that is defined as paid. Paid amount should be reported as 0 and the corresponding Allowed, Contractual, and Deductible Amounts should be calculated accordingly. Claims that are paid under a *global payment*, or *capitated payment*, thus are zero paid.

Medical File Characteristics

Certain data elements of claim level data are repeated in every row in order to report unique line item processing. Claim-line level data is required to capture accurate details of claims and encounters.

The reporting of Voided Claims maintains logic integrity between services utilized and deductibles applied.

Claims may be isolated by grouping claim lines by the following elements:

Payer Claim Control Number (MC004) +Payer Org ID (MC001)

Types of Data Collected in the Medical Claims File

Payer-assigned Identifiers

CHIA requires various Payer-assigned identifiers for matching-logic to the other files, for instance, the Product File and Member Eligibility file. Examples of this type of field include MC003, MC006, MC137 and MC141.

Claims Data

CHIA requires the line-level detail of all Medical Claims for analysis, which aids with identifying utilization within products across Payers. The specific medical data reported in MC039 through MC062, MC083 through MC088, MC108, MC109, MC111, MC126, and MC136 would be the same elements that are reported to a Payer on the UB04, HCFA 1500, the HIPAA 837I and 837P or a Payer specific direct data entry system.

Subscriber and Member (Patient) Payer unique identifiers are requested to aid with the matching algorithm, see MC137 and MC141.

Servicing Provider Data

The set of fields MC024, MC026, MC027, MC031, MC032, MC034 and MC035 are all related to the servicing provider entity. The intent is to collect entity level rendering provider information, at the lowest

level achievable by the payer. A physician's office is also appropriate here, but not the physician. The physician or other person providing the service is expected in MC134.

If the payer only knows the billing entity, and the billing entity is not a *service rendering* provider. The payer would need a variance request for the service provider fields.

If the payer only has the data for a main *service rendering* site but not the specific satellite information where services are rendered, then the main service site *is* acceptable for the service provider fields.

For example, XYZ Orthopedic Group is acceptable, if XYZ Orthopedic Group Westside is not available. However, XYZ Orthopedic Group Westside is preferable, and, ultimately, the goal.

Fields MC134 (Plan Rendering Provider) and MC135 (Provider Location)

The intent of these fields is to capture servicing or rendering provider at the physician or other licensed person rendering level. These fields should describe precisely where the service was performed and to whom. If the payer does not know who actually performed the service or the specific site where the service was actually performed, the payer will need a variance request for one or both of these fields. It is not appropriate to report facility or billing information here.

Non-Massachusetts Residents

CHIA does not require payers submitting claims and encounter data on behalf of an employer group to submit claims data for employees who reside outside of Massachusetts, unless the payer is required by contract with the Group Insurance Commission (GIC) or is subject to regulations from the Division of Insurance.

Adjudication Data

CHIA requires adjudication-centric data on the file for analysis of Member Eligibility to Product. The elements typically used in an adjudication process are MC017 through MC023, MC036 through MC038, MC063 through MC069, MC081, MC089, MC092 through MC099, MC113 through MC119, MC122, MC123, and MC138 and are variations of paper remittances as defined by HIPAA 835 4010.

Denied Claims

Payers are not required to submit wholly denied claims.

> **Note:** The provider must submit data for partially paid claims.

The Medical Claims Provider ID

Element MC024 (Service Provider ID), MC134 (Plan Rendering Provider) and MC135 (Provider Location) are critical fields in the MA APCD; they are used to link the Provider identified on the Medical Claims file with the corresponding Provider ID (PV002) and Provider Delegate (Derived PV9) in the Provider File. (See The Provider ID for more information.)

The purpose of PV002 and Derived PV9 are twofold: to help identify provider data elements associated with provider data, submitted in the claim line, and to identify the details of the Provider Affiliation. This allows linking to the PV file Provider ID. See also *Linking Across File Types* for greater detail on this process.

Medical Claims File Versioning

Highest Version Flag created for Medical Claim Files has the following characteristics:

- Data Element Name: Highest Version Flag (Derived-MC10)
- CHIA's standard versioning process includes applying cleaning logic, identifying duplicates, voids/back -outs, and replacements/amendments, and setting the highest version flag. Versioning logic has been reviewed with each carrier.
- A highest versioning flag is used in Release 4.0. A value of 0 or 1 has been assigned to each medical claim line from the following carriers: 290, 293, 295, 296, 300, 301, 3156, and 3505. 3735, 4962, 7041, 7422, 7655, 8026, 8647, 10353, 10441, 10442, 10647, 10920, 10929, 11215, 11474, 11701, 11726, partial on 10632. Claim lines from all other carriers should have a value of 9. (See also *Claim Versioning Overview* on page 10.) [2]
- Data Limitations: OrgID 10632 has been versioned from May 2013 forward. Any data prior to May 2013 is not versioned.

[2] For services rendered on or after 3/1/2010 only. Claim lines for services rendered before 3/1/2010 should have a value of 9.

PHARMACY CLAIMS (PC) FILE

As part of the MA APCD, payers will be required to submit a Pharmacy Claims File. The Pharmacy Claims File includes individual claim lines for each requested year. The Pharmacy Claims lines are are assigned a *Date of Service To*. In the event that *Date of Service To* is unavailable, the following data elements are used:

- DatePrescriptionFilled;
- Paid Date;
- DatePrescriptionWritten;
- DateOfServiceApproved; or
- Submission Period (YYYMM) less 1 day.

CHIA assigns a release ID for each claim line in the Pharmacy file. The Release ID is a unique ID for each claim in the data release.

CHIA instructs payers to submit any pharmacy claim that is considered paid. Claims paid under a *global payment* or *capitated payment* are designated 0 paid. Payers should report the Paid amount as 0 and the corresponding *Allowed*, *Contractual*, and *Deductible Amounts* should be calculated accordingly.

Below we have provided details on business rules, data definitions, and the potential uses of this data.

Types of Data Collected in the Pharmacy Claims File

Payer-assigned Identifiers

CHIA collects various Payer-assigned identifiers for matching-logic to the other files, i.e., Product File and Member Eligibility. PC001 is linkage element for the Pharmacy File in the LDS and can be linked using matching algorithm across other file types. See also *Linking Across File Types* on page 14.

Claims Data

CHIA requires line-level detail of all Pharmacy Claims for analysis. The line-level data aids with understanding utilization within products across Payers. Subscriber and Member (Patient) Payer unique identifiers included linked data using the matching algorithms; see the data elements PC107 and PC108. See also *Linking Across File Types* on page 14.

Non-Massachusetts Residents

CHIA does not require payers submitting claims and encounter data on behalf of an employer group to submit claims data for employees who reside outside of Massachusetts, unless the payer is required to by contract with the Group Insurance Commission (GIC)) or is subject to regulations from the Division of Insurance.

Adjudication Data

CHIA requires adjudication-centric data in order to comply with analytic requirements. The elements typically used in an adjudication process are PC017, PC025, PC036, PC040 through PC042, PC063, PC066, PC068, PC069, PC070 and PC110 and are variations of paper remittances or HIPAA 835 4010.

Denied Claims

CHIA does not require payers to submit wholly denied claims.

> **Note:** The provider *must* submit data for all claims paid partially or in whole.

Provider Identifiers

CHIA collects numerous identifiers that may be associated with a provider. The identifiers will be used to help link providers across payers in the event that the primary linking data elements are not a complete match. The additional identifying elements will improve the quality of the matching algorithms. Examples of these identifying elements include PC043, PC048. PC054 and PC055 relating to the Prescribing Provider.

The Pharmacy File Provider ID

Elements PC043 (Prescribing Provider ID) and PC048 (Prescribing Physician NPI) are critical fields which link the Prescribing Provider identified on the Pharmacy Claims file with the corresponding record in the Provider File (PV002) and Provider Delegate (Derived PV9). See The Provider ID for more information.

The purpose of PV002 and Derived PV9 are twofold: to help identify provider data elements associated with provider data, submitted in the claim line, and to identify the details of the Provider Affiliation. This allows linking to the PV file Provider ID. See also *Linking Across File Types* for greater detail on this process.

Pharmacy File Claim Versioning

For linkage purposes, the *same re-identified integer values* were substituted into the Pharmacy file. (See the *Claim Versioning Overview* on page 10 for supplemental information.)

A highest version flag is provided in Release 4.0. A value of 0 or 1 has been assigned to each Pharmacy file claim line from the following carriers: MassHealth (3156), BCBS of MA (291), Harvard Pilgrim Health Plan (300), and Tufts Health Plan (8647[3]) for incurred periods January 2010 through December 2014. Claim lines from all other carriers have a value of 9.

Claim ID

Claims may be isolated by grouping claim lines by the following elements:

Payer Claim Control Number (PC004) +Payer Org ID (PC001)

Denied Claim Lines

Wholly denied claims are not submitted to CHIA. However, if a single procedure is denied within a paid claim that denied line is reported. Denied line items of an adjudicated claim may aid with analysis in the MA APCD in terms of covered benefits and/or eligibility.

[3] Medicare claim lines for pharmacy services incurred in 2012, 2013, and 2014 have not been versioned and, therefore, contain a value of 9 for Tufts Health Plan.

MEMBER ELIGIBILITY (ME) FILE

As part of the MA APCD, payers are required to submit a Member Eligibility file. Annual eligibility files contain all eligibility records with at least one day of member eligibility within the calendar year. For Release 4.0, one file per year will be released (e.g. December 2010, and forward). Each year's Eligibility File will contain a 24-month rollback of eligibility. If data from 2010-2012 is requested, then three Eligibility Files will be released (December 2010, December 2011, and December 2012).

There are a number of elements in the ME file that are poorly reported. Individual elements each have a reporting threshold setting, which allows Payers to meet reporting requirements. The variance process allows for Payers to address any inability to meet threshold requirements. See *Variance Process* on page 12 for additional information.

Types of Data Collected in the Member Eligibility File

General Data Characteristics

If a Member is eligible for more than one Product, then the Member will be reported on multiple records in the same month.

If a Member has more than one Primary Care Physician (PCP) under the same Product, then the Member and Product will be reported on multiple records in the same month.

If a member has a break in eligibility, this results in multiple records.

A break in eligibility allows for the opportunity to compare information on Member Eligibility to Products and Claims to better understand utilization. CHIA uses enrollment data to calculate member months by product and by provider.

Coverage attributes such as PCP should reflect the values most relevant to:

- The end period for the Eligibility segment (if an inactive segment) or
- The Member Eligibility file end period. (12/31/2009)

Subscriber/Member Information

The file includes both member and subscriber information; however, information on eligibility relates strictly to the *member*, who may or may not be the subscriber. CHIA primarily uses provider-supplied data to link a member to a subscriber.

Non-Massachusetts Residents

CHIA does not require payers who submit eligibility data on behalf of an employer group to submit eligibility data for employees who reside outside of Massachusetts, unless the payer is required by contract with the Group Insurance Commission or is subject to regulations from the Division of Insurance.

Coverage Indicators

CHIA collects coverage indicator flags indicating a member has medical, dental, pharmacy, behavioral health, and vision and/or lab coverage. These fields can be compared against the Product file and are helpful in understanding benefit design.

Dates

CHIA collects two sets of start and end dates:

- ME041 and ME042 are the dates associated with the member's enrollment with a specific product. ME041 captures the date the member enrolled in the product and ME042 captures the end date or is Null if they are still enrolled.
- ME047 and ME048 are the dates a member is enrolled with a specific PCP. For plans or products without PCPs, these fields will not be populated.

Member Eligibility File Features

CHIA defines the ME File detail level as at least one record per member, per Product ID, per beginning and ending date of eligibility for that product. Each row represents a unique instance of a Member and their Product Eligibility and other attributes. Multiple records for "Member and Product" may exist, but begin and end eligibility dates within a product should not overlap. Only a product change, or break in eligibility, triggers a requirement for a new eligibility record.

Multiple Rows in the ME File

The ME File contains *one record per member per product per eligibility time period*. For example, if medical and pharmacy benefits are delivered via two separate products rather than a bundled product (that is, HMO Medical 1000 and RX Bronze) we expect two records, one for HMO Medical 1000 and one for RX Bronze. In this example, the Medical Coverage indicator (ME020) would have a value of 1 for Yes and the Prescription Drug Coverage indicator (ME019) would have a value of 2 for No in the HMO Medical 1000 eligibility record. These field values would be reversed in the RX Bronze eligibility record.

ME File Impact on Product File (PR) Entries

This convention (*one record per member per product per eligibility time period*) also impacts the Product File. Each product listed in the ME File must also be present in the Product File, with PR006 indicating that the product is a Pharmacy, Medical or other product. The product Benefit Type should correlate to the flags in the Member Eligibility File. For example, for the Product File record for the HMO Medical 1000 we would expect PR006 product Benefit Type to be 1, which equals a description of 'Medical Only' and RX Bronze's Product File record would have a value of 2 for 'Pharmacy Only' in PR006.

Redundancy in ME Claims Data Elements

Many of the segments in the file use semantics similar to claims data, and some fields are exact duplicates of fields in claims files. CHIA collects contents of the Payer's Member File regardless of the information contained in Claims files. Member Eligibility needs this extra or similar information across files to support analysis of its variations. This is also a requirement of other states.

PRODUCT (PR) FILE

As part of the MA APCD, payers are required to submit a Product File. Release 4.0 has one Product File that consists of aggregated and unduplicated records across multiple years.

Product Definition

A Product, often described by the business model that it conforms to, starts as a base offering, for example, HMO, PPO, Indemnity, etc.

Product Line of Business Model (PR004) is collected by the MA APCD to define the type of business model. The data must be submitted using a CHIA-provided lookup table, which can be found in the MA APCD Release 4.0 Non-Government LDS *Data Elements Reference Tables,* located on the CHIA MA APCD *web site*:

http://www.chiamass.gov/ma-apcd/

Below are details on business rules, data definitions, and the potential uses of this data. For a full list of elements refer to the MA APCD Release 4.0 Non-Government LDS *Data Elements Reference Tables* mentioned above.

The Release 4.0 Product File

Release files are in an asterisk delimited text file in the same order as found in the MA APCD Release 4.0 Non-Government LDS *Data Elements Reference Tables*. Empty or null data elements have no spaces or characters between the asterisks. Each user receives only the data elements requested and approved.

Each row represents a unique instance of a Product. However, some payers have reported products on separate rows that differ only in aspects that are not specified in the Product File. Therefore, for some payers there may be appear to be duplicate rows, when, in fact, they are distinct products.

Types of Data Collected in the Product File

Product Linkage

CHIA collects product identifiers in all claim files associated with their respective claim lines and whose attributes are collected in the product file, under PR001. To help users identify and select one record with the attributes associated to any given PR001 product, CHIA has added an identifier data element Product Delegate (Derived PR4). Please refer to *Masked Data Elements and Linking* on page 14 for additional information.

Product Identifiers

CHIA collects elementary identifiers associated with a Product. The data in fields PR003, PR004, PR005, PR006 and PR008 can be used when analyzing Product data across payers. The identifiers help to link Product data to the Member Eligibility File.

Product Dates

CHIA collects two date fields for each Product record. The Start and End Dates (PR009 and PR010) for each Product describes the dates the Product was active with the payer and usable by eligible members. For Products that were still active at the end of 2011, the End Date should be Null. For Products that were not active, but may still have claims being adjudicated against them, the End Date should be the End Date reported to the Division of Insurance or the date the license was terminated.

THE PROVIDER (PV) FILE

CHIA collects date provider data, which can be used to analyze claims data when submitted in accordance with Submission Guide Standards. Since claims data is collected monthly, the provider file can be synced with the claims file, and provides a snapshot of how the provider file looked at the end of the period for which claims are sent.

The Provider File (PV) is a compilation of all payer provider files. A unique provider record exists for *each instance* where the provider is found in a payer submission. A provider record may also repeat within a payer for each attribute change. (See the *Provider Definition* section below).

> **Note:** Providers who have not been active since January 2008 do not need to be included in the collection process; however, some payers have elected to do so.

This section provides details on business rules, data definitions, and the potential uses of this data.

Provider Definition

CHIA defines a Provider as an organization or person that is:

- Providing services to patients, and/or
- Submitting claims for services on behalf of a servicing provider, and/or
- Providing business services or contracting arrangements for a servicing provider.

A Provider may be a health care practitioner, health care facility, health care group, medical product vendor, or pharmacy.

The Release 4.0 Provider File

Each row represents a unique instance of a provider entity within a payer, and may repeat rows for each attribute change, such as affiliation to another entity

Types of Data Collected in the Provider File

Provider Linkage

CHIA collects numerous identifiers that may be associated with a provider. CHIA uses these identifiers to link providers across payers in the event that the primary linking data elements are not a complete match. These extra identifying elements improve the quality of the matching algorithms. Please refer to *Masked Data Elements and Linking* on page 13 for additional information.

The Provider ID

Provider IDs (found in all three claims files) are some of the most critical fields in the MA APCD process as they link the Provider identified on the claims file with the corresponding record in the Provider File (PV002). The definition of PV002, Provider ID, is:

> "…the unique number for every service provider (persons, facilities or other entities involved in claims transactions) that a payer has in its system. This field is used to uniquely identify a provider and that provider's affiliation and a provider and a provider's practice location within this provider file."

Since PV002 frequently contains sensitive personal information, CHIA applied Derived PV9, a substitution linkage element to this element for this release. This substituted element provides linkage to the Provider File and greater ability to reference Provider Affiliation. Refer to *Linking Across File Types* for addition information on this process.

Appendix A. External Code Sources

The External Source Codes are an essential source for the collection and maintenance of the MA APCD data. These sources provide guidance through lookup tables and codes enabling CHIA to properly collect, standardize, and clean the data collected from the payers and providers. In the lookup tables featured in each file type's layout, the data element delineates whether an external source code was used to populate a lookup table.

1. MA APCD: EXTERNAL CODE SOURCES

Type	Organization	URL
Countries	American National Standards Institute 25 West 43rd Street, 4th Floor New York, NY 10036	http://webstore.ansi.org/SdoInfo.aspx?sdoid=39&source=iso_member_body
States and Other Areas of the US	U.S. Postal Service National Information Data Center P.O. Box 2977 Washington, DC 20013	https://www.usps.com/
National Provider Identifiers **National Plan & Provider Enumeration System**	Department of Health and Human Services 200 Independence Avenue, S.W. Washington, D.C. 20201 Centers for Medicare and Medicaid Services 7500 Security Boulevard Baltimore, MD 21244	**https://nppes.cms.hhs.gov/NPPES/**
Provider Specialties **Center for Medicare and Medicaid Services (CMS)**	Centers for Medicare and Medicaid Services 7500 Security Boulevard Baltimore, MD 21244	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
Health Care Provider Taxonomy Washington Publishing Company	The National Uniform Claim Committee c/o American Medical Association 515 North State Street Chicago, IL 60610	http://www.wpc-edi.com/reference/
North American Industry Classification System (NAICS) United States Census Bureau	U.S. Census Bureau 4600 Silver Hill Road Washington, DC 20233	http://www.census.gov/eos/www/naics/
Language Preference **United States Census Bureau**	U.S. Census Bureau 4600 Silver Hill Road Washington, DC 20233	http://www.census.gov/hhes/socdemo/language/about/index.html
International Classification of Diseases 9 & 10 **American Medical Association**	American Medical Association AMA Plaza 330 N. Wabash Ave. Chicago, IL 60611-5885	http://www.ama-assn.org/
HCPCS, CPTs and Modifiers American Medical Association	American Medical Association AMA Plaza 330 N. Wabash Ave.	http://www.ama-assn.org/

Type	Organization	URL
	Chicago, IL 60611-5885	
Dental Procedure Codes and Identifiers American Dental Association	American Dental Association 211 East Chicago Avenue Chicago, IL 60611-2678	http://www.ada.org/
Logical Observation Identifiers Names and Codes Regenstrief Institute	Regenstrief Institute, Inc. 410 West 10th Street, Suite 2000 Indianapolis, IN 46202-3012	http://loinc.org/
National Drug Codes and Names U.S. Food and Drug Administration	U.S. Food and Drug Administration 10903 New Hampshire Avenue Silver Spring, MD 20993	http://www.fda.gov/drugs/informationondrugs/ucm142438.htm
Standard Professional Billing Elements Centers for Medicare and Medicaid Services	Centers for Medicare and Medicaid Services 7500 Security Boulevard Baltimore, MD 21244	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
Standard Facility Billing Elements National Uniform Billing Committee (NUBC)	National Uniform Billing Committee American Hospital Association One North Franklin Chicago, IL 60606	http://www.nubc.org/
DRGs, APCs and POA Codes Centers for Medicare and Medicaid Services	Centers for Medicare and Medicaid Services 7500 Security Boulevard Baltimore, MD 21244	http://www.cms.gov/
Claim Adjustment Reason Codes Washington Publishing Company	Blue Cross / Blue Shield Association Interplan Teleprocessing Services Division 676 N. St. Clair Street Chicago, IL 60611	http://www.wpc-edi.com/reference/
Race and Ethnicity Codes Centers for Disease Control	Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA 30333, USA	http://www.cdc.gov/nchs/data/dvs/Race_Ethnicity_CodeSet.pdf

Appendix B. Linking Across Files (Coming Soon) - LDS

Appendix C. Glossary

Term	Definition
Accident Indicator	A yes/no indicator that originates from the Professional Claims format to assess insurance liability, financial responsibility and aid with clinical assessments.
Adjudication Data	Any data that describes how a claim was processed for payment. Typically information that would go back to the provider of services is used, but could include contract level information as well.
Admitting Diagnosis	This is the diagnosis (of a unique set of diagnoses) that supports a physician's order to admit a patient into an inpatient setting at a facility.
All Payer Claims Database (APCD)	The All Payer Claims Data Base (APCD) is a dataset of members, providers, products and claims from payers that allow for a broad understanding of cost and utilization across institutions and populations.
Ambulatory Payment Classification (APC)	A payment methodology applied to outpatient claims in a facility; defined by Federal Balanced Budget Act for Medicare claims originally.
Ancillary Services	Any service that supports the primary reason for the medical visit. This can be laboratory, X-ray or other services within or outside of the same facility.
APC	See Ambulatory Payment Classification.
APCD	See All Payer Claims Database.
APCD Field Threshold	The percentage of correct data that needs to be submitted for a particular field to ensure that it "passes". See Variance Request.
Applicant	An individual or organization that requests health care data and information.
Attending Provider	A provider that has direct care oversight of the patient. Typically an individual reported on Facility Inpatient Claims.
Billing Provider	A provider entity that sends claims and requests for adjudication to a carrier for payment.
Capitated Encounter Flag	A MA APCD Flag Indicator that reports a line-item as being covered under a capitation arrangement.
Capitated Payment	Capitation is a contractual payment arrangement between provider and payer. It is the 'per member per month' methodology that does not take 'per service' into account during the contract timeframe.
Carrier-Specific Unique Member ID	The number a carrier uses internally to uniquely identify the member.
Carrier-Specific Unique Subscriber ID	This is the number the carrier uses internally to uniquely identify the subscriber.
Center For Health Information and Analysis	An agency of the Commonwealth of Massachusetts responsible for providing reliable information and meaningful analysis for those seeking to improve health care quality, affordability, access, and outcomes. Formerly the Division of Health Care Finance and Policy until November 5, 2012.
Center	See Center for Health Information and Analysis.
CDT Code	See Common Dental Terminology Code.
CHIA	See Center for Health Information and Analysis.
Claim	A request for payment on rendered services to likely members. Claims can be in many formats: see UB04, HIPAA 837, Reimbursement Form, and Direct Data Entry.
Claim Line	An individual service reporting of a claim. See Line Counter.
Claim Line Type	A MA APCD value that reports a claim line status that moderately relates to the final digit (Frequency Code) of the

Term	Definition
	Type of Bill or Place of Service code on a claim. Options are Original, Void, Replacement, Back Out and Amendment.
Claim Status	A MA APCD value that reports how a claim was processed by the reporting carrier. Relates to reimbursement order on claims.
Claims Adjudication	An evaluation process employed by insurance companies and/or their designees to process claims data for payment to providers.
Claims Data	Information consisting of, or derived directly from, member eligibility information, medical claims, pharmacy claims, dental claims, and all other data submitted by health care payers to CHIA.
CMS	See Centers for Medicare & Medicaid Services.
COB	See Coordination of Benefits.
COBRA	See Consolidated Omnibus Budget Reconciliation Act.
Coinsurance Amount	Usually defined as a percentage of the claim that the subscriber pays on covered services to the provider after deductibles have been met, per the plan contract.
Common Dental Terminology Code (CDT Code)	A code set developed for dental procedure reporting by the American Dental Association.
Compound Drug Indicator	A MA APCD Flag Indicator that reports if a pharmacy line had to be compounded for the patient due to patient-specific needs (weight, allergies, administration route) or unavailability of the drug in certain measures.
Consolidated Omnibus Budget Reconciliation Act (COBRA)	Refers to the COBRA legislation that requires offering continued health care coverage when a qualifying event occurs with the employed family member. Usually only required of large group employers (20+ employees) under a modified payment schedule for same level of coverage.
Coordination of Benefits (COB)	A process that occurs between provider, subscriber(s) of same household, and two or more payers to eliminate multiple primary payments.
Coordination of Benefits/TPL Liability Amount	The amount calculated by a primary payer on a claim as the amount due from a secondary or other payer on the same claim when the primary payer is aware of other payers.
Copayment Amount	Usually defined as a set amount paid by the subscriber to the provider for a given outpatient service, per the plan contract.
Coverage Level Code	A MA APCD value submitted by the carrier that refines a line of eligibility to report the definition and size of covered lives.
Covered Days	The number of inpatient days covered by the plan under the member's eligibility. See Non-covered Days.
Data Element Name	The Submission Guide element name reference if applicable or the description of derived element if created by CHIA.
Date Service Approved (AP Date)	This is the date that the claim line was approved for payment. It can be several days (or weeks) prior to the Paid Date or on the Paid Date, but cannot fall after the Paid Date.
DC File	See Dental Claim File
DDE	See Direct Data Entry
Deductible	Usually defined as an annual set amount paid by the subscriber to the provider prior to the plan applying benefits. Deductibles can be inpatient and/or outpatient as they are payer/plan specific.
Delegated Benefit Administrator	CHIA assigned Org ID for Benefit Administrator. A Delegated Benefit Administrator is an entity that performs a combination of activities related to benefit enrollment, management and premium collection on behalf of a payer.
Denied Claims	Claims and/or Claim Lines that a payer will not process for payment due to non-eligibility or contractual conflicts.

Term	Definition
Dental Claim File (DC File)	A MA APCD File Type for reporting all Paid Dental Claim Lines of a given time period. File accommodates Replacement and Void lines.
Diagnostic Related Group (DRG)	Diagnostic Related Group: A system to classify hospital inpatient admits into a defined set of cases by numeric representation. Payment categories that are used to classify patients for the purpose of reimbursing providers for each case in a given category with a fixed fee regardless of the actual costs incurred.
Disability Indicator Flag	Indicator that a member has a disability. A yes/no indicator that originates from the Professional Claims format to assess insurance liability, financial responsibility and aid with clinical assessments.
Disease Management Enrollee Flag	A MA APCD Flag Indicator that reports if a member's chronic illness is managed by plan or vendor of plan.
Dispense as Written Code	Prescription Dispensing Activity Code
DRG	See Diagnostic Related Group
DRG Level	A reporting refinement from the Diagnostic Related Group coding that reports a level of severity of the case.
DRG Version	The version of the Diagnostic Related Group, a numbering system within the application used to allocate claims into the appropriate grouping date. This is mostly an annual process, although other updates are received.
E-Code	See External Injury Code
EFT	See Electronic Funds Transfer
EHS	Executive Office of Health and Human Services
EHS DW	Executive Office of Health and Human Services Data Warehouse
Employer EIN	Employer Identification Number (Federal Tax Identification Number) of the member's employer.
Employment Related Indicator	Service related to Employment Injury. A yes/no indicator that originates from the Professional Claims format to assess insurance liability, financial responsibility and aid with clinical assessments.
Encounter Data	Detailed data about individual services provided by a capitated managed care entity.
EOB	See Explanation of Benefits.
EPO	See Exclusive Provider Organization.
EPSDT Indicator	Indicates that Early Periodic Screening, Diagnosis and Treatment (EPSDT) were utilized. A yes/no indicator that originates from the Professional Claims format to assess insurance liability, financial responsibility and aid with clinical assessments.
Excluded Expenses	Amount that the plan has determined to be above and beyond plan/benefit limitations for a given patient. Related to non-covered services.
Exclusive Provider Organization (EPO)	A managed care product type that requires each member to have a PCP assignment within a limited network but offers affordable coverage.
Executive Office of Health and Human Services	EHS
Executive Office of Health and Human Services Data Warehouse	EHS DW
External Code Source	External code sources are lists of values generally accepted as a standard set of values for a given element. Example: Revenue Codes as defined by the National Uniform Billing Committee.
External Injury Code (E-Code)	ICD Diagnostic External Injury Code for patients with trauma

Term	Definition
	or accidents. A subsection of the International Classification of Diseases Diagnosis Codes that specifically enumerate various types of accidents and traumas before diagnoses are applied.
Fee for Service	A payment methodology where each service rendered is considered for individual reimbursement.
Former Claim Number	This is a prior claim number originally assigned to the claim by the provider of service. Its use in the MA APCD dataset is usually to aid with versioning of a claim where versioning cannot be applied due to system limitations.
Formulary Code	A MA APCD Flag Indicator that reports a line-item as being listed on a payers list of covered drugs. This reporting helps to understand patient-out-of-pocket expenses.
Fully-Insured	In a fully insured plan, the employer pays a per-employee premium to an insurance company, and the insurance company assumes the risk of providing health coverage for insured events.
GIC	See Group Insurance Commission.
Global Payment	Payments received of a fixed-value for predefined services on members within a predefined time frame.
Global Payment Flag	A MA APCD Flag Indicator that reports a line-item as being paid under a Global Payment arrangement. See Global Payment.
Group Insurance Commission	The Group Insurance Commission (GIC) is an entity charged with overseeing health and tangent benefits of state employees, retirees and dependents.
Grouper	A tool/application that evaluates each claim and determines where the claim falls clinically across a broad spectrum of values (cases). This can be applied to inpatient and outpatient claims based on the grouper used.
Health Care Home	See Patient Centered Medical Home.
Health Care Payer	A Private or Public Health Care Payer that contracts or offers to provide, deliver, arrange for, pay for, or reimburse any of the costs of health services. A Health Care Payer includes an insurance carrier, a health maintenance organization, a nonprofit hospital services corporation, a medical service corporation, Third-Party Administrators, and self-insured plans.
Health Plan Information	Information submitted by Health Care Payers
HCQCC	(Massachusetts) Health Care Quality and Cost Council (HCQCC) Established in 2006, HCQCC collected claim-level detail from third party payers. By 2009, HCQCC's responsibilities were transferred to the Division of Health Care Finance and Policy (DHCFP) and then, in 2012, CHIA was created as an independent agency for the collection and analysis of heath care data.
ICD9-CM	See International Classification of Diseases, 9th edition, Clinical Modification.
Individual Relationship Code	Indicator defining the Member/Patient's relationship to the Subscriber.
Insurance Type Code/Product	This field indicates the type of product the member has, such as HMO, PPO, POS, Auto Medical, Indemnity, and Workers Compensation.
International Classification of Diseases, 9th Edition, Clinical Modification	Refers to the International Classification of Diseases, 9th Revision Codes, and Clinical Modification (ICD-9-CM) procedure codes.
Last Activity Date	This is the date that a subscriber's or member's eligibility for any given product was last edited.

Term	Definition
LDS	Limited Data Set
Line Counter	An enumeration process to define each service on a claim with a unique number. Process follows standard enumeration from other billing forms and formats.
Logical Observation Identifiers, Names and Codes (LOINC)	Lab Codes for Logical Observation Identifiers, Names and Codes. A method for reporting laboratory findings of specimens back to a health care provider / system.
LOINC	See Logical Observation Identifiers, Names and Codes.
LTC	Long Term Care
Major Diagnostic Category (MDC)	The Major Diagnostic Categories (MDC) is a classification system that parses all principal diagnoses into one of 25 categories primarily for use with DRGs and reimbursement activity. Each Category relates to a physical system, disease, or contributing health factor.
Managed Care Organization	A product developed to control costs of care management through various methods such as limited networks, PCP assignment, and case management.
Market Category Code	A MA APCD ME File refinement code that explains what market segment the policy that the subscriber/member has selected falls under.
Masking	Indicates field is masked in the output extract file (masked output that creates the same random value each time for a specific source value).
MassHealth	The Massachusetts Medicaid program.
MC File	See Medical Claim File.
MCE	Manage Care Entity
MCO	See Managed Care Organization.
MDC	See Major Diagnostic Categories.
Medicaid MCO	A Medicaid Managed Care Organizations is a private health insurance that has contracted with the state to supply Managed Care products to a select population.
Medical Claim File (MC File)	A MA APCD File Type for reporting all Paid Medical Claim Lines of a given time period. File accommodates Facility, Professional, Reimbursement Forms and Replacement and Void lines.
Medicare Advantage	A Medicare Advantage Plan (Part C) is a Medicare health plan choice offered by private companies approved by Medicare. The plan will provides all Part A (Hospital Insurance) and Part B (Medical Insurance) coverage and may offer extra coverage such as vision or dental coverage Medicare Benefits (Part A & B)
Medicare Benefits (Part A & B)	Health insurance available under Medicare Part A and Part B through the traditional fee-for-service payment system. Part A is hospital insurance that helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home health care. Part B helps cover medically-necessary services like doctors' services, outpatient care, durable medical equipment, home health services, and other medical services.
Member	A person who holds an individual contract or a certificate under a group arrangement contracted with a Health Care Payer.
Member Deductible	Annual maximum out of pocket Member Deductible across all benefit types. See Deductible.
Member Deductible Used	Member deductible amount incurred.
Member Eligibility File	A file that includes data about a person who receives health care coverage from a payer, including but not limited to subscriber and member identifiers; member demographics; race, ethnicity and language information; plan type; benefit

Term	Definition
	codes; enrollment start and end dates; and behavioral and mental health, substance abuse and chemical dependency and prescription drug benefit indicators.
Member PCP Effective Date	Begin date for member enrollment with Primary Care Provider (PCP).
Member PCP ID	The member's Primary Care Physician's ID.
Member PCP Termination Date	Member termination date from that Primary Care Provider (PCP).
Member Rating Category	Utilized for Medicaid MCO members only, it defines the Member Medicaid MCO category.
Member Self Pay Amount	The amount that a Patient pays towards the claim/service prior to submission to the carrier or its designee.
Member Suffix / Sequence Number	Uniquely numbers the member within the health insurance contract.
Members SIC Code	A code describing the line of work the enrollee is in. Carriers will use Standard Industrial Classification (SIC) code values.
MMIS	Medicaid Management Information System
NAICS	See North American Industry Classification System.
National Billing Provider ID	National Provider Identification (NPI) of the Billing Provider.
National Council for Prescription Drug Programs (NCPDP)	The Standards Organization for the pharmacy industry.
National Plan ID	Unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans.
National Provider Identification (NPI)	A unique identification number for covered health care providers and health plans required under the Health Insurance Portability and Accountability Act (HIPPA) for Administrative Simplification.
National Service Provider ID	National Provider Identification (NPI) of the Servicing Provider.
NCPDP	See National Council for Prescription Drug Programs
Non Covered Days	The number of inpatient days not covered by the plan under the member's eligibility. See Covered Days.
Non-Covered Amount	An amount that refers to services that were not considered covered under the member's eligibility.
North American Industry Classification System (NAICS)	A standard classification system used to define businesses and the tasks within a business for statistical analysis, used by Federal statistical agencies for the purpose of collecting, analyzing, and publishing statistical data related to the U.S. business economy
NPI	See National Provider Identification
Organization Identification (Org ID)	A CHIA contact management unique enumeration assigned to any entity to allow for identification of that entity. This internally generated ID is used by CHIA to identify everything from carriers to hospitals in addition to other sites of service.
OrgID	See Organization Identification
P4P	See Pay for Performance
Paid Date	The date that a claim line is actually paid. Date that appears on the check and/or remit and/or explanation of benefits and corresponds to any and all types of payment. This can be the same date as Processed Date.
Patient	An individual that is receiving direct clinical care or oversight of self-care.
Patient Centered Medical Home (PCMH)	An approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family
Patient Control Number	This is a unique identifier assigned by the provider for

Term	Definition
	individual encounters of care or claims.
Payer	See Health Care Payer
Payer Claim Control Number	A unique identifier within the payer's system that applies to the entire claim for the life of that claim. Not to be confused with Patient Control Number that originates at the provider site.
Payment	Financial transfer from payer to provider for services rendered to patients, quality maintenance, performance measures or training initiatives.
PBM	See Pharmacy Benefit Manager.
PC File	See Pharmacy Claim File.
PCMH	See Patient Centered Medical Home.
PCP	See Primary Care Physician.
PCP Indicator	A MA APCD Flag Indicator that reports a claim line-item as being performed by the patient's Primary Care Physician. See Primary Care Physician.
Pharmacy Benefit Manager (PBM)	A Pharmacy benefit manager (PBM) is a company that administers all or some portion of a drug benefit program of an employer group or health plan.
Pharmacy Claim File (PC File)	A MA APCD File Type for reporting all Paid Pharmacy Claim Lines of a given time period. File accommodates Replacement and Void lines.
Plan Rendering Provider Identifier	Carrier's unique code which identifies for the carrier who or which individual provider cared for the patient for the claim line in question.
Plan Specific Contract Number	Plan assigned contract number. This should be the contract or certificate number for the subscriber and all of his/her dependents.
PMPM	Per Member Per Month
Point of Service (POS)	A point-of-service (POS) plan is a health maintenance organization (HMO) and a preferred provider organization (PPO) hybrid. POS plans resemble HMOs for in-network services. Services received outside of the network are usually reimbursed in a manner similar to conventional indemnity plans.
POS	See Point of Service
PR File	See Product File
Preferred Provider Organization (PPO)	A plan where coverage is provided to participants - a network of selected health care providers (such as hospitals and physicians). The enrollees may go outside the network, but would incur larger costs in the form of higher deductibles, higher coinsurance rates, or non-discounted charges from the providers.
PCC	Primary Care Clinician
Primary Care Physician (PCP)	A physician who serves as a member's primary contact for health care. The primary care physician provides basic medical services, coordinates and, if required, authorizes referrals to specialists and hospitals.
Primary Insurance Indicator	A MA APCD Flag Indicator that reports if the payer adjudicated a Claim Line as the Primary Payer.
Private Health Care Payer	A carrier authorized to transact accident and health insurance under chapter 175, a nonprofit hospital service corporation licensed under chapter 176A, a nonprofit medical service corporation licensed under chapter 176B, a dental service corporation organized under chapter 176E, an optometric service corporation organized under chapter 176F, a self-insured plan to the extent allowable under federal law governing health care provided by employers to

Term	Definition
	employees, or a health maintenance organization licensed under chapter 176G.
Product	Any offering for sale by a health plan or vendor. It typically describes carrier-based business models such as HMO, PPO but is also synonymous with processing services, network leasing, re-pricing vendors.
Product Enrollment End Date	The date the member dis-enrolled in the product.
Product Enrollment Start Date	The date the member enrolled in the product
Product File (PR File)	A MA APCD file that reports all products that a carrier maintains as a saleable service. Typically these products are listed with the Division of Insurance.
Product Identifier	A unique identifier created by the submitter to each Product offered. It is used to link eligibilities to products and to validate claim adjudication per the product.
Provider	A health care practitioner, health care facility, health care group, medical product vendor, or pharmacy.
Provider, as defined by CHIA	A Provider is an entity or person associated with either: 1. Providing services to patients, 2. Submitting claims for services on behalf of a servicing provider, or 3. Providing business services or contracting arrangements for a servicing provider. A Provider may be a health care practitioner, health care facility, health care group, medical product vendor, or pharmacy.
Provider File (PV File)	A MA APCD file containing information on all types of health care provider entities. Typically these are active, contracted providers.
Provider ID	A unique identifier assigned by the carrier or designee and reported in the MA APCD files.
Public Health Care Payer	The Medicaid program established in chapter 118E; any carrier or other entity that contracts with the office of Medicaid or the Commonwealth Health Insurance Connector to pay for or arrange for the purchase of health care services on behalf of individuals enrolled in health coverage programs under Titles XIX or XXI, or under the Commonwealth Care Health Insurance program, including prepaid health plans subject to the provisions of section 28 of chapter 47 of the acts of 1997; the Group Insurance Commission established under chapter 32A; and any city or town with a population of more than 60,000 that has adopted chapter 32B. Also includes Medicare.
PUF	Public Use File
PV File	See Provider File
QA	See Quality Assurance
Quality Assurance (QA)	The process of verifying the reliability and accuracy of data within the thresholds set and rationales reported.
Rebate Indicator	A MA APCD Flag Indicator that reports if a pharmacy line was open for any rebate activity.
Referral Indicator	A MA APCD Flag Indicator that reports if a claim line required a referral regardless of its final adjudication.
Reimbursement Form	A form created by a carrier for subscribers/members to submit incurred costs to the carrier that are reimbursable under the benefit plan.
Risk Type	Refers to whether a product was fully-insured or self-insured.
Route of Administration	Indicates how drug is administered. Orally, injection, etc.
Script number	The unique enumerated identifier that appears on a prescription form from a provider.
Self-Insured	A plan offered by employers who directly assume the

Term	Definition
	major/full cost of health insurance for their employees. They may bear the entire risk, or insure against large claims by purchasing stop-loss coverage. The self-insured employers may contract with insurance carriers or third party administrators for claims processing and other administrative services; others are self-administered by the employer.
Service Provider Entity Type Qualifier	A MA APCD identifier used to refine a provider reporting into one of two categories, a person, or one of several non-person entity types.
Service Provider Specialty	The specialty of the servicing provider with whom a patient sought care.
Service Rendering Provider	The health care professional that performed the procedure or provided direct patient oversight.
Severity Level	See DRG Level
Single/Multiple Source Indicator	Drug Source Indicator. An identifier used to report pharmacy product streams.
Site of Service - on NSF/CMS 1500 Claims	Place of Service Code as used on Professional Claims. This is a two-digit code that reports where services were rendered by a health care professional.
Special Coverage	A MA APCD identifier used to refine eligibility with non-traditional coverage models to explain covered services and networks for this population. Valid choices are Commonwealth Care, Health Safety Net or N/A if not applicable.
Submission Guide	The document that defines the required data file format, record specifications, data elements, definitions, code tables and edit specifications.
Submitter	Any entity that has been registered with CHIA as a data submitter. This can be health plans, TPAs, PBMs, DBAs, or any entity approved to submit data on behalf of another entity; requires registration with CHIA. See *Organization ID, above*.
Subscriber	The subscriber is the insurance policy holder. The individual that has opted into and pays a premium for health insurance benefits under a defined policy. In some instances, the subscriber can be the Employer, or a non-related individual in cases of personal injury.
Third-Party Administrator (TPA)	Any person or entity that receives or collects charges, contributions, or premiums for, or adjusts or settles claims for, Massachusetts residents on behalf of a plan sponsor, health care services plan, nonprofit hospital or medical service organization, health maintenance organization, or insurer.
Third-Party Liability (TPL)	Refers to the coverage provided by a specific carrier for certain risks; typically work, auto, personal injury related.
Threshold Reduction	A process of the MA APCD Variance Request that a submitter performs to reduce the percentage of quality data that they must submit. This is performed prior to submitting a file to insure that A-Level Thresholds are met to pass the file into Quality Assurance.
TPA	See Third-Party Administrator.
TPL	See Third-Party Liability.
Type of Bill - on Facility Claims	This is a two-digit code that reports the type of facility in which services were rendered.
UB04	See Universal Billing Form 04.
Unemployed	An individual that does not hold a paying position with a company.
Universal Billing Form 04	A standard billing form created by the National Universal Billing Committee for Facility Claims. The 04 refers to the

Term	Definition
	last updated version of the claim format. It is typically a paper form but electronic versions of it exist.
Variance	See Variance Request
Variance Request (VR)	A request to CHIA that explains why an organization cannot submit a field (or fields), meet a threshold (or thresholds), or submit a file (or files). This is a form, developed by the MA APCD, which defines base reporting percentages for all data elements on all filing types, where the submitter may disclose reasons for not meeting base-percentage reporting, and request a threshold reduction to percentages that can be met.
Version Number	Version number of this claim service line. An enumeration process required by the MA APCD Claims Files to insure that the most recent line(s) of any given claim are used in that claims analysis at time of reporting.
Voided Claims	Claim lines filed that will be excluded from analysis (i.e. Claims that were deemed not eligible for submittal).

CONTACT INFORMATION

Please contact CHIA with questions regarding the content and use of the data.

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General APCD questions should be sent to the APCD mailbox:

CHIA-APCD@state.ma.us

Please direct questions regarding data requests/applications to the APCD data application mailbox:

apcd.data@state.ma.us