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center
for health
information
and analysis

The All-Payer Claims Database

Release 2.0

Documentation Guide

Dental Claims File

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Commonwealth of Massachusetts

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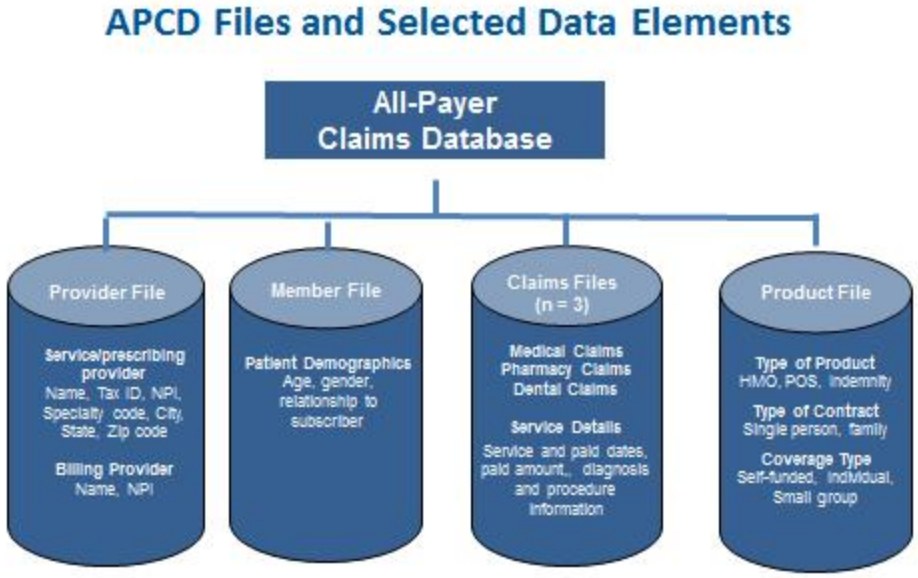
Contents



For ease of use, the Center for Health Information and Analysis (CHIA) has created separate documents for **each** APCD file type and one for the appendices—for a total of seven separate documents. All are available on the CHIA website.

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 **All-Payer Claims Database (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 is provided as a manual to accompany the release of data from the APCD.

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

APCD data collection and data release are governed by **regulations** which are available on the APCD website (see http://www.mass.gov/chia/gov/laws-regs/chia-regulations.html).

APCD DATA COLLECTION

History

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 under contact to the HCQCC. 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 for the HCQCC. 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 APCD – that were previously performed by the Division of Health Care Finance and Policy (DHCFP).

According to Chapter 224, the purpose of the Massachusetts APCD is **Administrative Simplification:**

> **"**The center shall collect, store and maintain such data in a payer and provider claims database. The center shall acquire, retain and oversee all information technology, infrastructure, hardware, components, servers and employees necessary to carry out this section. All other agencies, authorities, councils, boards and commissions of the commonwealth seeking health care data that is collected under this section shall, whenever feasible, utilize the data before requesting data directly from health care providers and payers. In order to ensure patient data confidentiality, the center shall not contract or transfer the operation of the database or its functions to a third-party entity, nonprofit organization or governmental entity; provided, however, that the center may enter into interagency services agreements for transfer and use of the data. "

A Preliminary Release of the APCD – covering dates of service CY 2008-2010 and paid through February 28, 2011 – was released in 2012. Release 1.0 covered dates of service CY 2009-2011 and paid through February 2013. Release 2.0 covers dates of service CY2009-2012 and paid through June 2013.

APCD Data Collection Process

The data collected from the payers for the 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**[1] 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.

Edits

When payers submit their data to CHIA for the APCD, an **Edits process** is run on each file to check that the data complies with requirements for the file and for each data element in the file.

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 (i.e. alpha vs. numeric), contains invalid characters (i.e. negative values, decimals, future dates) or is missing values (i.e. nulls). If these edits detect any issues with a file, they are identified on a report that is sent to the payer.

Data elements are grouped into four categories (A, B, C, and Z) which indicate their relative analytic value to the Center and APCD users. Refer to the **File Layout** sections of each document to view the Edit Level for each Data Element:

- '**A**' level fields must meet their **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 will result in a failed file submission for the payer and a discussion with their liaison regarding corrective action.
- The other categories (**B, C, and Z**) are also **monitored**, but the thresholds are not presently enforced.

Variances

The **Variance process** is a collaborative effort between the payer and CHIA to reach a mutually agreed upon **threshold percentage** for any data element which may not meet the APCD standard. Payers are allowed to 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 carefully reviews each request and follows up with a discussion with the payers about how to improve data quality and possibly suggest alternative threshold rates or possibly "ramping up" overtime to the threshold. CHIA's goal is to work with payers to improve the quality of the APCD overtime.

Once this process is complete, the variance template is loaded into production so that any submissions from the payer are held to the CHIA standard thresholds and any approved variances. The payer receives a report after each submission is processed which compares their data against the required threshold percentages. 'Failed' files are reviewed by the Center liaisons and discussed with the payer for corrective action.[2]

[1] For more information on External Source Codes, refer to **Appendix 9** in the Appendices Release Document.
[2] For more information on variance see **Appendix 6**.

Broad Caveats

Researchers using the APCD Release 2.0 data should be aware of the following:

- Release files include data submitted to the Center through June 2013. Data submitted to the Center after June 2013 is **NOT** included in the files.
- Due to the variance process, data quality may vary from one payer to another. Consult Appendix 6 for more information.
- Claim Files submitted **through June 2010** were accepted with **relaxed edits**. (Refer to the edits section of this document.)
    - The release files contain the data submitted to the Center including valid and invalid values.
- Certain data elements were cleaned when necessary. Detail on the cleaning logic applied is described at the end of each file layout.
- Certain data elements were redacted to protect against disclosure of sensitive information.[3]
- Some Release Data was manipulated for compliance with HIPAA:
    - Assignment of linkage IDs to replace reported linkage identifiers (see **Appendix 4**).
    - 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.

APCD Release 2.0 Overview

The **APCD** is comprised of data elements collected from **all Private and Public Payers**[4] of eligible **Health Care Claims** for Massachusetts Residents.[5] Data is collected in six file types: **Product (PR)**, **Member Eligibility (ME)**, **Medical Claims (MC)**, **Dental Claims (DC)**, **Pharmacy Claims (PC)**, and **Provider (PV)**. Each is described separately in this user manual.

Highlights of the release include:

- Data is available for dates of service from January 1, 2009 to December 31, 2012 as paid through June 2013.
- Release 2.0 contains more comprehensive and recently updated data, including resubmissions from several large carriers.
- Data elements are classified as either Level 2 or Level 3 data elements. Level 2 include data elements that pose a risk of re-identification of an individual patient. Level 3 data elements are generally either Direct Personal information, such as name, social security number, and date of birth, that uniquely identifies an individual or are among the 18 identifiers specified by HIPAA. Refer to the **File Layout** sections for listings of Level 2 and Level 3 data elements for each file.[6]
- Public Use Files (PUFs), which are de-identified extracts of the Medical Claims (MC) and Pharmacy Claims (PC) files, will be release separately. The PUFs incorporate certain levels of aggregation and a much more limited list of elements to help ensure data privacy protection.
- Certain identifying or sensitive data elements are **Masked** in the release in order to protect personally identifiable information 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). Refer to the **File Layout** sections for detail.

[3] Detail on the redaction process is available in **Appendix 3.**

[4] Medicare data is only available to state agencies. Medicaid data requires separate approval from the Massachusetts Executive Office of Health and Human Services.

[5] In certain instances out of state residents are included. Most notably enrollees in the State's Group Insurance Commission medical programs and enrollees in plans subject to the Massachusetts risk adjustment program for the Affordable Care Act.

[6] Note that Level 1 (de-identified) extracts of the Medical Claims (MC) and Pharmacy Claims (PC) APCD files will be released by CHIA in the coming months.

DENTAL CLAIMS FILE

As part of the All Payer Claims Database (APCD), payers are required to submit a Dental Claims File. The Dental Claim File will release **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.

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

Types of Data Collected in the Dental Claims File

Payer-assigned Identifiers

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

Claims Data

The Center requires the 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 can be used to aid with the **matching** algorithm; see DC056 and DC057.

Non-Massachusetts Resident

The Center will 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.

Adjudication Data

The Center 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 are variations of paper remittances or the HIPAA 835 4010.

Denied Claims

Payers are not required to submit wholly denied claims.

The Provider ID

Element DC018 (Provider ID) is one of the most critical fields in the APCD process as it links the Provider identified on the Dental 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.*

The goal of PV002 is to help identify provider data elements associated with provider data that was submitted in the claim line detail, and to identify the details of the Provider Affiliation.

However, due to the fact that PV002 frequently contains sensitive personal information, the element PV002 has received a **substitution linkage element** (with the added suffix "_Linkage_ID") for this release by CHIA which allows linking to the Provider File. Refer to the Linkage Section of the Appendices for greater detail on this process.

Dental Claims Release File Structure:

<table>
<tr><th>Issue</th><th>Clarification</th></tr>
<tr><td>Release File Format</td><td>Release files will be in an asterisk-delimited text file.
Only the requested and approved Data Elements will be included in the release file.
Released elements will be delimited in the same order as is found in the File Layout section of this document.</td></tr>
<tr><td>Rows</td><td>Each row in the APCD Dental Claims file represents one claim line.
If there are multiple services performed and billed on a claim, each of those services will be uniquely identified and reported on a line.
Line item data provides an understanding of how services are utilized and adjudicated by different payers.</td></tr>
<tr><td>Release ID</td><td>A unique id for each claim line in the data release will assigned by the Center.
All Level 1 and Level 2 file records will contain Release IDs to enable linking between the records in the public use file and the records in the restricted use files.</td></tr>
<tr><td>Redundancy</td><td>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.</td></tr>
<tr><td>Changes to Claim Lines</td><td>Claim line Versioning is triggered by the Claim Line Type field:
<table>
<tr><th>Claim Line Type Code</th><th>Claim Line Type Description</th><th>Action/Source</th></tr>
<tr><td>O</td><td>Original</td><td></td></tr>
<tr><td>V</td><td>Void</td><td>Delete line referenced / Provider</td></tr>
<tr><td>R</td><td>Replacement</td><td>Replace line referenced / Provider</td></tr>
<tr><td>B</td><td>Back Out</td><td>Delete line referenced / Payer</td></tr>
<tr><td>A</td><td>Amendment</td><td>Replace line referenced / Payer</td></tr>
</table>
Note that claims lines are not versioned in the version 2.0 dental claims files.</td></tr>
<tr><td>Claim ID</td><td>Claims may be isolated by grouping claim lines by the following elements:
Payer Claim Control Number (DC004)/Payer Org ID (DC001)</td></tr>
<tr><td>Denied claim lines</td><td>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 APCD in terms of covered benefits and/or eligibility.</td></tr>
<tr><td>Claims that are paid under a ‘global payment’, or ‘capitated payment’, thus zero paid</td><td>Payers are instructed by CHIA to submit any dental claim that is considered ‘paid’. Paid amount should be reported as 0 and the corresponding Allowed, Contractual, Deductible Amounts should be calculated accordingly.</td></tr>
</table>

Issue	Clarification
Previously paid but now **Voided** claims	The reporting of Voided Claims maintains logic integrity between services utilized and deductibles applied.

Dental Claims File Layout

Restricted Release Elements:

- Each **row** in the release file contains one record of the indicated file type. There is an **asterisk-delimited field** in each row for every data element listed in the Restricted Release sections for each file type.
- Data Elements will be delimited in the order displayed in the File Layout sections of this document.
- **Empty** or **null** data elements will have no spaces or characters between the asterisks.

Lookup Tables:

- **Element-specific** Lookup Tables are included in this document after each File Type Layout section.
- A **Carrier-Specific Master Lookup** table is included with each data extract. Refer to the **Carrier-Specific Reference** and **Linking** sections in this document for more information.
- **External Code Sources** are listed in Appendix 9.

Masked Elements:

- For the Data Release, some of the data elements have been **Masked** to provide confidentiality for Payers and Providers, and individuals, while allowing for linkage between claims, files, and lookup tables. Refer to the **Data Protection/Confidentiality** and **Linkage** sections of the Appendices for more information.

File Layout Section Columns

- **Element**: The code name of the element, with reference to the Regulation and the Submission files received by the Center from Payers. The first two digits refer to the File Type and the following numbers to the ordering in the Submission Files.
- **Data Element Name**: Name of the element.
- **Max Length:** Maximum Length of the data column in the APCD's SQL Server database at the Center.
- **Data Type Guide:** Data Type of the column in the APCD's SQL Server database at the Center. When the APCD Release text file is imported to a database or other file type by the final user of the data, these data types provide a guide to setting up the columns in the receiving file.
- **Description:** Description of the element.
- **Release Notes:** Additional information about the element in the release.
- **Edit Level:** Level of enforcement of the data element's requirements by the Center on Payer Submissions. Refer to the **Edits** section of this document.
- **APCD Threshold:** The expected percentage of validity for instances of the element in each submission file by the Payer.

Release Text File Column Titles

- **Appendix 10: Release File Column Names** included in this document lists the column name for each data element in the Level 2 and Level 3 release files. The text files exported from the APCD SQL Database include these SQL column names in the first row.

Dental Claims – Level 2 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level[7]**	**APCD Threshold[8]**
Derived - DC1	Submission Month	2	int	Month of the file submission—derived by CHIA.	Month of the file submission—derived by CHIA.	N/A	N/A
Derived - DC2	Submission Year	4	int	Year of the file submission—derived by CHIA.	Year of the file submission—derived by CHIA.	N/A	N/A
Derived - DC3	County of Member	3	varchar	County of the Member/Patient—derived by CHIA	County of the Member/Patient—derived by CHIA	N/A	N/A
Derived - DC4	County of Service Provider	3	varchar	County of the Service Provider—derived by CHIA	County of the Service Provider—derived by CHIA	N/A	N/A
Derived - DC5	Dental Claim ID	NULL	int	Unique record ID per submission control ID	With each submission control ID this number is reset to 1 and sequentially incremented by one for every record submitted	N/A	N/A
Derived - DC6	Member ZIP code (first 3 digits)	256	varbinary	Member Zip Code (first 3 digits)—derived by CHIA	Member Zip Code (first 3 digits)—derived by CHIA	N/A	N/A
Derived - DC7	Release ID	NULL	int	Unique record ID derived specifically for this release file type	With each release file type table this number is reset to 1 and sequentially incremented by one for every record released	N/A	N/A
Derived - DC8	Submission Control ID	NULL	int	Unique sequential number assigned to any new file type submitted to CHIA across all carriers	With each file submission this number is incremented by one	N/A	N/A
Derived - DC9	CHIA Incurred Date (Year and Month Only)		int	This is a derived YYYYMM value as best determined by CHIA. Determination was based on availability of valid date data – typically “Date of Service”.	This is a derived YYYYMM value.	N/A	N/A

[7] See pg. 5 for a discussion on Edit Levels.
[8] See pg. 5 for a discussion on APCD Thresholds.

Dental Claims – Level 2 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level[7]**	**APCD Threshold[8]**
DC001	Payer	8	varchar	Carrier Specific Submitter Code as defined by APCD. This must match the Submitter Code reported in HD002	A CHIA-assigned identifier for any APCD Data Submitter; Insurance, Benefit Manager/Administrator, TPA, Vendor	A0	100
DC002	National Plan ID	30	varchar	CMS National Plan Identification Number (PlanID)	Unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans.	Z	0
DC003	Dental Insurance Type Code/Product	2	char	Dental Product/Type Identifier (Lookup Table)	A code that defines the type of insurance applied to the claim line. This value can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	C	98
DC004	Payer Claim Control Number	35	varchar	Payer Claim Control Identification	Unique identifier within the payer's system that applies to the entire claim.	A0	100
DC005	Line Counter	4	int	Incremental Line Counter	The line number for this service on the claim. First line should start with 1 and each additional line incremented by 1.	A0	100
DC005A	Version Number	4	int	Claim Service Line Version Number	Incrementing counter for a claim line that is reprocessed for any reason over the course of time. Highest value should indicate latest reprocessing of line by the carrier/submitter.	A0	100
DC011	Individual Relationship Code	2	varchar	Member/Patient to Subscriber Relationship Code (Lookup Table)	Numeric indicator to report the Patient's relationship to the Subscriber. This value can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	B	98
DC012	Member Gender	1	varchar	Member/Patient's Gender (Lookup Table)	A code that defines the Patient's gender. This can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	B	100
DC013	Member Birth (Year Only)	4	int	Member/Patient's year of birth	Year of the Birth date of the Patient.	B	99
DC013	Member Birth Month		int	Member/Patient's month of birth	Month of the Birth date of the Patient.	B	99

Dental Claims – Level 2 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level[7]**	**APCD Threshold[8]**
DC014	Member City Name	50	varbinary	City name of the Member/Patient	City of the Patient.	B	99
DC015	Member State or Province	2	varchar	State of the Member/Patient	State of the Patient.	B	99
DC016	Member ZIP Code	5	varbinary	Zip Code of the Member/Patient	5 or 9 digit Zip Code of the Patient.	B	99
DC017	Date Service Approved (AP Date)	8	datetime	The date the claim or service was approved for payment.	The date the service was approved for payment by the carrier or its designee. (YYYY-MM-DD 00:00:00.000)	C	98
DC018	Service Provider Number	30	varchar	Service Provider Identification Number	Link to PV002 on Provider File to obtain detailed attributes of the Service Provider.	A1	100
DC020	National Service Provider ID	20	int	National Provider Identification (NPI) of the National Service Provider	The National Provider ID (NPI) of the Service Provider.	C	98
DC021	Service Provider Entity Type Qualifier	1	varchar	Service Provider Entity Identifier Code (Lookup Table)	Numeric indicator to define the Service Provider as a person or non-person. This value drives various 'person' –type requirements; First Name, Date of Birth, Gender, etc.	A0	98
DC022	Service Provider First Name	25	varchar	First name of Service Provider	First name of the Service Provider, when appropriate.	C	98
DC023	Service Provider Middle Name	25	varchar	Middle name of Service Provider	Middle name / initial of the Service Provider when appropriate.	C	2
DC024	Service Provider Last Name or Organization Name	60	varchar	Last name or Organization Name of Service Provider	Last name, or Organization name, of the Service Provider.	B	98
DC025	Delegated Benefit Administrator Organization ID	10	varchar	CHIA-assigned Org ID for Benefit Administrator	Linking ID used by carriers to identify their Benefit Administrators / Managers, Vendors, etc. This value is a CHIA-assigned identifier.	A2	98
DC026	Service Provider Specialty (Standard Values/Carrier-Specific Custom Values)	10	varchar	Specialty Code	A standardized taxonomy code (External Code Source 13) OR a carrier-defined specialty code of the Servicing Provider (APCD Master Lookup Table). Value is required to be in carrier-defined table if provided.	B	98
DC027	Service Provider City Name	30	varchar	City name of the Provider	City of the Service Provider.	B	98

Dental Claims – Level 2 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level[7]**	**APCD Threshold[8]**
DC028	Service Provider State	2	varchar	State of the Service Provider	State of the Service Provider.	B	98
DC029	Service Provider ZIP Code	11	varchar	Zip Code of the Service Provider	Zip Code of the Service Provider.	B	98
DC030	Facility Type - Professional	2	varchar	Place of Service Code as used on Professional Claims	Place of Service Code as used on Professional Claims	B	80
DC031	Claim Status	2	varchar	Claim Line Status (Lookup Table)	Numeric indicator that reports if the claim line was paid by the carrier or its designee, and the COB order of the payment.	A0	90
DC032	CDT Code	5	varchar	HCPCS / CDT Code	The procedure code reported for this claim line.	A2	99
DC033	Procedure Modifier - 1	2	varchar	HCPCS / CPT Code Modifier	The first modifier for the procedure code reported on this claim line.	C	0
DC034	Procedure Modifier - 2	2	varchar	HCPCS / CPT Code Modifier	The second modifier for the procedure code reported on this claim line.	C	0
DC035	Date of Service - From	8	datetime	Date of Service	First date of service for this claim line. (YYYY-MM-DD 00:00:00.000)	A0	99
DC036	Date of Service - Thru	8	datetime	Last date of service for this service line.	Last date of service for this claim line. (YYYY-MM-DD 00:00:00.000)	B	0
DC037	Charge Amount	10	money	Amount of provider charges for the claim line	Amount provider charged for the claim line service.	A0	99
DC038	Paid Amount	10	money	Amount paid by carrier for the claim line	The amount paid to the provider for this claim line.	A0	99
DC039	Copay Amount	10	money	Amount of Copay member/patient is responsible to pay	The copay amount applied to a claim line or full claim as calculated by the carrier or its designee.	A1	99
DC040	Coinsurance Amount	10	money	Amount of coinsurance member/patient is responsible to pay	The coinsurance amount applied to a claim line or full claim as calculated by the carrier or its designee.	A1	99
DC041	Deductible Amount	10	money	Amount of deductible member/patient is responsible to pay on the claim line	The deductible amount applied to a claim line or full claim as calculated by the carrier or its designee.	A1	99

Dental Claims – Level 2 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level[7]**	**APCD Threshold[8]**
DC042	Product ID Number	30	varchar	Product Identification Number	Link to PR001 on the Product File to obtain detailed attributes of the Product to which this claim line's member eligibility is associated.	A0	100
DC045	Paid Date	8	Datetime	Paid date of the claim line	The date that appears on the check and/or remit and/or explanation of benefits, and corresponds to any and all types of payment for this claim line. (Paid in full, partial, and/or zero paid.) This can be the same date as Processed Date. (YYYY-MM-DD 00:00:00.000)	A0	98
DC046	Allowed Amount	10	money	Allowed Amount	The maximum amount contractually allowed and payable for this claim line as defined by the carrier or its designee.	A2	99
DC047	Tooth Number/Letter	20	varchar	Tooth Number or Letter Identification	Standard enumeration of tooth when appropriate for the service provided.	A2	100
DC048	Dental Quadrant	1	varchar	Dental Quadrant	Standard identification of oral quadrants when appropriate for the service provided.	B	100
DC049	Tooth Surface	10	varchar	Tooth Service Identification	Standard identification of tooth surface(s) when appropriate for the service provided.	A2	100
DC056	CarrierSpecificUniqueMemberID [Masked]	256	varbinary	Member/Patient Carrier Unique Identification	Unique, internal identification assigned by the carrier or its designee to the Member. This can be used to link Claim Lines to member eligibility segments.	A0	100
DC057	CarrierSpecificUniqueSubscriberID [Masked]	256	varbinary	Subscriber Carrier Unique Identification	Unique, internal identification assigned by the carrier or its designee to the Subscriber. This can be used to link Claim Lines to eligibility segments.	A0	100
DC059	Claim Line Type	10	varchar	Claim Line Activity Type Code (Lookup Table)	A code that reports the final outcome of the claim line during the submission period of the carrier or its designee. Example: Original, Void, Replacement, Back Out, Amendment.	A2	98

Dental Claims – Level 2 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level[7]**	**APCD Threshold[8]**
DC060	Former Claim Number	35	varchar	Previous Claim Number	The Payer Claim Control Number previously assigned to this claim line in a prior reporting period.	B	0

Dental Claims – Level 3 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**
Derived - DC5	Dental Claim ID	NULL	int	Unique record ID per submission control ID	With each submission control ID this number is reset to 1 and sequentially incremented by one for every record submitted	N/A	N/A
Derived - DC7	Release ID	NULL	int	Unique record ID derived specifically for this release file type	With each release file type table this number is reset to 1 and sequentially incremented by one for every record released	N/A	N/A
Derived - DC8	Submission Control ID	NULL	int	Unique sequential number assigned to any new file type submitted to CHIA across all carriers	With each file submission this number is incremented by one	N/A	N/A
DC006	Insured Group or Policy Number	256	varbinary	Carrier's group or policy number	The carrier assigned group / policy number for this claim line. This information is often filed as reported by the provider.	C	98
DC007	Subscriber SSN	256	varbinary	Subscriber's Social Security Number	Tax ID of the Subscriber.	B	70
DC008	Plan Specific Contract Number	256	varbinary	Plan Specific Contract Number	Plan-assigned contract/certificate number for the Subscriber and all of the corresponding dependents. This identifier must not disclose individuals.	C	70
DC009	Member Suffix or Sequence Number	20	varchar	Member/Patient's Contract Sequence Number	A unique identifier that is assigned to each beneficiary under a contract.	B	98
DC010	Member Identification Code	256	varbinary	Member/Patient's Social Security Number	Tax ID of the Patient.	B	70

Dental Claims – Level 3 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**
DC013	Member Date of Birth	256	varbinary	Member/Patient's date of birth	Birth date of the Patient.	Z	0
DC019	Service Provider Tax ID Number	10	varchar	Service Provider's Tax ID number	Tax ID of the Service Provider.	C	99
DC043	Member Street Address	256	varbinary	Street address of the Member/Patient	Street address of the Patient.	B	90
DC044	Billing Provider Tax ID Number	256	varbinary	The Billing Provider's Federal Tax Identification Number (FTIN)	Tax ID of the Billing Provider.	C	90
DC050	Subscriber Last Name	256	varbinary	Last name of Subscriber	Last name (or entity name) of the Subscriber.	B	100
DC051	Subscriber First Name	256	varbinary	First name of the Subscriber, when appropriate	First name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. Example: Anne-Marie becomes ANNEMARIE.	B	100
DC052	Subscriber Middle Initial	1	varchar	Middle initial of Subscriber	Middle initial of the Subscriber.	C	2
DC053	Member Last Name	256	varbinary	Last name of Member/Patient	Last name of the Patient.	B	100
DC054	Member First Name	256	varbinary	First name of Member/Patient	First name of the Patient.	B	100
DC055	Member Middle Initial	1	varchar	Middle initial of the Member/Patient	Middle initial of the Patient.	C	2
DC058	Member Address 2	256	varbinary	Secondary Street Address of the Member/Patient	Street address 2 of the Patient.	B	2
DC899	Record Type	2	varchar	File Type Identifier		A0	100

APCD Lookup Tables for Dental Claims, by Element								
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Level 2/3**
DC003	Dental Insurance Type Code/Product	2	varchar	Dental Product/Type Identifier (Lookup Table)	A code that defines the type of insurance applied to the claim line. This value can be derived from the claim as submitted by the provider or reassigned by	C	98%	2

APCD Lookup Tables for Dental Claims, by Element								
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Level 2/3**
					the carrier or its designee.			
				Claim Insurance Type Code	***Claim Insurance Type***			
				09	Self-pay			
				10	Central Certification			
				11	Other Non-Federal Programs			
				12	Preferred Provider Organization (PPO)			
				13	Point of Service (POS)			
				14	Exclusive Provider Organization (EPO)			
				15	Indemnity Insurance			
				16	Health Maintenance Organization (HMO) Medicare Risk			
				17	Dental Maintenance Organization (DMO)			
				AM	Automobile Medical			
				BL	Blue Cross / Blue Shield			
				CC	Commonwealth Care			
				CE	Commonwealth Choice			
				CH	Champus			
				CI	Commercial Insurance Co.			
				DS	Disability			
				HM	Health Maintenance Organization			
				LI	Liability			
				LM	Liability Medical			
				MA	Medicare Part A			
				MB	Medicare Part B			
				MC	Medicaid			

APCD Lookup Tables for Dental Claims, by Element								
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Level 2/3**
				OF	Other Federal Program			
				TV	Title V			
				VA	Veterans Administration Plan			
				WC	Workers' Compensation			
DC011	Individual Relationship Code	2	varchar	Member/Patient to Subscriber Relationship Code (Lookup Table)	Numeric indicator to report the Patient's relationship to the Subscriber. This value can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	B	98%	2
				Individual Relationship Code	***Individual Relationship***			
				1	Spouse			
				4	Grandfather or Grandmother			
				5	Grandson or Granddaughter			
				7	Nephew or Niece			
				10	Foster Child			
				15	Ward			
				17	Stepson or Stepdaughter			
				19	Child			
				20	Self/Employee			
				21	Unknown			
				22	Handicapped Dependent			
				23	Sponsored Dependent			
				24	Dependent of a Minor Dependent			
				29	Significant Other			
				32	Mother			
				33	Father			

APCD Lookup Tables for Dental Claims, by Element								
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Level 2/3**
				36	Emancipated Minor			
				39	Organ Donor			
				40	Cadaver Donor			
				41	Injured Plaintiff			
				43	Child Where Insured Has No Financial Responsibility			
				53	Life Partner			
				76	Dependent			
DC012	Member Gender	1	varchar	Member/Patient's Gender (Lookup Table)	A code that defines the Patient's gender. This can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	B	100%	2
				Gender Code	***Gender***			
				F	Female			
				M	Male			
				O	Other			
				U	Unknown			
DC021	Service Provider Entity Type Qualifier	1	varchar	Service Provider Entity Identifier Code (Lookup Table)	Numeric indicator to define the Service Provider as a person or non-person. This value drives various 'person' –type requirements; First Name, Date of Birth, Gender, etc.	A0	98%	2
				Service Provider Entity Type Qualifier Code	***Service Provider Entity Type Qualifier***			
				1	Person			
				2	Non-person entity			
DC031	Claim Status	2	varchar	Claim Line Status (Lookup Table)	Numeric indicator that reports if the claim line was paid by the carrier or its designee, and the COB order of the payment.	A0	90%	2
				Claim Status Code	***Claim Status***			

APCD Lookup Tables for Dental Claims, by Element								
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Level 2/3**
				01	Processed as primary			
				02	Processed as secondary			
				03	Processed as tertiary			
				04	Denied			
				19	Processed as primary, forwarded to additional payer(s)			
				20	Processed as secondary, forwarded to additional payer(s)			
				21	Processed as tertiary, forwarded to additional payer(s)			
				22	Reversal of previous payment			
DC059	Claim Line Type	10	varchar	Claim Line Activity Type Code (Lookup Table)	A code that reports the final outcome of the claim line during the submission period of the carrier or its designee. Example: Original, Void, Replacement, Back Out, Amendment.	A2	80%	2
				Claim Line Type Code	***Claim Line Type***			
				O	Original			
				V	Void			
				R	Replacement			
				B	Back Out			
				A	Amendment			

APCD Dental Claims: External Code Sources

Refer to Appendix 9 in the Appendices: External Code Sources

Dental Claims File Cleaning, Standardization, and Redaction

APCD Dental Claims File Cleaning Logic, by Element				
Element	**Data Element Name**	**Format/Length**	**Description**	**Cleaning Logic**
DC012	Member Gender	char[1]	Patient's Gender	Change 'm' to 'M', 'f' to 'F', 'o' to 'O', 'u' to 'U'. Nullify invalid values based on lookup table.
DC013	Member Birth Year	Ing[4]	Member Birth Year	If age based on date of birth > 89 as of the last day of the service year, then set member birth year to 999. Nullify member birth year if age > 115.
DC020	National Service Provider ID	int[10]	National Provider Identification (NPI) of the Service Provider	Nullify values if not 10-digit integer.
DC023	Service Provider Middle Name	varchar[25]	Middle initial of Service Provider	Nullify all values equal to 'NULL'.
DC025	Delegated Benefit Administrator Org ID	varchar[6]	CHIA defined and maintained Org ID for linking across submitters	Nullify invalid values based on CHIA assigned organization ID.
DC031	Claim Status	varchar[2]	Claim Line Status	Zero pad single digit values.
DC037	Charge Amount	money	Amount of provider charges for the claim line	**For MassHealth (Org. ID 3156) data only:** submitted values multiplied by 100
DC038	Paid Amount	money	Amount paid by carrier for the claim line	**For MassHealth (Org. ID 3156) data only:** submitted values multiplied by 100
DC039	Copay Amount	money	Amount of Copay member/patient is responsible to pay	**For MassHealth (Org. ID 3156) data only:** submitted values multiplied by 100
DC046	Allowed Amount	money	Allowed Amount	**For MassHealth (Org. ID 3156) data only:** submitted values multiplied by 100
DC059	Claim Line Type	char[1]	Claim Line Activity Type Code	Change: 'ORIGINAL' to 'O', 'AMENDMENT' to 'A'.

APCD Dental Claims File Standardization, by Element using Melissa Data[9]			
Element	**Data Element Name**	**Format/Length**	**Description**
Derived-DC3	County of Member	[3]	
Derived-DC4	County of Service Provider	[3]	
Derived-DC6	Member ZIP code (first 3 digits)	varchar[3]	Zip Code of the Member / Patient (first 3 digits)
DC014	Member City Name	varchar[50]	City name of the Member/Patient
DC015	Member State or Province	char[2]	State / Province of the Patient
DC016	Member ZIP Code	varchar[9]	Zip Code of the Member / Patient
DC027	Service Provider City Name	varchar[30]	City name of the Provider
DC028	Service Provider State	char[2]	State of the Service Provider
DC029	Service Provider ZIP Code	varchar[9]	Zip Code of the Service Provider
DC043	Member Street Address	varchar[50]	Street address of the Member/Patient
DC058	Member Address 2	varchar[50]	Secondary Street Address of the Member/Patient

APCD Dental Claims File SSN Redaction, by Element			
Element	**Data Element Name**	**Format/Length**	**Description**
DC024	Service Provider Last Name or Organization Name	varchar[60]	Last name or Organization Name of Service Provider

APCD Dental Claims File Reidentification, by Element			
Element	**Data Element Name**	**Format/Length**	**Description**
DC018	Service Provider Number	varchar[30]	Service Provider Identification Number
DC042	Product ID Number	varchar[30]	Product Identification

[9] Please refer to **Appendix 3** for details on the Melissa standardization process and the redaction process. Please see **Appendix 4** for the reidentification process.