CENTER FOR HEALTH INFORMATION AND ANALYSIS

MASSACHUSETTS ALL PAYER CLAIMS DATABASE

MA APCD

RELEASE 5.0

NON-GOVERNMENT USERS

2011-2015 DOCUMENTATION GUIDE

CHIA.

Document Revision History

Date	Version Number	Changed/Created by	Requested by:	Change:
July 2016	1.0	K.Walsh		Initial Release

Contents

INTRODUCTION

The Center for Health Information and Analysis (CHIA) (CHIA) pursuant to M.G.L. c. 12C, is the agency of record serves as the Commonwealth's hub for health care data and health care analytics that support policy development and the systematic improvement of health care access and delivery in Massachusetts.

CHIA's enabling statute allows for the collection of data from commercial payers, third party administrators and public programs (Medicare and MassHealth, Massachusetts' Medicaid program). To that end, CHIA collects Massachusetts All Payer Claims Database (MA APCD). The MA APCD detailed claims level data is available to approved data users to provide a deeper understanding of the Massachusetts health care delivery system essential to improving quality, reducing costs, and promoting transparency. This document provides government data users with information on Release 5.0 of the MA APCD.

This document provides non-government users[1] with information on the MA APCD Release 5.0 Limited Data Set (LDS).

Overview

MA APCD is comprised of medical, pharmacy, and dental claims and information from the member eligibility, provider, and product files that are collected from health insurance payers licensed to operate 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 957 CMR 8.00 and 957 CMR 5.00. 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 APCD file types:

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

Figure 1 on page 6 shows an overview of the file types and their content.

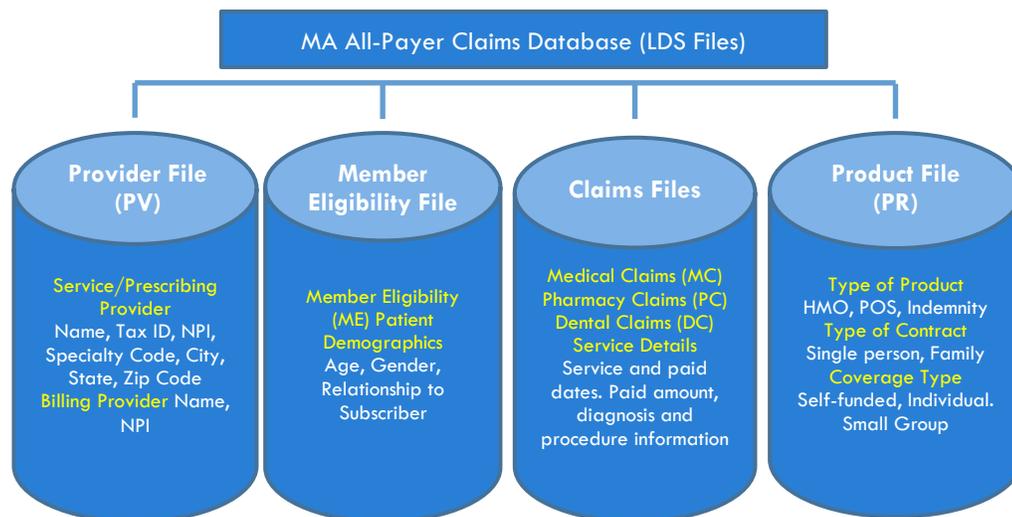[1] As defined by CHIA's data release regulations 957 CMR 5.00.

Figure 1. **MA APCD LDS 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. CHIA 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 (2.0) of the MA APCD covering dates of service CY 2008-2010 occurred in 2012 followed by subsequent Releases, 2.1 in 2013, 3.0 in 2014 and 4.0 in 2015. The new 2016 Release 5.0 covers dates of service CY 2011-2015 (with a minimum run-out of March 31, 2016).

MA APCD Release 5.0 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, 2011 to December 31, 2015 with minimum run-out through March 30, 2016.

- Release 5.0 contains updated data. (This data includes resubmitted data for dates of service prior to 2015 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 set forth 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, and preserves patient privacy while increasing analytic value.

- Some data elements have been derived by CHIA from the submitted data elements or have been added to the database to aid in versioning and identifying your claims database (e.g. Unique Record IDs and status flags). Please refer to the *Massachusetts All-Payer Claims Database (MA APCD), R5.0 Data Specifications Reference Table Non- Government Data Set.*

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 team works with the payers to collect the data on a regular, predetermined, basis and ensure completeness and accuracy. The Data Quality Assurance and Data Standardization and Enhancement teams work to clean and standardize kety data elements to ensure practice alignment with accepted industry external source codes (see *Appendix A*) from outside government agencies including CMS, medical and dental professional associations, and other vendors to ensure that the data collectors properly utilized codes and lookup tables to ensure data uniformity.

Data Collection and Processing for Release

Implementation of ICD-10-CM

Since the United States transition from International Classification of Diseases, Ninth Revision, Clinical Modification ICD-9-CM) to the Tenth Revision (ICD-10-CM) code set began in October 2015, data submissions in MA APCD contain both ICD 9-CM for data collected by carriers prior to the October 2015 transitionand ICD 10-CM for data collected by carriers after providers began transitioning to ICD-10-CM.

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. In such instances some records may be represented twice – once by the payer, and once by the TPA.

CHIAseeks to create a comprehensive all payer claims database that includes data from all health care payers and third-party administrators.

Payer Edit Processing

When payers initially submit their data to CHIA for the MA APCD, an automated edit process is run on each file to check for requirement conditions in accordance with filing thresholds in 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. Refer to the *MA APCD Release 5.0 Data Elements Specification* to view the condition requirements, thresholds and Edit Levels 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 levels (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

Variance Processing

Variance Processing is a collaborative effort between the payer and CHIA to reach a threshold percentage for any data element that does not meet the MA APCD threshold 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 addressing critical data quality issues, create plans to reach the threshold over time, and to seek a response to internal and external data user findings.

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 do not meet the required 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

Processing Data for Release

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 5.0 Non-Government LDS *Data Elements Reference Tables*.

- Data Elements are delimited as shown in the MA APCD Release 5.0 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/

o External Code Sources support lookup table references in the Submission Guide. See Appendix A for more information.

o Encrypted data elements: For the Data Release, some of the data elements have been emcrypted encrypted 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 who are required through a legal data use agreement to document their commitment to data privacy and security, as well as complying with CHIA's restrictions on the disclosure and use of Data.. Please refer to the Data Release regulations located on CHIA's website using the address below:

http://www.chiamass.gov/regulations

Redaction and Data Standardization

PATIENT IDENTIFICATION AND REDACTION

In order to protect against the unintended disclosure of patient's private information, certain data elements were subjected to a redaction process. When redacted, the data element has been scanned for specific content (such as the presence of Social Security Number (SSN)) and associated values have been set to null.

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

DATA STANDARDIZATION USING MELISSA DEMOGRAPHIC 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 5.0 Data Elements Specification*.

In cases where demographic elements could *not* be standardized, the original reported data values have been released. As a precaution, reported data was subjected to redaction for SSN-like values (see *Error! Reference source not found.*Linking Across File Types

DATA ENCRYTION 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 encrypted using *integer* values that have no identification risks associated with them. This action preserves linkage yet still protects patient confidentiality. *Table 1, below* defines the linked Data Elements by File Type, Element Code, and Data Element Name.

Member Entity Identification (EID) Element

Massachusetts All Payer Claims Database (MA APCD)

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 1* for specific references to File Type.

Error! Reference source not found. lists the the data elements to use for between file linkagea elements by file type. For more information on these Data Elements, please refer to the *MA APCD Release 5.0 Data Elements Specification.*

Table 1.　　　　LINKED DATA ELEMENTS BY FILE TYPE

File	Element Code	Data Element Name
DC	DC018	Service Provider Number
DC	DC042	Product ID Number
DC	DC056	Carrier Specific Unique Member ID
DC	DC057	Carrier Specific Unique Subscriber ID
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	MC137	Carrier Specific Unique Member ID
MC	MC141	Carrier Specific Unique Subscriber ID
MC	Derived MC16	Member Link EID
ME	ME036	Health Care Home (PCMH) Number
ME	ME040	Product ID Number
ME	ME046	Member PCP ID
ME	ME107	Carrier Specific Unique Member ID
ME	ME117	Carrier Specific Unique Subscriber 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	PC107	Carrier Specific Unique Member ID
PC	PC108	Carrier Specific Unique Subscriber 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

File	Element Code	Data Element Name
PV	PV054	Medical / Healthcare Home ID
PV	PV056	Provider Affiliation

Data Limitations

Researchers using the MA APCD Release 5.0 data should be aware of the following:

- The recent Supreme Court decision, *Gobeille v. Liberty Mutual*, has had an impact on the completeness and robustness of the MA APCD. Although many carriers are voluntarily submitting data from their self insured plans, as allowed under law, some carriers have removed that data from submission. You will, therefore, note that the MA APCD may show limitations in the volumes previously seen for some Carriers and/or data analyses The APCD remains an important resource to support Massachusetts' efforts to lower costs and improve access and quality.

Due to the variance process, data quality may vary from one payer to another. (See When payers initially submit their data to CHIA for the MA APCD, an automated edit process is run on each file to check for requirement conditions in accordance with filing thresholds in 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. Refer to the *MA APCD Release 5.0 Data Elements Specification* to view the condition requirements, thresholds and Edit Levels 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 levels (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

- Variance Processing in this document.)
- Claim Files submitted for the release period 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.
- Certain data elements were redacted to protect against disclosure of sensitive information.
- Some Release Data was manipulated to protect patient privacy:
  - Linkage IDs were to integral values to mask values while retaining linkage,
  - 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.

THE CLAIM FILES

Provider and agencies collect health care data in a variety and levels of completeness and submit them to CHIA. From these submissions, CHIA has created a comprehensive and consistent MA APCD All Payer Claims Database (APCD) with medical, pharmacy, and dental claims complied from fully-insured, self-insured, Medicare, Medicaid and Supplemental Policy data.

This section describes the claim file types. The claims files are:

- The Dental Claims (DC) file,

- Medical Claims (MC) file, and the

- Pharmacy Claims (PC) file.

MA APCD submissions are at the claim line level. Typically, each time a claim is adjudicated a line is created. As a result, each claim may have multiple lines. Identifying the highest version of the claim allows analysts to determine total charges, discounts, payments, etc. Highest version flags, based on carrier-specific logic, are available for the ten largest carriers for Medical Claims and the top four carriers for Pharmacy Claims.

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).)

Denied Claims

CHIA does not require providers to submit data from wholly denied claims. The provider *must* submit data for all claims paid partially or in whole. If a single procedure is denied within a paid claim, the provider must report the denied line. In the MA APCD, denied line items of adjudicated claims can assist in the analysis of covered benefits and/or patient eligibility.

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.

Changes to Claim Lines

The Claim Line Type field determines how a claim line versioning (see *Table 2* below).

Table 2.   **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 data users 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 3.   **VERSIONINDICATOR FLAG**

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

Typically a value of one 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 4, below). However in such a case, the value one 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 4.   **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 one 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 5. **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 6. **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 =one 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.

For additional information on version for Medical Claims and Pharmacy Claims, seeMedical Claims File Versioning and **Error! Reference source not found.**

Dental Claims (DC) File

As part of the MA APCD, payers are required to submit a Dental Claims File. The Dental Claims 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.

Payers are instructed by CHIA to submit any dental claim that is considered paid. The paid amount should be reported as zero 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

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

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. When paired against ME003 in the Member Eligibility File, please be aware that a greater granularity exists in that element that allows for senior and supplemental coverage options beyond those that may appear in the DC003 element.

DENTAL 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.

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. For more information on these elements, see the *MA APCD Release 5.0 Data Elements Specification*.

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 *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 5.0 Data Elements Specification*.

In cases where demographic elements could *not* be standardized, the original reported data values have been released. As a precaution, reported data was subjected to redaction for SSN-like values (see *Error! Reference source not found.*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 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 are 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 5.0 Non-Government LDS *Data Elements Reference Tables*.

Payers are instructed by CHIA to submit any medical claim that is defined as paid. Paid amount should be reported as zero 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)

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. When paired against ME003 in the Member Eligibility File, please be aware that a greater granularity exists in that element that allows for senior and supplemental coverage options beyond those that may appear in the M C003 element.

MEDICAL 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 to use in the Servicing Provider field. For example, XYZ Orthopedic Group is acceptable, if XYZ Orthopedic Group Westside is not available. However, XYZ Orthopedic Group Westside is preferable.

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.

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.

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 *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 5.0 Data Elements Specification.*

In cases where demographic elements could *not* be standardized, the original reported data values have been released. As a precaution, reported data was subjected to redaction for SSN-like values (see ***Error! Reference source not found.***Linking Across File Types for greater detail on this process.

Medical Claims File Versioning

Highest Version Flag created for Medical Claims 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 5.0. A value of zero 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 nine. (See *also Claim Versioning Overview on page 14*.)

- Data Limitations: OrgID 10632 has been versioned from May 2013 forward. Any data prior to May 2013 has not been versioned.

Pharmacy Claims (PC) File

As part of the MA APCD, , payers must submit a Pharmacy Claims 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 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 (YYYYMM) 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.

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 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 5.0 Data Elements Specification*.

In cases where demographic elements could *not* be standardized, the original reported data values have been released. As a precaution, reported data was subjected to redaction for SSN-like values (see *Error! Reference source not found.*Linking Across File Types on page 10.

PHARMACY CLAIMS DATA

CHIA requires line-level detail of all Pharmacy Claims for analysis. The line-level data aids with understanding utilization within products across carriers. Subscriber and member (patient) payer unique identifiers included linked data using the matching algorithms; see the data elements PC107 and PC108. See also 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 5.0 Data Elements Specification*.

In cases where demographic elements could *not* be standardized, the original reported data values have been released. As a precaution, reported data was subjected to redaction for SSN-like values (see *Error! Reference source not found.*Linking Across File Types on page 10.

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.

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 that link the Prescribing Provider identified on the Pharmacy Claims file with the corresponding record in the Provider File (PV002)/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 *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 5.0 Data Elements Specification.*

In cases where demographic elements could *not* be standardized, the original reported data values have been released. As a precaution, reported data was subjected to redaction for SSN-like values (see ***Error! Reference source not found.***Linking Across File Types for greater detail on this process.

Pharmacy Claims File Versioning

For linkage purposes, the same re-identified integer values were substituted into the Pharmacy file.

A highest version flag is provided in Release 5.0. A value of zero or one has been assigned to each Pharmacy file claim line from the following ORGIDs listed in Table 7 for incurred periods January 2011 through December 2015. Grouped ORGIDs illustrate single Carrier reporting.

Table 7.　　MA APCD PHARMACY VERSIONING ORG IDS

MA APCD R5.0 - PHARMACY VERSIONING ORG ID LIST	
(Grouped ORG IDs illustrate single Carrier reporting)	
Submitter Org ID	**Caveat(s)**
10441, 10442, 10929, 11745	
291	Pharmacy claims submitted by ORG ID 291 contains anomalies related to Charge Amount (PC035) and Pharmacy Number (PC018) which have a minor impact on versioning, but the anomalies do not have a material impact on ORG ID 291's total pharmacy dollars within the Release. CHIA and ORG ID 291 reviewed the anomalies together and agreed the impact was less than 1% on Total Allowed Amount (PC068.) CHIA is currently working with ORG ID 291 to address the issues and refine the versioning logic for a future release of MA APCD.
3505	
10920	
11474, 11726, 295	1. Based on the action plan approved by ORG IDs 11474, 11726 and 295, CHIA versioned the claims as of January 2014, incurred period. 2. This Carrier is not reporting back-out claims lines within their MA APCD Pharmacy submissions. As a result, the Carrier estimates there are 30 claims per month that may have been backed out by the pharmacy benefit manager, but are marked as highest version because ORG ID is not sending back-outs. Again, this issue is present for all three submitting Org IDs (11726, 295, and 11474) across all submitting years. The Carrier is working with their PBM to obtain and report back-outs to MA APCD in the future.
7041	ORG ID 7041 is reporting a small number of claims (less than 100 claims across all years) where the Pharmacy Number (PC018) changes in later versions of the claim from the true value of the pharmacy number to a value of '1111111'. According to the Carrier, these exception lines occur when a refund is issued to the member.
8026, 296, 12122	Based on the action plan approved by this Carrier's grouped ORG IDs (8026, 296, 12122), CHIA versioned the claims as of January 2014, incurred period.
11541	
300	
3156	
3735	

MA APCD R5.0 - PHARMACY VERSIONING ORG ID LIST (Grouped ORG IDs illustrate single Carrier reporting)	
4962	1. Based on the action plan approved by ORG ID 4962, CHIA versioned the claims as of January 2014, incurred period. 2. Due to an anomaly within the submitted data, CHIA was unable to version 1.5% of each month's claims. All claim lines related to this issue are marked as not-highest version within MA APCD Release 5.0. Further investigation is needed to determine if this anomaly will be corrected in a future release.
8647 (Commercial, Medicare)	1. Based on the action plan approved by ORG ID 8647, CHIA versioned the claims from the carrier's Medicare platform as of January 2012, incurred period. 2. ORG ID 8647 reported that 17% to 19% of monthly claims from the Medicare Platform represent Single Transaction Coordination of Benefit (STCOB) encounters. These encounters contain more than one claim for the same prescription. According to the carrier, STCOB claims occur when enhanced coverage is provided in addition to the primary coverage. Please contact CHIA Data Support at apcd.data@state.ma.us for additional information. Note: ORG ID 8647 - Claims from commercial platform are versioned for the entire 2011-15 incurred period.
10926, 7789, 313, 10444, 312	ORG ID 7789 - Based on the action plan approved by the Carrier, CHIA versioned the claims as of October 2013 incurred period. ORG ID 313 - Based on the action plan approved by the Carrier, CHIA versioned the claims as of January 2013 incurred period. ORG ID 10444 - Based on the action plan approved by the Carrier, CHIA versioned the claims as of January 2013 incurred period. ORG ID 312 - Based on the action plan approved by the Carrier, CHIA versioned the claims as of January 2013 incurred period. **Note:** 10926 was versioned for the entire 2011-15 incurred period

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 5.0, one file per year will be released (e.g. December 2011, and forward). Each year's Eligibility File will contain a 24-month rollback of eligibility. If data from 2013-2015 is requested, then three Eligibility Files will be released (December 2013, December 2014, and December 2015).

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 *When payers* initially submit their data to CHIA for the MA APCD, an automated edit process is run on each file to check for requirement conditions in accordance with filing thresholds in 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. Refer to the *MA APCD Release 5.0 Data Elements Specification* to view the condition requirements, thresholds and Edit Levels 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 levels (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

Data Collected in the Member Eligibility File

General Data Characteristics

Data In the Member Eligibility file has the following characteristcs:

- 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. (12/31/2015)

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 for 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

When 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 one (1) for Yes and the Prescription Drug Coverage indicator (ME019) would have a value of two (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

The mulpitple row convention, as described earlier, also impacts the Product File. Each product listed in the ME File also must 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 one (1), which equals a description of 'Medical Only' and RX Bronze's Product File record would have a value of two (2) for 'Pharmacy Only' in PR006.

Redundancy in 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. This extra or similar information across files is needed to support analysis of the variations of Member Eligibility. It 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 5.0 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 5.0 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 5.0 Non-Government LDS *Data Elements Reference Tables* mentioned above.

The Release 5.0 Product Files

Release files are in an asterisk delimited text file in the same order as found in the MA APCD Release 5.0 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 limited data sets 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.

Data Collected in the Product File

This section discusses the types of data collected in the Product File, including product dates, identifiers, and file linking.

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.

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 Linking

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 *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 5.0 Data Elements Specification*.

In cases where demographic elements could *not* be standardized, the original reported data values have been released. As a precaution, reported data was subjected to redaction for SSN-like values (see ***Error! Reference source not found.***Linking Across File Types*on page 10* for additional information.

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 5.0 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.

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.

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 *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 5.0 Data Elements Specification.*

In cases where demographic elements could *not* be standardized, the original reported data values have been released. As a precaution, reported data was subjected to redaction for SSN-like values (see ***Error! Reference source not found.***Linking Across File Types for addition information on this process.

Appendix A.   External Code Sources

External 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/

Massachusetts All Payer Claims Database (MA APCD)

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 File Type (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 Type of Bill or Place of Service code on a claim. Options are

Term	Definition
	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.
Dental Claim File (DC File)	A MA APCD File Type for reporting all Paid Dental Claim

Term	Definition
	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 or accidents. A subsection of the International Classification

Term	Definition
	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.
LDS	Limited Data Set

Term	Definition
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.
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 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

Term	Definition
	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 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

Term	Definition
	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 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,

Term	Definition
	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 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

Term	Definition
	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 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

Term	Definition
	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:

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

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