



The Commonwealth of Massachusetts
Center for Health Information and Analysis

**The Massachusetts
All-Payer Claims Database**

**Supplemental Diagnosis File
Submission Guide**

DRAFT

February 2017

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Commonwealth of Massachusetts

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| Version [6.0](#)

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Revision History

Date	Version	Description	Author
2/2015	4.0	• Initial Draft	K. Hines
2/2016	5.0	• Administrative Bulletin 16-03	K. Hines
2/2016	5.0	• Update Cover Sheet, CHIA website	K. Hines
2/2016	5.0	• Update APCD Version Number – HD009 – to 5.0	K. Hines
2/2017	6.0	• Initial 6.0 updates	K. Hines

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Introduction

Access to timely, accurate, and relevant data is essential to improving quality, mitigating costs, and promoting transparency and efficiency in the health care delivery system. A valuable source of data can be found in health care claims. Using its broad statutory authority to collect, store and maintain health care information data in a payer and provider claims database pursuant to M.G.L. c. 12C, the Center for Health Information and Analysis (CHIA) has adopted regulations to collect medical, pharmacy, and dental claims as well as provider, product, and member eligibility information derived from fully-insured, self-insured (where allowed), Medicare, Medicaid and Supplemental Policy data, which CHIA stores in a comprehensive All Payer Claims Database (APCD). CHIA serves as the Commonwealth's primary hub for health care data and a primary source of health care analytics that support policy development.

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To facilitate communication and collaboration, CHIA actively maintains a MA APCD website (<http://www.chiamass.gov/apcd-information-for-data-submitters/>) with resources that currently include the submission and release regulations, Administrative Bulletins, the technical submission guide with examples, and support documentation. These resources are periodically updated with materials and CHIA staff are dedicated to working with all submitters to ensure full compliance with the regulation.

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CHIA is committed to establishing and maintaining a MA APCD that promotes transparency, improves health care quality, and mitigates health care costs. We welcome your ongoing suggestions for revising reporting requirements that facilitate our shared goal of administrative simplification. If you have any questions regarding the regulations or technical specifications we encourage you to utilize the online resources and reach out to our staff for any further questions.

Thank you for your partnership with CHIA on the all payer claims database.

957 CMR 8.00: APCD and Case Mix Data Submission

957 CMR 8.00 governs the reporting requirements regarding health care data and information that health care Payers and Hospitals must submit pursuant to M.G.L. c. 12C in connection with the APCD and the Acute Hospital Case Mix and Charge Data Databases. The regulation establishes the data submission requirements for the health care claims data and health plan information that Payers must submit and the procedures and timeframe for submitting such health care data and information. CHIA collects data essential for the continued monitoring of health care cost trends, minimizes the duplication of data submissions by payers to state entities, and promotes administrative simplification among state entities in Massachusetts.

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Except as specifically provided otherwise by CHIA or under Chapter 12C, claims data collected by CHIA for the APCD is not a public record under clause 26 of section 7 of chapter 4 or under chapter 66. No public disclosure of any health plan information or data shall be made unless specifically authorized pursuant to 957 CMR 5.00. CHIA has

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developed the data release procedures defined in CHIA regulations to ensure that the release of data is in the public interest, as well as consistent with applicable Federal and State privacy and security laws.

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Patient Identifying Information

No patient identifying information may be included in any fields not specifically instructed as such within the element name, description and submission guideline outlined in this document. Patient identifying information includes name, address, social security number and similar information by which the identity of a patient can be readily determined.

Deleted: 957 CMR 8.00 governs the reporting requirements for Health Care Payers to submit data and information to CHIA in accordance with M.G.L. c. 118G, § 6. The regulation establishes the data submission requirements for health care payers to submit information concerning the costs and utilization of health care in Massachusetts. CHIA will collect data essential for the continued monitoring of health care cost trends, minimize the duplication of data submissions by payers to state entities, and promote administrative simplification among state entities in Massachusetts.¶

¶ Health care data and information submitted by Health Care Payers to CHIA is not a public record. No public disclosure of any health plan information or data shall be made unless specifically authorized under 957 CMR 5.00.

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Acronyms Frequently Used

APCD – All-Payer Claims Database
CHIA – Center for Health Information and Analysis
CSO – Computer Services Organization
DBA – Delegated Benefit Administrator
DBM – Dental Benefit Manager
DOI – Division of Insurance
GIC – Group Insurance Commission
ID – Identification; Identifier
MA APCD – Massachusetts’ All-Payer Claims Database
NPI – National Provider Identifier
PBM – Pharmacy Benefit Manager
QA – Quality Assurance
RA – Risk Adjustment; Risk Adjuster
TME / RP – Total Medical Expense / Relative Pricing
TPA – Third Party Administrator

The File Types:

DC – Dental Claims
MC – Medical Claims
ME – Member Eligibility
PC – Pharmacy Claims
PR – Product File
PV – Provider File
BP – Benefit Plan Control Total File
SD – Supplemental Diagnosis Code File (Connector Risk Adjustment plans only)

The MA APCD Quarterly Supplemental Diagnosis (“SD”) File

As part of the MA APCD, submitters involved in the state’s Risk Adjustment program may choose to submit a supplemental diagnosis file. CHIA, in an effort to decrease any programming burden, has maintained the file layout structure previously used. This layout will connect appropriately across other required filings for the MA APCD.

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

Specification Question	Clarification	Rationale
What is the frequency of submission?	Supplemental diagnosis files <u>are</u> submitted quarterly.	CHIA requires this frequency to maintain a current dataset for the Connector’s Risk Adjustment.
What is the format of the file?	Each submission must be a variable field length asterisk delimited file.	An asterisk cannot be used within an element in lieu of another character. Example: if the file includes “Smith*Jones” in the Last Name, the system will read an incorrect number of elements and drop the file.
What <u>does</u> each row in the file represent?	Each row represents a diagnosis code to be added to or deleted from a claim line submitted in the medical claim file. If there are multiple diagnoses, each of those diagnoses will be uniquely identified and reported on a line.	It is necessary to separate line items to allow carriers to submit an unlimited number of diagnoses for addition/deletion.

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Types of Data collected in the Supplemental Diagnosis File

Submitter-Assigned Identifiers

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CHIA requires various Submitter-assigned identifiers in order to allow users to link the data to the Medical Claims and Member Eligibility files. Some examples of these elements include SD002 – SD007. This matching allows for data aggregation and required reporting.

Claims and Supplemental Diagnosis Data

CHIA requires the line-level detail of all Medical Claims within the [Medical Claims](#) (MC) file. The line-level data aids with understanding utilization within products across submitters. The specific medical data reported in the majority of the MC file correspond to elements found on the UB04, HCFA 1500 and the HIPAA 837I and 837P data sets or a Carrier-specific direct data entry system. CHIA and the Connector understand that supplemental diagnoses may be added/deleted after the claims data has been submitted through the MC files. To assist carriers in capturing supplemental diagnosis data CHIA has created the Supplemental Diagnosis (SD) File Submission to complement the Medical Claims file and capture these additional diagnoses for the purposes of [Risk Adjustment](#).

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Member (Patient) submitter unique identifier and claim elements are being requested to aid with the matching algorithm.

CHIA is committed to working with all submitters and their technical teams to ensure compliance with applicable laws and regulations. CHIA will continue to provide support through technical assistance calls and resources available on the CHIA website, <http://www.chiamass.gov/apcd-information-for-data-submitters/>.

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File Guideline and Layout

Legend

1. File: Identifies the file per element as well as the Header and Trailer Records that repeat on all MA APCD File Types. Headers and Trailers are Mandatory as a whole, with just a few elements allowing situational reporting.
2. Col: Identifies the column the data resides in when reported
3. Elmt: This is the number of the element in regards to the file type
4. Data Element Name: Provides identification of basic data required
5. Date Modified: Identifies the last date that an element was adjusted.
6. Type: Defines the data as Decimal, Integer, Numeric or Text. Additional information provided for identification, e.g., Date Period – Integer
7. Type Description: Used to group like-items together for quick identification
8. Format / Length: Defines both the reporting length and element min/max requirements. See below:
 - a. char[n] – this is a fixed length element of [n] characters, cannot report below or above [n]. This can be any type of data, but is governed by the type listed for the element, Text vs. Numeric.
 - b. varchar[n] – this is a variable length field of max [n] characters, cannot report above [n]. This can be any type of data, but is governed by the type listed for the element, Text vs. Numeric.
 - c. int[n] – this is a fixed type and length element of [n] for numeric reporting only. This cannot be anything but numeric with no decimal points or leading zeros.

The plus/minus symbol (±) in front on any of the Formats above indicate that a negative can be submitted in the element under specific conditions. **Example:** When the Claim Line Type (MC138) = V (void) or B (backout) then certain claim values can be negative.
9. Description: Short description that defines the data expected in the element
10. Element Submission Guideline: Provides detailed information regarding the data required as well as constraints, exceptions and examples.
11. Condition: Provides the condition for reporting the given data
12. %: Provides the base percentage that the MA APCD is expecting in volume of data in regards to condition requirements.

13. Cat: Provides the category or tiering of elements and reporting margins where applicable. ‘A’ level fields must meet their APCD threshold percentage in order for a file to pass. The other categories (B, C, Z) are also monitored but will not cause a file to fail. Header and Trailer Mandatory element errors will cause a file to drop. Where elements have a conditional requirement, the percentages are applied to the number of records that meet the condition.

HM = Mandatory Header element; HS = Situational Header element; HO = Optional Header element; A0 = Data is required to be valid per Conditions and must meet threshold percent with 0% variation; A1= Data is required to be valid per Conditions and must meet threshold percent with no more than 1% variation; A2 = Data is required to be valid per Conditions and must meet threshold percent with no more than 2% variation; B and C = Data is requested and errors are reported, but will not cause a file to fail; Z = Data is not required; TM = Mandatory Trailer element; TS = Situational Trailer element; TO = Optional Trailer element.

Elements that are highlighted indicate that a MA APCD lookup table is present and contains valid values expected in the element. In very few cases, there is a combination of a MA APCD lookup table and an External Code Source or Carrier Defined Table.

It is important to note that Type, Format/Length, Condition, Threshold and Category are considered as a suite of requirements that the intake edits are built around to insure compliance, continuity and quality. This insures that the data can be standardized at other levels for greater understanding of healthcare utilization.

File	Col	Elmt	Data Element Name	Date Modified	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%	Cat
HD-SD	1	HD001	Record Type	2/10/15	Text	ID Record	char[2]	Header Record Identifier	Report HD here. Indicates the beginning of the Header Elements of the file.	Mandatory	100%	HM
HD-SD	2	HD002	Submitter	2/10/15	Integer	ID OrgID	varchar[6]	Header Submitter / Carrier ID defined by CHIA	Report CHIA defined, unique Submitter ID here. TR002 must match the Submitter ID reported here. This ID is linked to other elements in the file for quality control.	Mandatory	100%	HM
HD-SD	3	HD003	National Plan ID	2/10/15	Integer	ID Nat'l PlanID	int[10]	Header CMS National Plan Identification Number (PlanID)	Do not report any value here until National PlanID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans.	Situational	0%	HS
HD-SD	4	HD004	Type of File	2/10/15	Text	ID File	char[2]	Defines the file type and data expected.	Report SD here. Indicates that the data within this file is expected to be diagnosis-based. This must match the File Type reported in TR004.	Mandatory	100%	HM

File	Col	Elmt	Data Element Name	Date Modified	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%	Cat
HD-SD	5	HD005	Period Beginning Date	2/10/15	Date Period - Integer	Century Year Month - CCYYMM	int[6]	Header Period Start Date	Report the Year and Month of the reported submission period in CCYYMM format. This date period must be repeated in HD006, TR005 and TR006. This same date must be selected in the upload application for successful transfer.	Mandatory	100%	HM
HD-SD	6	HD006	Period Ending Date	2/10/15	Date Period - Integer	Century Year Month - CCYYMM	int[6]	Header Period Ending Date	Report the Year and Month of the reporting submission period in CCYYMM format. This date period must match the date period reported in HD005 and be repeated in TR005 and TR006.	Mandatory	100%	HM
HD-SD	7	HD007	Record Count	2/10/15	Integer	Counter	varchar[10]	Header Record Count	Report the total number of records submitted within this file. Do not report leading zeros, space fill, decimals, or any special characters.	Mandatory	100%	HM
HD-SD	8	HD008	Comments	2/10/15	Text	Free Text Field	varchar[80]	Header Carrier Comments	May be used to document the submission by assigning a filename, system source, compile identifier, etc.	Optional	0%	HO
HD-SD	9	HD009	APCD Version Number	2/2016	Decimal - Numeric	ID Version	char[3]	Submission Guide Version	Report the version number as presented on the APCD Medical Claim File Submission Guide in 0.0 Format. Sets the intake control for editing elements. Version must be accurate else file will drop. EXAMPLE: 4.0 = Version 4.0	Mandatory	100%	HM
								Code	Description			
								4.0	Version 4.0; required for reporting periods October 2013 ; No longer VALID as of August 2016			
								5.0	Version 5.0: required for reporting periods October 2013 onward as of August 2016; no longer valid as of August 2017.			
								<u>6.0</u>	<u>Version 6.0: required for reporting periods October 2013 onward as of August 2017.</u>			

File	Col	Elmt	Data Element Name	Date Modified	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%	Cat
HD-SD	10	HD010	Claim Count	2/10/15	Integer	Counter	Varchar[10]	Header Claim Count	Report the total number of unique payer claim control numbers (SD002) submitted within this file. Do not report leading zeros, space fill, decimals, or any special characters.	Mandatory	100%	HM
HD-SD	11	HD011	Member Count	2/10/15	Integer	Counter	Varchar[10]	Header Member Count	Report the total number of unique member IDs (SD005) submitted within this file. Do not report leading zeros, space fill, decimals, or any special characters.	Mandatory	100%	HM
SD	1	SD001	Submitter	2/10/15	Integer	ID Submitter	varchar[6]	CHIA defined and maintained unique identifier	Report the Unique Submitter ID as defined by CHIA here. This must match the Submitter ID reported in HD002.	All	100%	A0
SD	4	SD002	Payer Claim Control Number	2/10/15	Text	ID Claim Number	varchar[35]	Payer Claim Control Identification	Report the Unique identifier within the payer's system that applies to the claim for this diagnosis.	All	100%	A0
SD	5	SD003	Line Counter	2/10/15	Integer	ID Count	varchar[4]	Incremental Line Counter	Report the line number for this diagnosis within the claim.	All	100%	A0
SD	6	SD004	Version Number	2/10/15	Integer	Counter	varchar[4]	Claim Service Line Version Number	Report the version number of this claim service line.	All	100%	B
SD	138	SD005	Carrier Specific Unique Member ID	2/10/15	Text	ID Link to ME107	varchar[50]	Member's Unique ID	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to validate Unique Member ID and link back to Member Eligibility (ME107) and Medical Claims (MC137).	All	100%	A0
SD	60	SD006	Date of Service - From	2/10/15	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Date of Service	Report the date of service for the claim line in CCYYMMDD Format.	All	98%	A0
SD	61	SD007	Date of Service - To	2/10/15	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Date of Service	Report the end service date for the claim line in CCYYMMDD Format. For inpatient claims, the room and board line may or may not be equal to the discharge date.	All	98%	A0

File	Col	Elmt	Data Element Name	Date Modified	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%	Cat
SD	25	SD008	Service Provider Number	2/10/15	Text	ID Link to PV002	varchar[30]	Service Provider Identification Number	Report the carrier / submitter assigned service provider number. This number should be the identifier used for internal identification purposes, and does not routinely change. The value in this field must match a record in the provider file in PV002.	All	99%	A1
SD	95	SD009	Type of Claim	2/10/15	Lookup Table - Text	tlkpTypeOfClaim	char[3]	Type of Claim Indicator	Report the value that defines the type of claim submitted for payment. EXAMPLE: 001 = Professional Claim Line	All	100%	A0
								Value	Description			
								001	Professional			
								002	Facility			
								003	Reimbursement Form			
SD	55	SD010	Revenue Code	2/10/15	External Code Source 14 - Numeric	External Code Source 14 - Revenue Code	char[4]	Revenue Code	Report the valid National Uniform Billing Committee Revenue Code here. Code using leading zeroes, left-justified, and four digits.	Required when SD009 = 002	98%	A0
SD	56	SD011	Procedure Code	2/10/15	External Code Source 9 - Text	External Code Source 9 - CPTs & HCPCS	varchar[10]	HCPCS / CPT Code	Report a valid Procedure code for the claim line as defined by MC130.	All	98%	A1
SD	59	SD012	ICD-CM Primary Procedure Code	2/10/15	External Codes Source 8 - Text	External Code Source 8 - ICDCM Procedure Codes	varchar[7]	ICD Primary Procedure Code	Report the primary ICD CM procedure code when appropriate. Repeat this code on all lines of the inpatient claim. Do not code decimal point.	Required when SD009 = 002	55%	A2
SD	108	SD013	ICD Indicator	2/10/15	Lookup Table - Integer	tlkpICDIndicator	int[1]	International Classification of Diseases version	Report the value that defines whether the diagnoses on claim are ICD9 or ICD10. EXAMPLE: 9 = ICD9	Required	100%	A0
								Value	Description			

File	Col	Elmt	Data Element Name	Date Modified	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%	Cat
								9	ICD-9			
								0	ICD-10			
SD	43	SD014	Diagnosis	2/10/15	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Diagnosis Code	Report here the ICD Diagnosis Code to be added or deleted from the claim.	All	100%	A0
SD	108	SD015	Add/Delete Indicator	2/10/15	Lookup Table - Integer	tlkpAddIndicator	int[1]	Add/Delete Indicator	Report the value that defines whether the diagnosis reported is added or deleted from the claim. EXAMPLE: A = ADD	Required	100%	A0
								Value	Description			
								A	ADD			
								D	DELETE			
SD	249	SD899	Record Type	2/10/15	Text	ID File	char[2]	File Type Identifier	Report SD here. This validates the type of file and the data contained within the file. This must match HD004 .	All	100%	A0
TR-SD	1	TR001	Record Type	2/10/15	Text	ID Record	char[2]	Trailer Record Identifier	Report TR here. Indicates the end of the data file.	Mandatory	100%	TM
TR-SD	2	TR002	Submitter	2/10/15	Integer	ID Submitter	varchar[6]	Trailer Submitter / Carrier ID defined by CHIA	Report the Unique Submitter ID as defined by CHIA here. This must match the Submitter ID reported in HD002.	Mandatory	100%	TM
TR-SD	3	TR003	National Plan ID	2/10/15	Integer	ID Nat'l PlanID	int[10]	CMS National Plan Identification Number (PlanID)	Do not report any value here until National PlanID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans.	Situational	0%	TS
TR-SD	4	TR004	Type of File	2/10/15	Text	ID File	char[2]	Validates the file type defined in HD004.	Report SD here. This must match the File Type reported in HD004.	Mandatory	100%	TM

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File	Col	Elmt	Data Element Name	Date Modified	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%	Cat
TR-SD	5	TR005	Period Beginning Date	2/10/15	Date Period - Integer	Century Year Month - CCYYMM	int{6}	Trailer Period Start Date	Report the Year and Month of the reported submission period in CCYYMM format. This date period must match the date period reported in HD005 and HD006.	Mandatory	100%	TM
TR-SD	6	TR006	Period Ending Date	2/10/15	Date Period - Integer	Century Year Month - CCYYMM	int{6}	Trailer Period Ending Date	Report the Year and Month of the reporting submission period in CCYYMM format. This date period must match the date period reported in TR005 and HD005 and HD006.	Mandatory	100%	TM
TR-SD	7	TR007	Date Processed	2/10/15	Full Date - Integer	Century Year Month Day - CCYYMMDD	int{8}	Trailer Processed Date	Report the full date that the submission was compiled by the submitter in CCYYMMDD Format.	Mandatory	100%	TM

Appendix – External Code Sources

8. **International Classification of Diseases 9 & 10**
American Medical Association
<http://www.ama-assn.org/>

SD012

9. **HCPCS, CPTs and Modifiers**
American Medical Association
<http://www.ama-assn.org/>

SD011

14. **Standard Facility Billing Elements**
National Uniform Billing Committee (NUBC)
<http://www.nubc.org/>

SD010



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