The Commonwealth of Massachusetts
Center for Health Information and Analysis

Two Boylston Street, Boston, MA 02116
617-988-3100 • Fax 617-727-7662
www.mass.gov/CHIA

**Administrative Bulletin 12-01**

**114.5 CMR 21.00: Health Care Payers Claims Data Submission**

Effective November 8, 2012

The Center for Health Information and Analysis ("Center") is issuing this Administrative Bulletin to notify Health Care Payers required to submit claims data to the Center in accordance with 114.5 CMR 21.03 of changes to the All-Payer Claims Database ("APCD") file submission guidelines.

The following table lists new data elements to be collected by the Center:

| Element | Element Name | Type | Length | Description | APCD Usage and Guidelines | Condition | Category | % |
|---|---|---|---|---|---|---|---|---|
| *Header Record* | | | | | | | | |
| HD009 | APCD Version # | Decimal | 3 | APCD Intake Specification Version in 0.0 format. Version must be accurate otherwise file will drop. | Sets the intake control for editing. | N/A | N/A | N/A |
| *Product File* | | | | | | | | |
| PR015 | Other Product Line of Business Model | Text | 30 | This must be reported when a product's line of business does not fall within the standard listing for PR004 Product Line of Business Model. | Needed to define the PR004 - Product Line when the carrier notes PR004 as Other. | Required when PR004 = ZZ. | A2 | 98 |
| PR016 | Other Risk Type | Text | 30 | This must be reported when a product's risk type is not the standard risk types – PR008. | Needed to define the PR008 – Risk Type when the carrier notes PR008 = 0. | Required when PR008 = 0. | A2 | 98 |
| PR017 | NAIC Code | Integer | 5 | National Association of Insurance Commissioners' Code | Need standard ID to identify payers for Division of Insurance requirement. | Assigned submitters. All lines must have a value reported. | A2 | 100 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| *Provider File* | | | | | | | | |
| PV031 | Provider Organization ID | Integer | 6 | Center assigned OrgID number for providers | Total Medical Expense reporting requirement. | Assigned submitters only | A2 | 100 |
| PV032 | Payment Arrangement Type | Numeric | 2 | tlkpPaymentArrangement Type | Total Medical Expenses & Relative Price reporting requirement. | Assigned submitters only | A2 | 100 |
| PV065 | TME – Non-Claims Payments: Incentive Programs | Integer | 10 | DDDDDCC | Total Medical Expenses & Relative Price reporting requirement. | Assigned submitters only | A2 | 100 |
| PV066 | TME – Non-Claims Payments: Risk Settlements | Integer | 10 | DDDDDCC | Total Medical Expenses & Relative Price reporting requirement. | Assigned submitters only | A2 | 100 |
| PV067 | TME – Non-Claims Payments: Care Management | Integer | 10 | DDDDDCC | Total Medical Expenses & Relative Price reporting requirement. | Assigned submitters only | A2 | 100 |
| PV068 | TME – Non-Claims Payments: Other | Integer | 10 | DDDDDCC | Total Medical Expenses & Relative Price reporting requirement. | Assigned submitters only | A2 | 100 |
| PV069 | TME – Non-Claims Payments: Total | Integer | 10 | DDDDDCC | Total Medical Expenses & Relative Price reporting requirement. | Assigned submitters only | A2 | 100 |
| PV070 | TME – Non-Claims Payments: Date | Date | 8 | CCYYMMDD | Total Medical Expenses & Relative Price reporting requirement. | Assigned submitters only | A2 | 100 |
| *Member Eligibility File* | | | | | | | | |
| ME119 | Tobacco Use Flag | Integer | 1 | tlkpFlagIndicators | Required for better risk adjustment alignment. | All lines must have a value reported. | A2 | 100 |
| ME120 | Actuarial Value | Decimal | 6 | 0.0000 | Required for Risk Assessment to determine cost of average patient within category. | Risk Holders report a value | A2 | 100 |
| ME121 | Metal Level | Integer | 1 | tlkpMetalLevel (1 = Bronze, 2 = Silver, etc.) | Metal Level refinement to Actuarial Value. Required for Risk Assessment. | Risk Holders report a value | A2 | 100 |
| ME122 | Coinsurance Maximum % (tlkpCoinsuranceMax) | Integer | 1 | This code identifies whether the coinsurance maximums fall within 25%, 50%, 80% for both | Required for better member cost sharing analysis based on in-network or out-of- | Risk Holders report a value | A2 | 100 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | in-network and out-of-network charges. | network. | | | |
| ME123 | Monthly Premium | Integer | 10 | Member's expected monthly premium | Required for DOI reporting and Risk Assessment. | Risk Holders report a value | A2 | 100 |
| ME124 | TME – Health Status Adjustment Tool | Text | 80 | Name of Health Status Adjustment Tool used | Required for Total Medical Expense Reporting. OrgID specific | Assigned submitters only | A2 | 100 |
| ME125 | TME – Health Status Adjustment Tool Version | Text | 20 | Version of Health Status Adjustment Tool used | Required for Total Medical Expense Reporting. OrgID specific | Assigned submitters only | A2 | 100 |
| ME126 | TME – Health Status Adjustment Tool Date | Date | 8 | CCYYMMDD | Required for Total Medical Expense Reporting. OrgID specific. Date identifies when the tool was run for calculation. | Assigned submitters only | A2 | 100 |
| ME127 | TME – Member's Health Status Adjustment Score | Decimal | 6 | 0.0000 | Required for Total Medical Expense Reporting. OrgID specific | Assigned submitters only | A2 | 100 |
| ME128 | TME – Member's Health Status Adjustment Score - Normalized | Decimal | 6 | 0.0000 | Required for Total Medical Expense Reporting. OrgID specific | Assigned submitters only | A2 | 100 |
| ME129 | TME – Member's Health Status Adjustment Score Start Date | Date | 8 | CCYYMMDD | Required for Total Medical Expense Reporting. OrgID specific. Date span identifies the reporting period for TME/RP data. | Assigned submitters only | A2 | 100 |
| ME130 | TME – Member's Health Status Adjustment Score End Date | Date | 8 | CCYYMMDD | Required for Total Medical Expense Reporting. OrgID specific. Date span identifies the reporting period for TME/RP data. | Assigned submitters only | A2 | 100 |
| ME131 | Payment Arrangement Type | Numeric | 2 | tlkpPaymentArrangement Type | Required for Total Medical Expense Reporting. OrgID specific | Assigned submitters only | A2 | 100 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ME132 | Employer Contribution | Integer | 10 | Employer's contribution to a Member's expected monthly premium | Required for Cost Trends Analysis. | Risk Holders report a value when ME060 = A, I, O or P and Member = Subscriber | A2 | 100 |
| ME133 | GIC ID | Integer | 9 | GIC assigned member ID | Required for GIC carriers' members. | | A0 | 100 |
| ME134 | APCD ID Code (tlkpAPCDIdentifier) | Integer | 1 | This code identifies whether the member is enrolled in GIC, MCO, SIG or Other plan. | This ID is required to count members that fall into each category and align threshold %s on claim lines. Will allow lower thresholds on certain fields for claims that do/do not fall into a particular plan type. | All lines must have a value reported. | A2 | 100 |
| *Medical Claims File* | | | | | | | | |
| MC142 thru MC153 | Other Diagnosis - ## (13-24) | Text | 7 | ICD Diagnosis Code | Additional diagnoses are being considered as rudimentary elements for researchers, 5010 allows up to 24. Carrier would report only if they captured. | | C | 1 |
| MC154 thru MC178 | Present on Admission (POA) - ## (Principal = 01) | Text | 1 | Report standard CMS UB (Uniform Billing) Present on Admission codes. tlkpPOAValue | Required for grouping specific inpatient claims in current versions of clinical grouping for any Inpatient Discharge on or after January 1, 2011. | Required when MC094 = 002 and Dx present. | A2 | 100 |
| MC179 - MC190 | Condition Codes - XX (01-12) | Text | 2 | Standard NUBC (Uniform Billing) Condition Codes | Element provides additional information for adjudication and grouping. Identifies conditions or events related to the clinical disposition of the claim. | | B | 1 |
| MC191 MC193 MC195 MC197 MC199 MC201 | Value Codes | Text | 2 | Report standard CMS UB (Uniform Billing) value codes. | This element provides additional deductible information to break amounts down into detailed categories or to define when Professional Charges | | B | 1 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| MC203<br>MC205<br>MC207<br>MC209<br>MC211<br>MC213 | | | | | are combined with Institutional and what those charges are. | | | |
| MC192<br>MC194<br>MC196<br>MC198<br>MC200<br>MC202<br>MC204<br>MC206<br>MC208<br>MC210<br>MC212<br>MC214 | Value Amount | Integer | 10 | Report the value that corresponds to the Value Code reported. | This element provides additional billing/cost information to break amounts down into detailed categories. | | B | 1 |
| MC215<br>MC217<br>MC219<br>MC221<br>MC223 | Occurrence Code | Text | 2 | Standard NUBC (Uniform Billing) Occurrence Codes | Element provides additional information for adjudication and grouping. Identifies dates or events related to the clinical disposition of the claim. This element can provide valuable coverage and adjudication information for cost reporting. | | B | 1 |
| MC216<br>MC218<br>MC220<br>MC222<br>MC224 | Occurrence Date | Date | 8 | CCYYMMDD | Required when Occurrence Code is reported. | | B | 1 |
| MC225<br>MC228<br>MC231<br>MC234<br>MC237 | Occurrence Span Code | Text | 2 | Standard NUBC (Uniform Billing) Occurrence Codes | Element provides additional information for adjudication and grouping. Identifies dates or events related to the clinical disposition of the claim. This element can provide valuable coverage and adjudication information for cost reporting. | | B | 1 |
| MC226<br>MC229<br>MC232<br>MC235 | Occurrence Span Start Date - XX (01-05) | Date | 8 | CCYYMMDD | Required when Occurrence Span Code is reported. | | B | 1 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| MC238 | | | | | | | | |
| MC227<br>MC230<br>MC233<br>MC236<br>MC239 | Occurrence Span End Date - XX (01-05) | Date | 8 | CCYYMMDD | Required when Occurrence Span Code is reported. | | B | 1 |
| MC240 | GIC ID | Integer | 9 | GIC assigned member ID | Required for GIC carrier claims. | | A0 | 100 |
| MC241 | APCD ID Code (tlkpAPCDIdentifier) | Integer | 1 | This code identifies whether the member is enrolled in GIC, MCO, SIG or Other plan. | This ID is needed to count members that fall into each category and align threshold %s on claim lines. Will allow lower thresholds on certain fields for claims that do/do not fall into a particular plan type. | All lines must have a value reported. | A2 | 100 |
| *Dental Claims File* | | | | | | | | |
| DC061 | Diagnosis | Text | 7 | International Classification of Diseases Code | Aligns with MC041 and is 5010 compliant. Allows for clinical association, grouping and categorizing of services. | Required when DC032 (CDT Code) is within the D7000 – D7999 range or D9220 or D9221. | B | 1 |
| DC062 | ICD Indicator | Integer | 1 | tlkpICDIndicator (1 = ICD9; 2 = ICD 10) | Allows for alignment for ICD9 and ICD10 without requiring carriers to submit extra data or place holders. Is 5010 compliant. | Required when DC061 is populated. | B | 100 |
| DC063 | Denied Flag | Integer | 1 | Denied Claim Line Indicator (1 = Yes, 2 = No) | Provides delineation of non-paid or zero paid lines as Denied vs. Paid. Aids with validation of claim type and versioning while providing continuity across claim files; MC123, PC113. | All lines must have a value reported. | A0 | 100 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| DC064 | Denial Reason | Text | 20 | Report the denial reason(s) in code format. Length allows for several per service. | Reason for denial of the claim line. Carrier must submit denial reason codes in separate table to the Center. | Required when DC063 = 1. | A2 | 98 |
| DC065 | Payment Arrangement Type | Numeric | 2 | tlkpPaymentArrangmentType | This information defines the payment methodology of the adjudicated service line. | All lines must have a value reported. | A0 | 98 |
| DC066 | GIC ID | Integer | 9 | GIC assigned member ID | Required for GIC carrier claims. | | A0 | 100 |
| DC067 | APCD ID Code | Integer | 1 | tlkpAPCDIdentifier | This ID is required to count members that fall into each category and align threshold %s on claim lines. Will allow lower thresholds on certain fields for claims that do/do not fall into a particular plan type. | All lines must have a value reported. | A2 | 98 |
| *Pharmacy Claims File* | | | | | | | | |
| PC112 | Medicare Indicator | Integer | 1 | tlkpFlagIndicator | Element required to refine carrier level processing. | All lines must have a value reported. | A0 | 100 |
| PC113 | Pregnancy Indicator | Integer | 1 | Patient is pregnant (1 = Yes, 2 = No, etc.) | This information aligns to typical clinical care coordination studies. | All lines must have a value reported. | A2 | 98 |
| PC114 | Diagnosis | Text | 7 | ICD Diagnosis Code | Matches MC041 and is NCPDP and 5010 compliant. Allows for clinical association, grouping and categorizing. | | B | 1 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| PC115 | ICD Indicator | Integer | 1 | This code will identify whether the diagnosis is ICD9 or ICD10. tlkpICDIndicator (1 = ICD9, 2 = ICD10) | Allows for alignment for ICD9 and ICD10 without requiring carriers to submit extra data or place holders. Is 5010 compliant. | Required when PC114 is populated. | B | 100 |
| PC116 | Denied Flag | Integer | 1 | Denied Claim Line Indicator (1 = Yes, 2 = No) | Provides delineation of non-paid or zero paid lines as Denied vs. Paid. Aids with validation of claim type and versioning while providing continuity across claim files; MC123, DC061. | All lines must have a value reported. | A0 | 100 |
| PC117 | Denial Reason | Text | 30 | Reason for denial of the claim line. | Required to report reason for denial when Denied Flag is set to 1 = Yes. Allows carrier to define denial reason and provides continuity across claim files; MC124, DC062. | Required when PC116 = 1. | A2 | 98 |
| PC118 | Payment Arrangement Type | Numeric | 2 | tlkpPaymentArrangementType | Required for Total Medical Expenses and Relative Price Reporting. | All lines must have a value reported. | A0 | 98 |
| PC119 | GIC ID | Integer | 9 | GIC assigned member ID | Required for GIC carrier claims. | | A0 | 100 |
| PC120 | APCD ID Code | Text | 1 | This code identifies whether the member is enrolled in GIC, MCO, SIG or Other plan. | This ID is required to count members that fall into each category and align threshold %s on claim lines. Will allow lower thresholds on certain fields for claims that do/do not fall into a particular plan type. | All lines must have a value reported. | A2 | 100 |

The following table lists current "Filler"data fields that have been updated to reflect required collection of new data elements and updated thresholds by the Center:

| ELEMENT | DATA ELEMENT NAME | TYPE | LENGTH | DESCRIPTION / GUIDELINE | APCD USAGE | Condition | Category | Threshold |
|---|---|---|---|---|---|---|---|---|
| *Eligibility File* | | | | | | | | |
| ME045 | Purchased through Massachusetts Exchange Flag | Integer | 1 | tlkpFlagIndicators | Identifies whether or not a policy was purchased through a health exchange. Required for Risk Assessment. | All lines must have a value reported. | A2 | 100 |
| ME055 | Business Type Code (tlkpBusinessType) | Integer | 1 | This code identifies whether the line data for this member is being submitted by a TPA/PBM/CSO/DBA | Allows better linkage between files. Will allow lower thresholds on certain fields depending on the type of business. | All lines must have a value reported. | A2 | 100 |
| ME072 | Family Size | Integer | 2 | Identifies number of family members covered. | Required for DOI reporting and Risk Assessment to determine number of covered members under this policy. | All lines must have a value reported. | A2 | 100 |
| ME078 | Employer Zip Code | Text | 5 | Employer Zip Code of the Subscriber | Required for DOI reporting and Risk Assessment. | All lines must have a value reported. | A2 | 90 |
| *Medical Claims File* | | | | | | | | |
| MC091 | Coinsurance Days | Integer | 3 | Count of Coinsurance days. | Needed for Medicare utilization but may be utilized for all payers as incorporated in benefit levels. | Required when MC094 = 002 and MC039 is populated. | B | 98 |
| MC107 | ICD Indicator | Integer | 1 | This code will identify whether the diagnosis is ICD9 or ICD10. tlkpICDIndicator (1 = ICD9, 2 = ICD10) | Allows for alignment for ICD9 and ICD10 without requiring carriers to submit extra data or place holders. Is 5010 compliant. | Required when MC094 = 001 or 002 and MC039 thru MC053 or MC142 thru MC153 is populated. | B | 100 |
| MC121 | Patient Total Out of Pocket Amount | Integer | 10 | The total out of pocket amount that is the patient's responsibility. | This amount required to aid with total amount due from patient to measure member costs for services. | All lines must have an amount reported. | A2 | 100 |

| ELEMENT | DATA ELEMENT NAME | TYPE | LENGTH | DESCRIPTION / GUIDELINE | APCD USAGE | Condition | Category | Threshold |
|---|---|---|---|---|---|---|---|---|
| *Medical Claims File cont.* | | | | | | | | |
| MC133 | Bill Frequency Code | Text | 1 | Report standard bill frequency codes. | Carriers have stated this will aid with identifying multiple types of claim iterations that a payer requires/reports. Versioning validation tool. | Required when MC094 = 001 or 002. | A2 | 100 |
| *Dental Claims File* | | | | | | | | |
| DC047 | Tooth Number | Text | 2 | Provides further detail on procedure. | Required for all procedures that are Tooth Specific. | Required when CDT is Tooth Specific. | A2 | 100 |
| DC048 | Dental Quadrant | Text | 1 | Provides further detail on procedure. | Required for all procedures that are Quadrant Specific. | Required when CDT is Quadrant and not Tooth Specific. | B | 100 |
| DC049 | Tooth Surface | Text | 5 | Provides further detail on procedure. | Required for all procedures that are Tooth Specific. | Required when DC047 is populated. | A2 | 100 |

The following table lists general changes and updates to be made to file types:

| ACTION | NARRATIVE |
|---|---|
| Reset | Set length of all tlkp driven elements to the bare-max of the given codes. |
| Reset | Adjust all SSN, TIN etc to Integer. |
| Update Field | Adjust Market Category Code bandwidths to align with DOI set. |
| Update Lookup Tables | Add additional values to lookup tables to account for carrier needs. |
| Update Requirement | Delegated Benefit Administrator OrgID will be required from the PBM/TPA and the Risk Holder. |
| Update Requirement | Provider Filing (PV) will be required from risk holders/PBMs/TPAs. |
| Update Requirement | All Flag data elements will move to Category A with a threshold of 98 / 100 as lookup tables allow the use of Other / Unknown / Not Applicable. |
| Update Requirement | Category and Threshold Updates were made to |

| | |
|---|---|
| | align to the GIC Thresholds, DOI/Risk Adjustment/TME/HCF requirements where applicable. Details listed with Submission Guides. |
| Update Narrative | Add clarity to Submission Guidelines. |