The All-Payer Claims Database

Release 2.0
Documentation Guide

Medical Claims File

December 2013

Deval L. Patrick, Governor
Commonwealth of Massachusetts

Áron Boros, Executive Director
Center for Health Information and Analysis

Contents

INTRODUCTION **4**

APCD DATA COLLECTION **4**

History 4

APCD Data Collection Process 5

Broad Caveats 6

APCD Release 2.0 Overview 6

MEDICAL CLAIMS FILE **7**

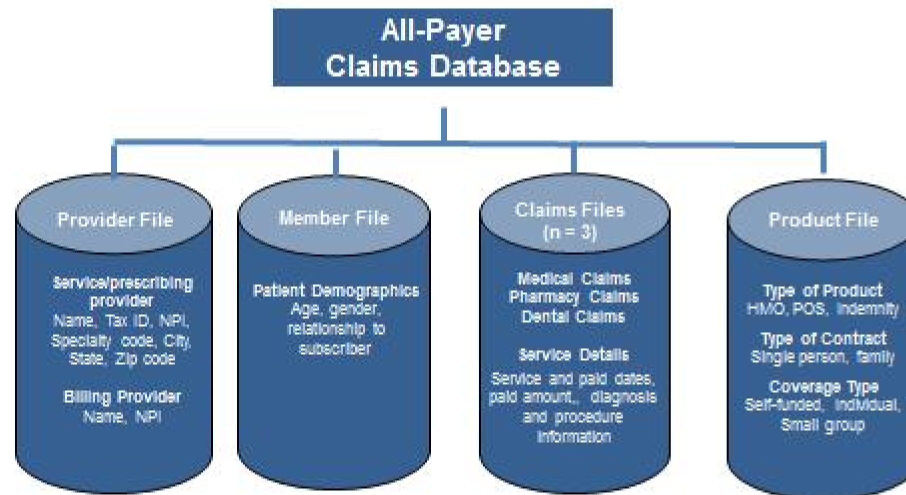
Types of Data Collected in the Medical Claims File: 7

Medical Claims File Layout 11

The APCD Medical Claims File 13

Medical Claims File Cleaning, Standardization, and Redaction 38

APCD Files and Selected Data Elements



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

INTRODUCTION

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

To this end, the **All-Payer Claims Database (APCD)** contributes to a deeper understanding of the Massachusetts health care delivery system by providing access to accurate and detailed claims-level data essential to improving quality, reducing costs, and promoting transparency. This document is provided as a manual to accompany the release of data from the APCD.

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

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

APCD DATA COLLECTION

History

Establishment of the Massachusetts APCD

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

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

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

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

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

APCD Data Collection Process

The data collected from the payers for the APCD is processed by the **Data Compliance and Support** team. Data Compliance works with the payers to collect the data on a regular, predetermined, basis and ensure that the data is as complete and accurate as possible. The **Data Quality Assurance** and **Data Standardization and Enhancement** teams work to clean and standardize the data to the fullest extent possible. Data Standardization relies on **external source codes**[1] from outside government agencies, medical and dental associations, and other vendors to ensure that the data collectors properly utilized codes and lookup tables to make data uniform.

Edits

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

The automated edits perform an important data quality check on incoming submissions from payers. They identify whether or not the information is in the expected format (i.e. alpha vs. numeric), contains invalid characters (i.e. negative values, decimals, future dates) or is missing values (i.e. nulls). If these edits detect any issues with a file, they are identified on a report that is sent to the payer.

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

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

Variances

The **Variance process** is a collaborative effort between the payer and CHIA to reach a mutually agreed upon **threshold percentage** for any data element which may not meet the APCD standard. Payers are allowed to request a lower threshold for specific fields, but they must provide a business reason (rationale) and, in some cases, a remediation plan for those elements. CHIA staff carefully reviews each request and follows up with a discussion with the payers about how to improve data quality and possibly suggest alternative threshold rates or possibly "ramping up" overtime to the threshold. CHIA's goal is to work with payers to improve the quality of the APCD overtime.

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

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

Broad Caveats

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

- Release files include data submitted to the Center through June 2013. Data submitted to the Center after June 2013 is **NOT** included in the files.
- Due to the variance process, data quality may vary from one payer to another. Consult Appendix 6 for more information.
- Claim Files submitted **through June 2010** were accepted with **relaxed edits**. (Refer to the edits section of this document.)
    - The release files contain the data submitted to the Center including valid and invalid values.
- Certain data elements were cleaned when necessary. Detail on the cleaning logic applied is described at the end of each file layout.
- Certain data elements were redacted to protect against disclosure of sensitive information.[3]
- Some Release Data was manipulated for compliance with HIPAA:
    - Assignment of linkage IDs to replace reported linkage identifiers (see **Appendix 4**).
    - Member Birth Year is reported as 999 for all records where the member age was reported as older than 89 years on the date of service.
    - Member Birth Year is reported as Null for all records where the member was reported as older than 115 years on the date of service.

APCD Release 2.0 Overview

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

Highlights of the release include:

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

---

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

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

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

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

MEDICAL CLAIMS FILE

As part of the All Payer Claims Database (APCD), payers are required to submit a Medical Claims File. The Medical Claims File consists of all **final paid claims** from all reporting payers segregated by **Date of Service** in 2009, 2010, 2011, and 2012 as reported through June 2013 (this represents a twelve month plus run-out period from 2012 data).

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

1) Discharge Date
2) Date of Service From or Admit Date
3) 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 File Layout section.

Types of Data Collected in the Medical Claims File:

Payer-assigned Identifiers:

The Center requires various **Payer-assigned identifiers** for matching-logic to the other files, i.e., Product File, Member Eligibility. Examples of this field include MC003, MC006, MC137 and MC141, which will all be used by the Center to aid with the matching algorithm to those other files.

Claims Data:

The Center requires the line-level detail of all Medical Claims for analysis. The line-level data aids with understanding utilization within products across Payers. The specific medical data reported in MC039 through MC062, MC071, MC072, MC075, MC083 through MC088, MC090, MC108, MC109, MC111, MC126, MC127, MC129, MC130, 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.

Fields MC024-MC035 - Servicing provider data:

The set of fields MC024-MC035 are all related to the servicing provider **entity**. The Center wishes to collect entity level rendering provider information here, and at the lowest level achievable by the payer.

If the payer only knows the billing entity, and the billing entity is not a ***service rendering*** provider, then the billing provider data (MC076-MC078) is ***not*** appropriate. In this case the payer would need a variance request for the service provider fields.

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

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

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

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 who and where the service was rendered. If the payer does not know who actually performed the service or the specific site where the service was actually performed, the payer will need a variance request for one or both of these fields. It is not appropriate to report facility or billing information here.

Non-Massachusetts Residents:

The Center does not require payers submitting claims and encounter data on behalf of an employer group to submit claims data for employees who reside outside of Massachusetts, unless the payer is required by contract with the Group Insurance Commission.

Adjudication Data:

The Center requires adjudication-centric data on the file for analysis of Member Eligibility to Product. The elements typically used in an adjudication process are MC017 through MC023, MC036 through MC038, MC063 through MC069, MC071 through MC075, MC080, MC081, MC089, MC092 through MC099, MC113 through MC119, MC122 through MC124, MC128, and MC138 and are variations of paper remittances or the HIPAA 835 4010.

The Center has made a conscious decision to collect numerous identifiers that may be associated with a provider. The provider 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 existence of these extra identifying elements in claims is part of our quality assurance process, and will be analyzed in conjunction with the provider file. We expect this will improve the quality of our matching algorithms within and across payers.

Denied Claims

Payers are not required to submit wholly denied claims.

The Provider ID

Element MC024 (Service Provider ID), MC134 (Plan Rendering Provider) and MC135 (Provider Location) are some of the most critical fields in the APCD process as it links the Provider identified on the Medical Claims file with the corresponding Provider ID (PV002) in the Provider File. The definition of the PV002 field is:

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

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

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

Medical Claims Release File Structure:

Following is information previously published in FAQ's about the **Medical Claims File,** as well as new information points about the Release Data:

Issue	Clarification
Release File Format	Release files will be in an **asterisk-delimited text file**. • Only the requested and approved Data Elements will be included in the release file. • Released elements will be delimited in the same order as is found in the File Layout section of this document.
Rows	Each row in the APCD Medical Claims file represents one **claim line**. If there are multiple services performed and billed on a claim, each of those services will be uniquely identified and reported on a line. It is necessary to obtain line item data to better understand how services are perceived and adjudicated by different payers.

<table>
<tr><th>Issue</th><th>Clarification</th></tr>
<tr><td>Release ID</td><td>A unique id for each claim line in the data release will assigned by the Center.

All Level 1 and Level 2 file records will contain Release IDs to enable linking between the records in the public use file and the records in the restricted use files.</td></tr>
<tr><td>Redundancy:</td><td>Certain data elements of claim level data will be 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.</td></tr>
<tr><td>Changes to Claim Lines</td><td>Claim line versioning is triggered by the Claim Line Type field:
<table>
<tr><th>Claim Line Type Code</th><th>Claim Line Type Description</th><th>Action/Source</th></tr>
<tr><td>O</td><td>Original</td><td></td></tr>
<tr><td>V</td><td>Void</td><td>Delete line referenced / Provider</td></tr>
<tr><td>R</td><td>Replacement</td><td>Replace line referenced / Provider</td></tr>
<tr><td>B</td><td>Back Out</td><td>Delete line referenced / Payer</td></tr>
<tr><td>A</td><td>Amendment</td><td>Replace line referenced / Payer</td></tr>
</table></td></tr>
<tr><td>Versioning Claim Lines</td><td>Highest Version Flag created for Medical Claim Files:

Element Name: FinalVersionFlagDecember
Doman Values:

0-Not Highest Version
1-Hightest Version
9-Undetermined

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 has been created in the version 2.0 release. A value of 0 or 1 has been assigned to each medical claim line from the following carriers: 291, 296*, 300, 3505, 4962, 7041, 8026*, 8647, and 11701. Claim lines from all other carriers should have a value of 9. Future releases will include versioning for additional carriers.

* For services rendered on or after 3/1/2010 only. Claim lines for services rendered before 3/1/2010 should have a value of 9.</td></tr>
<tr><td>Claim ID</td><td>Claims may be isolated by grouping claim lines by the following elements:

Payer Claim Control Number (MC004)/Payer Org ID (MC001)</td></tr>
<tr><td>Denied claim lines</td><td>Wholly denied claims are not submitted to CHIA. However, if a single procedure is denied within a paid claim that denied line is reported.

Denied line items of an adjudicated claim may aid with analysis in the APCD in terms of covered benefits and/or eligibility.</td></tr>
</table>

Issue	Clarification
Claims that are paid under a '**global payment', or 'capitated payment',** thus zero paid	Payers are instructed by CHIA to submit any medical claim that is considered 'paid'. Paid amount should be reported as 0 and the corresponding Allowed, Contractual, Deductible Amounts should be calculated accordingly.
Previously paid but now **Voided** claims	The reporting of Voided Claims maintains logic integrity between services utilized and deductibles applied.

Medical Claims File Layout

Restricted Release Elements:

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

Lookup Tables:

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

Masked Elements:

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

File Layout Section Columns

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

Release Text File Column Titles

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

The APCD Medical Claims File

Medical Claims File – Level 2 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**[7]	**APCD Threshold**[8]
Derived - MC1	Submission Month	2	int	Month of the file submission—derived by CHIA.	Month of the file submission—derived by CHIA.	N/A	N/A
Derived - MC2	Submission Year	4	int	Year of the file submission—derived by CHIA.	Year of the file submission—derived by CHIA.	N/A	N/A
Derived - MC3	County of Member	3	varchar	County of the Member/Patient—derived by CHIA	County of the Member/Patient—derived by CHIA	N/A	N/A
Derived - MC4	County of Service Provider	3	varchar	County of the Service Provider—derived by CHIA	County of the Service Provider—derived by CHIA	N/A	N/A
Derived - MC5	Medical Claim ID	NULL	int	Unique record ID per submission control ID	With each submission control ID this number is reset to 1 and sequentially incremented by one for every record submitted	N/A	N/A
Derived - MC6	Member ZIP code (first 3 digits)	256	varbinary	Zip Code of Member/Patient (first 3 digits)—derived by CHIA	Zip Code of Member/Patient (first 3 digits)—derived by CHIA	N/A	N/A
Derived - MC7	Release ID	NULL	Int	Unique record ID derived specifically for this release file type	With each release file type table this number is reset to 1 and sequentially incremented by one for every record released	N/A	N/A
Derived - MC8	Submission Control ID	NULL	int	Unique sequential number assigned to any new file type submitted to CHIA across all carriers	With each file submission this number is incremented by one	N/A	N/A
Derived - MC9	CHIA Incurred Date (Year and Month Only)		Int	This is a derived YYYYMM value as best determined by CHIA. Determination was based on availability of valid date data – typically "Date of Service To" or "Discharge date".	This is a derived YYYYMM value.	N/A	N/A

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

Medical Claims File – Level 2 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level[7]**	**APCD Threshold[8]**
Derived - MC10	Highest Version Flag		int	A derived flag indicating the version as applicable to December Release 2.0.	Determined by CHIA as of December Release 2.0. Domain values will be (0, 1, 9), representing not highest version, highest version, and undetermined as of December Release.	N/A	N/A
MC001	Payer	8	varchar	Carrier Specific Submitter Code as defined by APCD.	A CHIA-assigned identifier for any APCD Data Submitter; Insurance, Benefit Manager/Administrator, TPA, Vendor	A0	100
MC002	National Plan ID	30	varchar	CMS National Plan Identification Number (PlanID)	Unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans.	Z	0
MC003	Insurance Type Code/Product	2	varchar	Type / Product Identification Code (Lookup Table)	A code that defines the type of insurance applied to the claim line. This value can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	C	92
MC004	Payer Claim Control Number	35	varchar	Payer Claim Control Identification	Unique identifier within the payer's system that applies to the entire claim.	A0	100
MC005	Line Counter	4	int	Incremental Line Counter	The line number for this service on the claim. First line should start with 1 and each additional line incremented by 1.	A0	100
MC005 A	Version Number	4	int	Claim service line version number	Incrementing counter for a claim line that is reprocessed for any reason over the course of time. Highest value should indicate latest reprocessing of line by the carrier/submitter.	A0	100
MC011	Individual Relationship Code	2	varchar	Member/Patient to Subscriber Relationship Code (Lookup Table)	Numeric indicator to define the Patient's relationship to the Subscriber. This value can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	B	98

Medical Claims File – Level 2 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level[7]**	**APCD Threshold[8]**
MC012	Member Gender	1	varchar	Member/Patient's Gender (Lookup Table)	A code that defines the Patient's gender. This can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	B	98
MC013	Member Birth (Month Only)	2	int	Member/Patient's date of birth - Month Only	Derived by CHIA from MC013. The Member Birth Year is reported as 999 when the Member is age 89 or older as of the Date of Service From date.	B	98
MC013	Member Birth (Year Only)	4	int	Member/Patient's date of birth - Year Only	Derived by CHIA from MC013. The Member Birth Year is reported as 999 when the Member is age 89 or older as of the Date of Service From date.	B	98
MC014	Member City Name	256	varbinary	City name of the Member/Patient	City of the Patient.	B	98
MC015	Member State or Province	2	varchar	State of the Member/Patient	State of the Member/Patient	B	98
MC016	Member ZIP Code	256	varbinary	Zip Code of the Member/Patient	Zip Code of the Patient.	B	98
MC017	Date Service Approved (AP Date)	8	datetime	Date Service Approved	The date the service was approved for payment by the carrier or its designee. (YYYY-MM-DD 00:00:00.000)	C	93
MC018	Admission Date	8	datetime	Inpatient Admit Date	The date that the Patient was admitted into an inpatient setting at the facility. (YYYY-MM-DD 00:00:00.000)	A1	98
MC018	Admission Month	2	int	Inpatient Admit Date-Month Only	The date that the Patient was admitted into an inpatient setting at the facility.	A1	98
MC018	Admission Year	4	int	Inpatient Admit Date-Year Only	The date that the Patient was admitted into an inpatient setting at the facility.	A1	98
MC019	Admission Hour	4	varchar	Admission Time	The admission time of the Patient into an inpatient setting/facility and reported in military time.	C	5

Medical Claims File – Level 2 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level[7]**	**APCD Threshold[8]**
MC020	Admission Type	1	varchar	Admission Type Code (External Code Source 10)	A standardized, numeric code that reports the type of admission into an inpatient setting. Also known as Admission Priority.	A1	98
MC021	Admission Source	1	varchar	Admission Source Code (External Code Source 10)	A standardized code that reports the admission source of the Patient into an inpatient setting/facility and indicates how the Patient was referred into the inpatient setting.	A1	80
MC022	Discharge Hour	4	varchar	Discharge Time	The discharge/transfer time of the Patient from the inpatient setting/facility and reported in military time.	C	5
MC023	Discharge Status	2	varchar	Inpatient Discharge Status Code (External Code Source 10)	A standardized, numeric code that reports the discharge status of the Patient.	A1	98
MC024	Service Provider Number	30	varchar	Service Provider Identification Number	Link to PV002 on Provider File to obtain detailed attributes of the Service Provider.	A1	99
MC026	National Service Provider ID	20	varchar	National Provider Identification (NPI) of the Service Provider. (External Code Source 4)	The National Provider ID (NPI) of the Service Provider.	C	95
MC027	Service Provider Entity Type Qualifier	1	varchar	Service Provider Entity Type Identifier Code (Lookup Table)	Numeric indicator to define the Service Provider as a **Person or Non-person.** This value drives various 'person' -type requirements; First Name, Date of Birth, Gender, etc.	A0	98
MC028	Service Provider First Name	25	varchar	First name of Service Provider	First name of the Service Provider, when appropriate.	C	92
MC029	Service Provider Middle Name	25	varchar	Middle initial of Service Provider	Middle name / initial of the Service Provider when appropriate.	C	2
MC030	Servicing Provider Last Name or Organization Name	60	varchar	Last name or Organization Name of Service Provider	Last name, or Organization name, of the Servicing Provider.	A2	94
MC031	Service Provider Suffix	10	varchar	Provider Name Suffix (Lookup Table)	The generational title of the provider when the Service Provider Entity Type = 1 (Person)	Z	2

Medical Claims File – Level 2 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level[7]**	**APCD Threshold[8]**
MC032	Service Provider Specialty (Standard Values/Carrier-Specific Custom Values)	50	varchar	Specialty Code	A standardized taxonomy code (External Code Source 13) **OR** a carrier-defined specialty code of the Servicing Provider (APCD Master Lookup Table). Value is required to be in carrier-defined table if provided.	B	98
MC033	Service Provider City Name	30	varchar	City Name of the Provider	City of the Service Provider.	B	98
MC034	Service Provider State	2	varchar	State of the Service Provider (External Code Source 2)	State of the Service Provider.	B	98
MC035	Service Provider ZIP Code	11	varchar	Zip Code of the Service Provider (External Code Source 3)	Zip Code of the Service Provider.	B	98
MC036	Type of Bill - on Facility Claims	2	varchar	Type of Bill as used on Institutional Claims (External Code Source 10)	For Institutional Claims: a standardized code that reports the type of facility where the claim line service occurred.	A0	90
MC037	Site of Service - on NSF/CMS 1500 Claims	2	varchar	Place of Service Code as used on Professional Claims (External Code Source 9)	For Professional Claims, a standardized code that reports the type of facility where the claim line service occurred.	A0	65
MC038	Claim Status	2	varchar	Claim Line Status (Lookup Table)	Numeric indicator that reports if the claim line was paid by the carrier or its designee, and the COB order of the payment.	A0	98
MC039	Admitting Diagnosis	7	varchar	Admitting Diagnosis Code (External Code Source 5)	Diagnostic code assigned by the provider to support admission into an inpatient setting at the facility reported in Plan Rendering Provider ID and Provider Location.	A1	98
MC040	E-Code	7	varchar	ICD Diagnostic External Injury Code (External Code Source 5)	The ICD9 External Injury code for Patients with trauma or accidents.	C	3
MC041	Principal Diagnosis	7	varchar	ICD Primary Diagnosis Code (External Code Source 5)	Primary ICD9 Diagnosis Code.	A0	99
MC042	Other Diagnosis - 1	7	varchar	ICD Secondary Diagnosis Code (External Code Source 5)	Secondary ICD9 Diagnosis Code.	B	70
MC043	Other Diagnosis - 2	7	varchar	ICD Other Diagnosis Code (External Code Source 5)	Other ICD9 Diagnosis Code 2.	B	24

Medical Claims File – Level 2 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level[7]**	**APCD Threshold[8]**
MC044	Other Diagnosis - 3	7	varchar	ICD Other Diagnosis Code (External Code Source 5)	Other ICD9 Diagnosis Code 3.	C	13
MC045	Other Diagnosis - 4	7	varchar	ICD Other Diagnosis Code (External Code Source 5)	Other ICD9 Diagnosis Code 4.	C	7
MC046	Other Diagnosis - 5	7	varchar	ICD Other Diagnosis Code (External Code Source 5)	Other ICD9 Diagnosis Code 5.	C	4
MC047	Other Diagnosis - 6	7	varchar	ICD Other Diagnosis Code (External Code Source 5)	Other ICD9 Diagnosis Code 6.	C	3
MC048	Other Diagnosis - 7	7	varchar	ICD Other Diagnosis Code (External Code Source 5)	Other ICD9 Diagnosis Code 7.	C	3
MC049	Other Diagnosis - 8	7	varchar	ICD Other Diagnosis Code (External Code Source 5)	Other ICD9 Diagnosis Code 8.	C	2
MC050	Other Diagnosis - 9	7	varchar	ICD Other Diagnosis Code (External Code Source 5)	Other ICD9 Diagnosis Code 9.	C	1
MC051	Other Diagnosis - 10	7	varchar	ICD Other Diagnosis Code (External Code Source 5)	Other ICD9 Diagnosis Code 10.	C	1
MC052	Other Diagnosis - 11	7	varchar	ICD Other Diagnosis Code (External Code Source 5)	Other ICD9 Diagnosis Code 11.	C	1
MC053	Other Diagnosis - 12	7	varchar	ICD Other Diagnosis Code (External Code Source 5)	Other ICD9 Diagnosis Code 12.	C	1
MC054	Revenue Code	10	varchar	Revenue Code as defined for use on an Institutional Claim (External Code Source 10)	A standardized code that reports the revenue center of a facility where the claim line service occurred.	A0	90
MC055	Procedure Code	10	varchar	HCPCS / CPT Code (External Code Source 7)	The procedure code reported for this claim line.	A1	92
MC056	Procedure Modifier - 1	2	varchar	HCPCS / CPT Code Modifier (External Code Source 7)	The first modifier for the procedure code reported on this claim line.	B	20
MC057	Procedure Modifier - 2	2	varchar	HCPCS / CPT Code Modifier (External Code Source 7)	The second modifier for the procedure code reported on this claim line.	B	3

Medical Claims File – Level 2 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**[7]	**APCD Threshold**[8]
MC058	ICD9-CM Procedure Code	6	varchar	ICD Primary Procedure Code (External Code Source 5)	Primary ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary. Required for inpatient institutional claims.	A2	66
MC059	Date of Service - From	8	datetime	Date of Service	The first date of service for the claim line. Inpatient claims may or may not repeat this date on all lines.	A0	98
MC059	Date of Service - From (Month Only)	2	int	Date of Service - From Month only (Derived by DHCFP)	Month of the first date of service for the claim line. Inpatient claims may or may not repeat this date on all lines.	A0	98
MC059	Date of Service - From (Year Only)	4	int	Date of Service - From Year only (Derived by DHCFP)	Year of the first date of service for the claim line. Inpatient claims may or may not repeat this date on all lines.	A0	98
MC060	Date of Service - To	8	datetime	Date of Service	The last date of Service for the claim line. Inpatient claims may or may not repeat this date on all lines.	A0	98
MC060	Date of Service - To (Year Only)	4	int	Date of Service - To Year only	Year of the last date of Service for the claim line. Inpatient claims may or may not repeat this date on all lines.	A0	98
MC060	Date of Service - To (Month Only)	2	int	Date of Service - To Month only	Month of the last date of Service for the claim line. Inpatient claims may or may not repeat this date on all lines.	A0	98
MC061	Quantity	15	int	Claim line units of service	Count of services/units performed.	A1	98
MC062	Charge Amount	10	money	Amount of provider charges for the claim line	The amount the provider charged for the claim line service.	A0	99
MC063	Paid Amount	10	money	Amount paid by the carrier for the claim line	The amount paid to the provider for this claim line.	A0	99
MC064	Prepaid Amount	10	money	Amount carrier has pre-paid towards claim line	The amount the carrier or its designee has pre-paid towards a claim line.	B	99

Medical Claims File – Level 2 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level[7]**	**APCD Threshold[8]**
MC065	Copay Amount	10	money	Amount of Copay member/patient is responsible to pay	The copay amount applied to a claim line or full claim as calculated by the carrier or its designee.	A1	99
MC066	Coinsurance Amount	10	money	Amount of coinsurance member/patient is responsible to pay	The coinsurance amount applied to a claim line or full claim as calculated by the carrier or its designee.	A1	99
MC067	Deductible Amount	10	money	Amount of deductible member/patient is responsible to pay on the claim line	The deductible amount applied to a claim line or full claim as calculated by the carrier or its designee.	A1	99
MC068	Patient Control Number	20	varchar	Patient Control Number	The encounter/visit number assigned by the provider to identify Patient treatment at a facility.	A2	10
MC069	Discharge Date	8	datetime	Discharge Date	The date the Member was discharged from the inpatient facility. Inpatient claims may or may not repeat this date on all lines. (YYYY-MM-DD 00:00:00.000)	B	98
MC069	Discharge Month	2	int	Discharge Date - Month only	Month of the date the Member was discharged from the inpatient facility. Inpatient claims may or may not repeat this date on all lines.	B	98
MC069	Discharge Year	4	int	Discharge Date - Year only	Year of the date the Member was discharged from the inpatient facility. Inpatient claims may or may not repeat this date on all lines.	B	98
MC070	Service Provider Country Code	30	varchar	Country name of the Provider. Data requirement is a 3 digit code (External Code Source 1 (ISO 3166-1, alpha-3)).	Country of the Service Provider.	C	98
MC071	DRG	10	varchar	Diagnostic Related Group (DRG) Code (External Code Source 11)	CMS methodology when available. When the CMS methodology for DRGs is not available, but the All Payer DRG system is used, the insurer shall format the DRG and the complexity level within the same field with an "A" prefix, and with a hyphen separating the DRG and the complexity level (e.g. AXXX-XX).	B	20

Medical Claims File – Level 2 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level[7]**	**APCD Threshold[8]**
MC072	DRG Version	2	varchar	Diagnostic Related Group (DRG) Code Version Number (External Code Source 11)	Version identifier of the DRG Grouper used.	B	20
MC073	APC	5	varchar	Ambulatory Payment Classification (APC) Number	CMS APC methodology expected.	C	20
MC074	APC Version	2	varchar	Ambulatory Payment Classification (APC) Version	Version identifier of the APC Grouper used	C	20
MC075	Drug Code	11	varchar	National Drug Code (NDC)	A standard NDC Code as defined by the FDA in 5-4-2 format without hyphenation.	B	1
MC076	Billing Provider Number	30	varchar	Billing Provider Number	Link to PV002 on the Provider File to obtain detailed attributes of the Billing Provider.	B	99
MC077	National Billing Provider ID	20	varchar	National Provider Identification (NPI) of the Billing Provider (External Code Source 4)	The National Provider ID (NPI) of the Billing Provider.	B	99
MC078	Billing Provider Last Name or Organization Name	60	varchar	Last name or Organization Name of Billing Provider	Last name, or Organization name, of the Billing Provider.	B	99
MC079	Product ID Number	30	varchar	Product Identification Number	Link to PR001 on the Product File to obtain detailed attributes of the Product to which this claim line's member eligibility is associated.	A0	100
MC080	Reason for Adjustment (Carrier-Specific Custom Values)	15	varchar	Reason for Adjustment Code (Carrier Specific Lookup Table)	A code that reports the how the claim was processed for adjudication: describes the reason for the claims adjustment. Carriers shall submit a list of codes and descriptions for this field. NOTE: Description withheld by CHIA pending data cleansing.	A1	80
MC080	Reason for Adjustment (Standard Values)	15	varchar	Reason for Adjustment Code	A code that reports the how the claim was processed for adjudication: describes the reason for the claims adjustment.	A1	80

Medical Claims File – Level 2 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level[7]**	**APCD Threshold[8]**
MC081	Capitated Encounter Flag	1	varchar	Indicates if the service is covered under a capitation arrangement. (Lookup Table)	Numeric indicator that reports if a claim line is covered under a capitation arrangement.	A0	100
MC083	Other ICD-9-CM Procedure Code - 1	6	varchar	ICD Secondary Procedure Code (External Code Source 5)	Second ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary. Required for inpatient institutional claims.	C	1
MC084	Other ICD-9-CM Procedure Code - 2	6	varchar	ICD Other Procedure Code (External Code Source 5)	Third ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary. Required for inpatient institutional claims.	C	1
MC085	Other ICD-9-CM Procedure Code - 3	6	varchar	ICD Other Procedure Code (External Code Source 5)	Fourth ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary. Required for inpatient institutional claims.	C	1
MC086	Other ICD-9-CM Procedure Code - 4	6	varchar	ICD Other Procedure Code (External Code Source 5)	Fifth ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary. Required for inpatient institutional claims.	C	1
MC087	Other ICD-9-CM Procedure Code - 5	6	varchar	ICD Other Procedure Code (External Code Source 5)	Sixth ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary. Required for inpatient institutional claims.	C	1
MC088	Other ICD-9-CM Procedure Code - 6	6	varchar	ICD Other Procedure Code (External Code Source 5)	Seventh ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary. Required for inpatient institutional claims.	C	1

Medical Claims File – Level 2 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**[7]	**APCD Threshold**[8]
MC089	Paid Date	8	datetime	Paid date of the claim line	The date that appears on the check and/or remit and/or explanation of benefits and corresponds to any and all types of payment for this claim line (Claims paid in full, partial or zero paid). This can be the same date as Processed Date. (YYYY-MM-DD 00:00:00.000)	A0	98
MC092	Covered Days	4	int	Covered Inpatient Days	Amount of inpatient days paid for by the carrier. If not available, the number of days authorized by the carrier for the admission.	B	80
MC093	Non Covered Days	4	int	Non covered Inpatient Days	Amount of inpatient days that were not paid for by the plan for the inpatient event. Enter 0 when not applicable.	B	80
MC094	Type of Claim	3	varchar	Type of Claim Indicator (Lookup Table)	Numeric indicator of the type of claim received and processed by the carrier or its designee (Professional, Hospital, or Reimbursement Form).	A0	100
MC095	Coordination of Benefits/TPL Liability Amount	10	money	Amount due from a Secondary Carrier when known	The amount that another carrier/insurer is liable for, as determined by the carrier or its designee after their adjudication.	A2	98
MC096	Other Insurance Paid Amount	10	money	Amount paid by a Primary Carrier	The amount that another carrier paid for this claim line.	A2	90
MC097	Medicare Paid Amount	10	money	Amount Medicare paid on claim	The amount that Medicare paid towards this claim line prior to carrier adjudication.	B	98
MC098	Allowed amount	10	money	Allowed Amount	The maximum amount contractually allowed and payable for this claim line as defined by the carrier or its designee.	A2	99
MC099	Non-Covered Amount	10	money	Amount of claim line charge not covered	The amount that the carrier or its designee has determined to be above the plan limitations on this claim line.	B	98

Medical Claims File – Level 2 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level[7]**	**APCD Threshold[8]**
MC100	Delegated Benefit Administrator Organization ID	10	varchar	CHIA-assigned Org ID for Benefit Administrator	Linking ID used by carriers to identify their Benefit Administrators / Managers, Vendors, etc. This value is a CHIA-assigned identifier.	A2	98
MC108	Procedure Modifier - 3	2	varchar	HCPCS / CPT Code Modifier	The third modifier for the procedure code reported on this claim line.	C	0
MC109	Procedure Modifier - 4	2	varchar	HCPCS / CPT Code Modifier	The fourth modifier for the procedure code reported on this claim line.	C	0
MC110	Claim Processed Date	8	datetime	Claim Processed Date	The date the claim was processed by the carrier or its designee for adjudication.	A2	98
MC111	Diagnostic Pointer	1	varchar	Diagnostic Pointer Number	A numeric indicator that aligns each claim line service to a diagnosis: 1 for Principal Diagnosis; 2 for Other Diagnosis-1; 3 for Other Diagnosis-2, etc.	B	90
MC112	Referring Provider ID	28	varchar	Referring Provider Number	Link to PV002 on the Provider File to obtain detailed attributes of the Referring Provider.	B	98
MC113	Payment Arrangement Type	2	varchar	Payment Arrangement Code (Lookup Table)	Numeric indicator that reports how the payment was derived for the claim line by the carrier or its designee.	A0	90
MC114	Excluded Expenses	10	money	Amount not covered at the claim line due to benefit/plan limitation	The amount that a carrier or its designee has determined to be over the plan limitations for Patient utilization.	B	80
MC115	Medicare Indicator	1	varchar	Medicare Payment Indicator (Lookup Table)	Numeric indicator that reports if the claim line has any Medicare payments applied towards it as a Prior Payer on the claim.	A0	100
MC116	Withhold Amount	10	money	Amount to be paid to the provider upon guarantee of performance	The amount paid to the provider for this service if the provider qualifies / meets performance guarantees.	B	80
MC117	Authorization Needed	1	varchar	Indicates if the service required a pre-authorization number for payment. (Lookup Table)	Numeric indicator that reports if a claim line requires an authorization by the carrier or its designee.	B	100

Medical Claims File – Level 2 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**[7]	**APCD Threshold**[8]
MC118	Referral Indicator	1	varchar	Referral Required Indicator (Lookup Table)	Numeric indicator that reports if a claim line requires a referral by the carrier or its designee.	A0	100
MC119	PCP Indicator	1	varchar	PCP Service Performance Indicator (Lookup Table)	Numeric indicator that reports if a claim line was performed by the Patient's assigned Primary Care Provider.	B	100
MC120	DRG Level	3	varchar	Diagnostic Related Group (DRG) Code Level (External Code Source 11)	Severity adjustment level when applicable.	B	80
MC122	Global Payment Flag	1	varchar	Global Payment Method Indicator (Lookup Table)	Numeric indicator that reports if a claim line was processed / paid under a global payment arrangement.	A0	100
MC123	Denied Flag	1	varchar	Denied Claim Line Indicator (Lookup Table)	Numeric indicator that reports if the claim line was denied by the claims processor.	A0	100
MC124	Denial Reason (Standard Values/Carrier-Specific Custom Values)	15	varchar	Denial Reason Code	The Claim Line denial reason as assigned by the carrier or its designee.	B	80
MC125	Attending Provider	28	varchar	Attending Provider ID number found in the Provider File (PV002). This number is defined in the carrier's systems and may be equal to any other identifier, i.e., NPI, State License Number	Link to PV002 on the Provider File to obtain detailed attributes of the Attending Provider as defined at a facility.	A1	98
MC126	Accident Indicator	1	varchar	Service is related to an accident (Lookup Table)	Numeric indicator that reports if the claim line procedure was performed due to an accident (not employment based).	B	100
MC127	Family Planning Indicator	1	varchar	Service is related to Family Planning (Lookup Table)	Numeric indicator that reports the claim line service's relation to family planning.	A2	98
MC128	Employment Related Indicator	1	varchar	Service related to Employment Injury (Lookup Table)	Numeric indicator that reports if the claim line procedure was performed due to an employment related accident.	B	100

Medical Claims File – Level 2 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**[7]	**APCD Threshold**[8]
MC129	EPSDT Indicator	1	varchar	Service related to Early Periodic Screening, Diagnosis and Treatment (EPSDT) (Lookup Table)	Numeric indicator that reports the claim line service's relation to EPSDT services.	B	98
MC130	Procedure Code Type	1	varchar	Claim line Procedure Code Type Identifier (Lookup Table)	Numeric indicator that reports the type of procedure code expected on this claim line.	A1	80
MC131	InNetwork Indicator	1	varchar	Network rates applied identifier (Lookup Table)	Numeric indicator that reports if a claim line was processed / paid at In-Network rates.	A2	100
MC132	Service Class	2	varchar	Service Class Code (Carrier Defined Reference Table)	A code used to define Behavioral Health services to MassHealth and MassHealth Managed Care Organization patients.	C	10
MC134	Plan Rendering Provider Identifier	28	varchar	Plan Rendering Number	Link to PV002 on the Provider File to obtain detailed attributes of the Rendering Provider. This code identifies the actual individual that performed the service at the location reported via Provider Location.	A0	100
MC135	Provider Location	28	varchar	Location of Provider	Link to PV002 on the Provider File to obtain detailed attributes of the Provider Location. This code identifies the location/site where the service was performed by the Provider ID reported in Plan Rendering Provider Identifier.	B	98
MC136	Discharge Diagnosis	7	varchar	ICD Discharge Diagnosis Code (External Code Source 5)	The ICD9 diagnosis code assigned to the Patient upon discharge.	B	80
MC137	CarrierSpecificUniqueMemberID [Masked]	256	varbinary	Member/Patient Carrier Unique Identification	Unique, internal identification assigned by the carrier or its designee to the Member. This can be used to link Claim Lines to eligibility segments.	A0	100
MC138	Claim Line Type	10	varchar	Claim Line Activity Type Code (Lookup Table)	A code that reports the final outcome of the claim line during the submission period of the carrier or its designee. Example: Original, Void, Replacement, Back Out, Amendment	A0	90

Medical Claims File – Level 2 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level[7]**	**APCD Threshold[8]**
MC139	Former Claim Number	35	varchar	Previous Claim Number	The Payer Claim Control Number previously assigned to this claim line in a prior reporting period.	B	0
MC141	CarrierSpecificUniqueSubscriberID [Masked]	256	varbinary	Subscriber Carrier Unique Identification	Unique, internal identification assigned by the carrier or its designee to the Subscriber. This can be used to link Claim Lines to eligibility segments.	A0	100

Medical Claims File – Level 3 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**
Derived - MC5	Medical Claim ID	NULL	int	Unique record ID per submission control ID	With each submission control ID this number is reset to 1 and sequentially incremented by one for every record submitted	N/A	N/A
Derived - MC7	Release ID	NULL	Int	Unique record ID derived specifically for this release file type	With each release file type table this number is reset to 1 and sequentially incremented by one for every record released	N/A	N/A
Derived - MC8	Submission Control ID	NULL	int	Unique sequential number assigned to any new file type submitted to CHIA across all carriers	With each file submission this number is incremented by one	N/A	N/A
MC006	Insured Group or Policy Number	256	varbinary	Carriers group or policy number	The carrier assigned group / policy number for this claim line. This information is often filed as reported by the provider.	C	95
MC007	Subscriber SSN	256	varbinary	Subscriber's Social Security Number	Tax ID of the Subscriber.	B	79
MC008	Plan Specific Contract Number	256	varbinary	Plan Specific Contract Number	Plan assigned contract/certificate number for the Subscriber and all of the corresponding dependents. This identifier must not disclose individuals.	C	98

Medical Claims File – Level 3 Data Elements							
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**
MC009	Member Suffix or Sequence Number	20	varchar	Member/Patient's Contract Sequence Number	A unique identifier that is assigned to each beneficiary under a contract.	B	98
MC010	Member SSN	256	varbinary	Member/Patient's Social Security Number	Tax ID of the Patient.	B	73
MC013	Member Date of Birth	256	varbinary	Member/Patient's date of birth	Birth date of the Patient.	B	98
MC025	Service Provider Tax ID Number	10	varchar	Service Provider's Tax ID number	Tax ID of the Service Provider.	C	97
MC082	Member Street Address	256	varbinary	Street address of the Member/Patient	Street address of the Patient.	B	90
MC090	LOINC Code	7	varchar	Logical Observation Identifiers, Names and Codes (LOINC) Code	The Logical Observation Identifiers, Names and Code for laboratory test / results for the claim line.	B	0
MC101	Subscriber Last Name	256	varbinary	Last name of Subscriber	Last name (or entity name) of the Subscriber.	B	98
MC102	Subscriber First Name	256	varbinary	First name of the Subscriber	First name of Subscriber, when appropriate	B	98
MC103	Subscriber Middle Initial	1	varchar	Middle initial of Subscriber	Middle initial of the Subscriber, when appropriate.	C	2
MC104	Member Last Name	256	varbinary	Last name of Member/Patient	Last name of the Member.	B	98
MC105	Member First Name	256	varbinary	First name of Member/Patient	First name of the Patient.	B	98
MC106	Member Middle Initial	1	varchar	Middle initial of Member/Patient	Middle initial of the Patient.	B	98
MC140	Member Address 2	256	varbinary	Secondary Street Address of the Member/Patient	Street address 2 of the Patient.	B	1
MC899	Record Type	2	varchar	File Type Identifier	The APCD filing-type identifier that defines the data contained within the file.	A0	100

APCD Medical Claims File Lookup Tables, by Element								
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Level 2/3**
MC003	Insurance Type Code/Product	2	varchar	Type / Product Identification Code (Lookup Table)	A code that defines the type of insurance applied to the claim line. This value can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	C	92%	2
				Claim Insurance Type Code	***Claim Insurance Type***			
				09	Self-pay			
				10	Central Certification			
				11	Other Non-Federal Programs			
				12	Preferred Provider Organization (PPO)			
				13	Point of Service (POS)			
				14	Exclusive Provider Organization (EPO)			
				15	Indemnity Insurance			
				16	Health Maintenance Organization (HMO) Medicare Risk			
				AM	Automobile Medical			
				BL	Blue Cross / Blue Shield			
				CC	Commonwealth Care			
				CE	Commonwealth Choice			
				CH	Champus			
				CI	Commercial Insurance Co.			
				DS	Disability			
				HM	Health Maintenance Organization			
				LI	Liability			
				LM	Liability Medical			
				MA	Medicare Part A			
				MB	Medicare Part B			

APCD Medical Claims File Lookup Tables, by Element								
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Level 2/3**
				MC	Medicaid			
				OF	Other Federal Program			
				TV	Title V			
				VA	Veterans Administration Plan			
				WC	Workers' Compensation			
MC011	Individual Relationship Code	2	varchar	Member/Patient to Subscriber Relationship Code (Lookup Table)	Numeric indicator to define the Patient's relationship to the Subscriber. This value can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	B	98%	2
				Individual Relationship Code	***Individual Relationship***			
				1	Spouse			
				4	Grandfather or Grandmother			
				5	Grandson or Granddaughter			
				7	Nephew or Niece			
				10	Foster Child			
				15	Ward			
				17	Stepson or Stepdaughter			
				19	Child			
				20	Self/Employee			
				21	Unknown			
				22	Handicapped Dependent			
				23	Sponsored Dependent			
				24	Dependent of a Minor Dependent			
				29	Significant Other			
				32	Mother			
				33	Father			

APCD Medical Claims File Lookup Tables, by Element								
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Level 2/3**
				36	Emancipated Minor			
				39	Organ Donor			
				40	Cadaver Donor			
				41	Injured Plaintiff			
				43	Child Where Insured Has No Financial Responsibility			
				53	Life Partner			
				76	Dependent			
MC012	Member Gender	1	varchar	Member/Patient's Gender (Lookup Table)	A code that defines the Patient's gender. This can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	B	98%	2
				Gender Code	***Gender***			
				F	Female			
				M	Male			
				O	Other			
				U	Unknown			
MC027	Service Provider Entity Type Qualifier	1	varchar	Service Provider Entity Type Identifier Code (Lookup Table)	Numeric indicator to define the Service Provider as a **Person or Non-person.** This value drives various 'person' –type requirements; First Name, Date of Birth, Gender, etc.	A0	98%	2
				Service Provider Entity Type Qualifier Code	***Service Provider Entity Type Qualifier***			
				1	Person			
				2	Non-person entity			
MC031	Service Provider Suffix	10	varchar	Provider Name Suffix (Lookup Table)	The generational title of the provider when the Service Provider Entity Type = 1 (Person)	Z	2%	2
				Last Name Suffix ID	***Last Name Suffix***			
				0	Unknown / Not Applicable			

APCD Medical Claims File Lookup Tables, by Element								
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Level 2/3**
				1	I.			
				2	II.			
				3	III.			
				4	Jr.			
				5	Sr.			
MC038	Claim Status	2	varchar	Claim Line Status (Lookup Table)	Numeric indicator that reports if the claim line was paid by the carrier or its designee, and the COB order of the payment.	A0	98%	2
				Claim Status Code	***Claim Status***			
				01	Processed as primary			
				02	Processed as secondary			
				03	Processed as tertiary			
				04	Denied			
				19	Processed as primary, forwarded to additional payer(s)			
				20	Processed as secondary, forwarded to additional payer(s)			
				21	Processed as tertiary, forwarded to additional payer(s)			
				22	Reversal of previous payment			
MC081	Capitated Encounter Flag	1	varchar	Indicates if the service is covered under a capitation arrangement. (Lookup Table)	Numeric indicator that reports if a claim line is covered under a capitation arrangement.	A0	100%	2
				Value	***Description***			
				1	Yes			
				2	No			
				3	Unknown			

APCD Medical Claims File Lookup Tables, by Element								
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Level 2/3**
				4	Other			
				5	Not Applicable			
MC094	Type of Claim	3	varchar	Type of Claim Indicator (Lookup Table)	Numeric indicator of the type of claim received and processed by the carrier or its designee (Professional, Hospital, or Reimbursement Form).	A0	100%	2
				Type Of Claim Code	***Type Of Claim***			
				001	Professional			
				002	Hospital			
				003	Reimbursement Form			
MC113	Payment Arrangement Type	2	varchar	Payment Arrangement Code (Lookup Table)	Numeric indicator that reports how the payment was derived for the claim line by the carrier or its designee.	A0	90%	2
				Payment Arrangement Type Code	***Payment Arrangement Type***			
				01	Capitation			
				02	Fee for Service			
				03	Percent of Charges			
				04	DRG			
				05	Pay for Performance			
				06	Global Payment			
				07	Other			
MC115	Medicare Indicator	1	varchar	Medicare Payment Indicator (Lookup Table)	Numeric indicator that reports if the claim line has any Medicare payments applied towards it as a Prior Payer on the claim.	A0	100%	2
				Value	***Description***			
				1	Yes			
				2	No			

APCD Medical Claims File Lookup Tables, by Element								
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Level 2/3**
				3	Unknown			
				4	Other			
				5	Not Applicable			
MC117	Authorization Needed	1	varchar	Indicates if the service required a pre-authorization number for payment. (Lookup Table)	Numeric indicator that reports if a claim line requires an authorization by the carrier or its designee.	B	100%	2
				Value	***Description***			
				1	Yes			
				2	No			
				3	Unknown			
				4	Other			
				5	Not Applicable			
MC118	Referral Indicator	1	varchar	Referral Required Indicator (Lookup Table)	Numeric indicator that reports if a claim line requires a referral by the carrier or its designee.	A0	100%	2
				Value	***Description***			
				1	Yes			
				2	No			
				3	Unknown			
				4	Other			
				5	Not Applicable			
MC119	PCP Indicator	1	varchar	PCP Service Performance Indicator (Lookup Table)	Numeric indicator that reports if a claim line was performed by the Patient's assigned Primary Care Provider.	B	100%	2
				Value	***Description***			
				1	Yes			
				2	No			

APCD Medical Claims File Lookup Tables, by Element								
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Level 2/3**
				3	Unknown			
				4	Other			
				5	Not Applicable			
MC122	Global Payment Flag	1	varchar	Global Payment Method Indicator (Lookup Table)	Numeric indicator that reports if a claim line was processed / paid under a global payment arrangement.	A0	100%	2
				Value	***Description***			
				1	Yes			
				2	No			
				3	Unknown			
				4	Other			
				5	Not Applicable			
MC123	Denied Flag	1	varchar	Denied Claim Line Indicator (Lookup Table)	Numeric indicator that reports if the claim line was denied by the claims processor.	A0	100%	2
				Value	***Description***			
				1	Yes			
				2	No			
				3	Unknown			
				4	Other			
				5	Not Applicable			
MC126	Accident Indicator	1	varchar	Service is related to an accident (Lookup Table)	Numeric indicator that reports if the claim line procedure was performed due to an accident (not employment based).	B	100%	2
				Value	***Description***			
				1	Yes			
				2	No			

APCD Medical Claims File Lookup Tables, by Element								
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Level 2/3**
				3	Unknown			
				4	Other			
				5	Not Applicable			
MC127	Family Planning Indicator	1	varchar	Service is related to Family Planning (Lookup Table)	Numeric indicator that reports the claim line service's relation to family planning.	A2	98%	2
				Family Planning Code	***Family Planning***			
				0	Unknown / Not Applicable / Not Avail			
				1	Family planning services provided			
				2	Abortion services provided			
				3	Sterilization services provided			
				4	No family planning services provided			
MC128	Employment Related Indicator	1	varchar	Service related to Employment Injury (Lookup Table)	Numeric indicator that reports if the claim line procedure was performed due to an employment related accident.	B	100%	2
				Value	***Description***			
				1	Yes			
				2	No			
				3	Unknown			
				4	Other			
				5	Not Applicable			
MC129	EPSDT Indicator	1	varchar	Service related to Early Periodic Screening, Diagnosis and Treatment (EPSDT) (Lookup Table)	Numeric indicator that reports the claim line service's relation to EPSDT services.	B	98%	2
				EPSDT Indicator Code	***EPSDT Indicator***			
				0	Unknown / Not Applicable / Not Avail			
				1	EPSDT Screen			

APCD Medical Claims File Lookup Tables, by Element								
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Level 2/3**
				2	EPSDT Treatment			
				3	EPSDT Referral			
MC130	Procedure Code Type	1	varchar	Claim line Procedure Code Type Identifier (Lookup Table)	Numeric indicator that reports the type of procedure code expected on this claim line.	A1	80%	2
				Procedure Code Type Code	***Procedure Code Type***			
				0	Carrier Custom Code			
				1	CPT or HCPCS Level 1 Code			
				2	HCPCS Level II Code			
				3	HCPCS Level III Code (State Medicare code).			
				4	American Dental Association (ADA) Procedure Code (Also referred to as CDT code.)			
				5	State defined Procedure Code			
MC131	InNetwork Indicator	1	varchar	Network rates applied identifier (Lookup Table)	Numeric indicator that reports if a claim line was processed / paid at In-Network rates.	A2	100%	2
				Value	***Description***			
				1	Yes			
				2	No			
				3	Unknown			
				4	Other			
				5	Not Applicable			
MC138	Claim Line Type	10	varchar	Claim Line Activity Type Code (Lookup Table)	A code that reports the final outcome of the claim line during the submission period of the carrier or its designee. Example: Original, Void, Replacement, Back Out, Amendment	A0	90%	2
				Claim Line Type Code	***Claim Line Type***			
				O	Original			
				V	Void			

APCD Medical Claims File Lookup Tables, by Element								
Element	**Data Element Name**	**Max Length**	**Data Type Guide**	**Description**	**Release Notes**	**Edit Level**	**APCD Threshold**	**Level 2/3**
				R	Replacement			
				B	Back Out			
				A	Amendment			

Medical Claims File: External Code Sources

Refer to Appendix 9 in the Appendices: External Code Sources

Medical Claims File Cleaning, Standardization, and Redaction

APCD Medical Claims File Cleaning Logic, by Element				
Element	**Data Element Name**	**Format/Length**	**Description**	**Cleaning Logic**
MC012	Member Gender	char[1]	Patient's Gender	Change 'm' to 'M', 'f' to 'F', 'o' to 'O', 'u' to 'U'. Nullify invalid values based on lookup table.
MC013	Member Birth Year	Ing[4]	Member Birth Year	If age based on date of birth > 89 as of the last day of the service year, then set member birth year to 999. Nullify member birth year if age > 115.
MC023	Discharge Status	char[2]	Inpatient Discharge Status Code	Zero pad single digit values 1-7.
MC026	National Service Provider ID	int[10]	National Provider Identification (NPI) of the Service Provider	Nullify values if not 10-digit integer.
MC037	Site of Service	char[2]	Place of Service Code	Zero pad single digit values 1-9.
MC039	Admitting Diagnosis	varchar[7]	Admitting Diagnosis Code	Remove decimal
MC040	ECode	varchar[7]	ICD Diagnostic External Injury Code	Remove decimal
MC041	Principal Diagnosis	varchar[7]	ICD Primary Diagnosis Code	Remove decimal
MC042	Other Diagnosis 1	varchar[7]	ICD Secondary Diagnosis Code	Remove decimal
MC043	Other Diagnosis 2	varchar[7]	ICD Other Diagnosis Code	Remove decimal
MC044	Other Diagnosis 3	varchar[7]	ICD Other Diagnosis Code	Remove decimal
MC045	Other Diagnosis 4	varchar[7]	ICD Other Diagnosis Code	Remove decimal
MC046	Other Diagnosis 5	varchar[7]	ICD Other Diagnosis Code	Remove decimal
MC047	Other Diagnosis 6	varchar[7]	ICD Other Diagnosis Code	Remove decimal
MC048	Other Diagnosis 7	varchar[7]	ICD Other Diagnosis Code	Remove decimal
MC049	Other Diagnosis 8	varchar[7]	ICD Other Diagnosis Code	Remove decimal
MC050	Other Diagnosis 9	varchar[7]	ICD Other Diagnosis Code	Remove decimal
MC051	Other Diagnosis 10	varchar[7]	ICD Other Diagnosis Code	Remove decimal

APCD Medical Claims File Cleaning Logic, by Element				
Element	**Data Element Name**	**Format/Length**	**Description**	**Cleaning Logic**
MC052	Other Diagnosis 11	varchar[7]	ICD Other Diagnosis Code	Remove decimal
MC053	Other Diagnosis 12	varchar[7]	ICD Other Diagnosis Code	Remove decimal
MC054	Revenue Code	char[4]	Revenue Code	Zero pad values with length of three with one zero and zero pad values with length of two with two zeros.
MC055	Procedure Code	varchar[10]	HCPCS / CPT Code	Remove decimal
MC058	ICD9-CM Procedure Code	varchar [6]	Primary ICD-9 procedure code	Remove decimal
MC062	Charge Amount	money	Amount of provider charges for the claim line	**For MassHealth (Org. ID 3156) data only:** submitted values multiplied by 100.
MC063	Paid Amount	money	Amount paid by the carrier for the claim line	**For MassHealth (Org. ID 3156) data only:** submitted values multiplied by 100
MC064	Prepaid Amount	±varchar[10]	Amount carrier has prepaid towards the claim line	Nullify Prepaid Amounts = 99999999.99
MC065	Copay Amount	money	Amount of Copay member/patient is responsible to pay	**For MassHealth (Org. ID 3156) data only:** submitted values multiplied by 100
MC077	National Billing Provider ID	int[10]	National Provider Identification (NPI) of the Billing Provider	Nullify values if not 10-digit integer.
MC083	Other ICD9CM Procedure Code 1	varchar[7]	ICD Secondary Procedure Code	Remove decimal
MC084	Other ICD9CM Procedure Code 2	varchar[7]	ICD Other Procedure Code	Remove decimal
MC085	Other ICD9CM Procedure Code 3	varchar[7]	ICD Other Procedure Code	Remove decimal
MC086	Other ICD9CM Procedure Code 4	varchar[7]	ICD Other Procedure Code	Remove decimal
MC087	Other ICD9CM Procedure Code 5	varchar[7]	ICD Other Procedure Code	Remove decimal
MC088	Other ICD9CM Procedure Code 6	varchar[7]	ICD Other Procedure Code	Remove decimal
MC094	Type of Claim	char[3]	Type of Claim Indicator	Zero pad single digit values with two zeros and nullify values not in lookup table.

APCD Medical Claims File Cleaning Logic, by Element				
Element	**Data Element Name**	**Format/Length**	**Description**	**Cleaning Logic**
MC096	Other Insurance Paid Amount	money	Amount paid by a Primary Carrier	**For MassHealth (Org. ID 3156) data only:** submitted values multiplied by 100
MC097	Medicare Paid Amount	money	Amount Medicare paid on claim	**For MassHealth (Org. ID 3156) data only:** submitted values multiplied by 100
MC098	Allowed Amount	money	Allowed Amount	**For MassHealth (Org. ID 3156) data only:** submitted values multiplied by 100
MC099	Non-Covered Amount	money	Amount of claim line charge not covered	**For MassHealth (Org. ID 3156) data only:** submitted values multiplied by 100
MC100	Delegated Benefit Administrator Org ID	varchar[6]	CHIA defined and maintained Org ID for linking across submitters	Nullify invalid values based on CHIA assigned organization ID.
MC113	Payment Arrangement Type	char[2]	Payment Arrangement Type Value	Zero pad single digit values 1-9.
MC114	Excluded Expenses	money	Amount not covered at the claim line due to benefit/plan limitation	**For MassHealth (Org. ID 3156) data only:** submitted values multiplied by 100
MC136	Discharge Diagnosis	varchar[7]	ICD Discharge Diagnosis Code	Remove decimal

APCD Medical Claims File Standardization, by Element using Melissa Data[9]			
Element	**Data Element Name**	**Format/Length**	**Description**
Derived-MC3	County of Member	[3]	
Derived-MC4	County of Service Provider	[3]	
Derived-MC6	Member ZIP code (first 3 digits)	[3]	
MC014	Member City Name	varchar[30]	City name of the Member/Patient
MC015	Member State or Province	char[2]	State / Province of the Patient
MC016	Member ZIP Code	varchar[9]	Zip Code of the Member / Patient
MC033	Service Provider City Name	varchar[30]	City name of the Member/Patient
MC034	Service Provider State	char[2]	State / Province of the Patient

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

MC035	Service Provider ZIP Code	varchar[9]	Zip Code of the Member / Patient
MC082	Member Street Address	varchar[50]	Street address of the Member/Patient
MC140	Member Address 2	varchar[50]	Secondary Street Address of the Member/Patient

APCD Medical Claims File SSN Redaction, by Element			
Element	**Data Element Name**	**Format/Length**	**Description**
MC028	Service Provider First Name	varchar[25]	First name of Service Provider
MC030	Servicing Provider Last Name or Organization Name	varchar[60]	Last name or Organization Name of Service Provider
MC068	Patient Control Number	varchar[20]	Patient Control Number
MC078	Billing Provider Last Name or Organization Name	varchar[60]	Last name or Organization Name of Billing Provider

APCD Medical Claims File Reidentification, by Element			
Element	**Data Element Name**	**Format/Length**	**Description**
MC024	Service Provider Number	varchar[30]	Service Provider Identification Number
MC076	Billing Provider Number	varchar[30]	Billing Provider Number
MC079	Product ID Number	varchar[30]	Product Identification
MC112	Referring Provider ID	varchar[30]	Referring Provider ID
MC125	Attending Provider	varchar[30]	Attending Provider ID
MC134	Plan Rendering Provider Identifier	varchar[30]	Plan Rendering Number
MC135	Provider Location	varchar[30]	Location of Provider