Appendix E

Exhibit 1. Data Warehouse
Paid Encounter Data Set Request

Exhibit 2. Data Warehouse
Denied Claims Submissions Requirements

Exhibit 1.

COMMONWEALTH OF MASSACHUSETTS

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

MassHealth Data Warehouse

Paid Encounter Data Set Request (Expanded Format)

Version 4.11

May 2, 2019

Revision History

Date	Description	Author
05/03/2019	RENAMED: Field #232 - old name - "FILLER" - new name - "Provider Payment"	Alla Kamenetsky
03/19/2019	Removed all the mentioning of potentially duplicate claims	Alla Kamenetsky
February, 2019	ADDED: 1. Field #232 "Filler" 2. Field #233 "Filler" 3. "Physician-Administered Drug Claim" Definition - Segment 2.0 "Data Elements Clarification" UPDATED: 1. Field # 11 "Medicare Code" – added value "Part D Only" 2. Table O "Unit of Measure" 3. Field 11 "Medicare Code" description 4. Table I – B1 "Service Category (Using the SCO reporting groups) "– added value "309 B – Pharmacy/Drug (Non-Part D)"	Alla Kamenetsky
12/15/2018	REMOVED: 1. Table N "Submission Clarification Code" 2. Section 1.1 – Removed requirements for Monthly Financial Reports ADDED: 1. TABLE O - Unit Of Measure values 2. Field # 11 "Medicare Code" – added values (4 = Part A and D , 5 = Part B and D , 6 = Part A, B, and D) 3. Field #229 "Submission Clarification Code 2" 4. Field #230 "Submission Clarification Code 3" 5. Field #231 "Unit of Measure" 6. Submission Clarification Code description - Segment 2.0 "Data Elements Clarification" UPDATED: 3. TABLE C - Place of Service (HCFA 1500) Place of Service Codes for Professional Claims 4. TABLE M - POA Indicator Options and Definitions	Alla Kamenetsky
3/14/2018	The length of all Address Location Code fields has been increased to 15 C The length of MMIS Plan type (MBH only) has been increased to 5 C *Additions and corrected typos:* *SEGMENT "Data Requirements"* *Added* "MCO claims where "From Service Date" is prior to 03/01/2018, the value of MCO PIDSL should be entered in "Entity PIDSL" field (#3)" *ENCOUNTER* Field # 3: Entity PIDSL – added to the description "an ACO with which a PCC is contracted with" Field # 13: Submission Clarification Code – is required on Pharmacy claim lines only Field # 33: Type Of Bill – should be submitted on Hospital (H) and LTS (L) claims only Field # 36: Quantity - the values should be submitted on claims of all types, but Pharmacy (R – Prescription Drug)	Alla Kamenetsky

Date	Description	Author
	Field # 49: PCC Internal Provider ID – should be submitted on claims of all types Field # 92: PCC Internal Provider ID_Type - should be submitted on claims of all types *PROVIDER* To the list "The following fields are 100% required on all records": *Added* 19. Entity PIDSL Field# 35: Entity PIDSL - description changed to: "MCO/ACO providers a. if the provider is enrolled with MCO only (not with ACO) - MCO PIDSL in ENTITY_PIDSL b. if the provider is enrolled with ACO only - ACO PIDSL c. if the provider is enrolled with both, ACO and MCO, - ACO PIDSL d. if provider is enrolled with multiple ACOs (e.g. a specialist), and a plan is an active MCO - MCO PIDSL e. if provider is enrolled with multiple ACOs (e.g. a specialist) and a plan is not an active MCO old MCO SCO PIDSL for SCO providers One Care PIDSL for One Care providers" *Authorization Type Data Set Elements* table Field # 1: Org. Code - the length of the field corrected to 4	
12/06/2017	1.1 Data requirements segment Added new bullets that are marked as "*Bullet introduced in this version of the document*" 2.0 Data Elements Clarifications segment Provider IDs: added new lines marked as "*Line introduced in this version of the document".* **"Org. Code", field # 1 in all the files, is set to accept 3 N values. Encounter data set Provider Data Set MCE Internal Provider Type Data Set Elements with Record Layout Provider Specialty Data Set Elements Additional Reference Data Set Elements Member File Layout Member Enrollment File Layout Care Management Provider File Layout 3.1 Provider Data Set with Record Layout To "Reject the file if:" Added line: "c. Provider ID, or Provider ID Type, or Provider ID Location Code are missing" **Added:** • New segment "Potential Duplicate Claims" • Table N – Submission Clarification Code **Changes to the fields:** Encounter Field # 49: PCC Internal Provider ID (PCC Provider ID removed) Field # 92: PCC Internal Provider ID Type (PCC Provider ID Type removed) Field # 228: PCC Provider ID Address Location Code	Alla Kamenetsky

Date	Description	Author
11/16/2017	Field #1 in all the files : "MCE PIDSL" renamed to " Org. Code" Description – "Unique ID assigned by MH DW to each submitting organization." • The length of the field is changed from 10 to 3 • Data Type of the values in the field changes from "C" to "N" • "ACI PIDSL" in all the files has been renamed to "Entity PIDSL", • Description "ACO PIDSL for the ACO claims and MCO PIDSL for the MCO claims" • The length and data type remain the same – 10/C Encounter file: • Field #61: Gross Payment Amount - added missing length of the field (9) and datatype (SN) • Field #73: EPSDT Indicator - corrected data type to "N" Provider File: Field #16: Provider Type – corrected datatype to "N"	Alla Kamenetsky
11/09/2017	Few typos correction	Alla Kamenetsky
10/10/2017	**Added:** **Provider Data Set file** Field#40 : Provider Bundle ID Field#41: Provider ID Primary Address Location Indicator **2.0 Data Element Clarifications** ***Provider ID submission in Encounter and Provider Files*** segment with an example to illustrate how Provider IDs in claims file should correlate with the values in provider file **To the list of required fields in Provider file** 17. Provider ID Address Location Code (Field#36) 18. Provider Bundle ID (Field #40) **Changed:** All Provider ID Address Location Code fields : Length of the field = 5; Data Type = C Narrations In segment "***3.1 Provider Data Set with Record Layout***"	Alla Kamenetsky
09/20/2017	**Add to the list of changes:** Field#37: NDC Number – now will be required on Hospital and Professional claims in addition to the Pharmacy ones. Field#38: Metric Quantity - now will be required on Hospital and Professional claims in addition to the Pharmacy ones. **Removed ACO PIDSL field from :** • Internal Provider Type Data Set table • Provider Specialty Data Set Elements table • Member File Layout	Alla Kamenetsky
08/14/2017	**Secure FTP Server** - changes to the server related information in the section **Data Requirements** section – mentioning of ACO program implementation **Data Set Elements** tables are enhanced with Record Layout information. **Obsolete:** o Encounter Record Layout section o Provider Record Layout section **Encounter Data Set** *Changes to the existing fields* Field#1: MCE PIDSL (former Claim Payer) Field#3: ACO PIDSL (Former "Plan Identifier") Field#7: - Pricing Indicator (former "Filler") - the length changed from 9 to 20 Field#13: Submission Clarification Code "(former "Filler")	Alla Kamenetsky

Date	Description	Author
	Field#32: Gender Code, added value of "O" for "Other" Field #33: Type of Bill (former "Place of Service Type") Field#71: Added values of "7 = ACO-A", "8 = ACO-B" and "9= ACO-C" Field#195: ACO Categories, added value 'ACO' for ACO Service Category Type *Introducing new fields* Field #204: Value Code Field #205: Value Amount Field # 206 - 221: Surgical Procedure Codes 10-25 Field#222: Attending Prov. ID Address Location Code Field#223: Billing Provider ID Address Location Code Field#224: Prescribing Prov. ID Address Location Code Field#225: PCP Provider ID Address Location Code Field#226: Referring Provider ID Address Location Code Field#227: Servicing Provider ID Address Location Code Field#228: PCC Internal Provider ID Field#229: PCC Internal Provider ID_Type Field#230: PCC Provider ID Address Location Code **Provider Data Set Elements related tables and Additional Reference Data Set Elements:** *Changed and added fields* *Field* #1 "Claim Payer" is replaced with "MCE PIDSL" Added field "ACO PIDSL" at the end of the files **Provider Data Set file** **Internal Provider Type Data Set** **Provider Specialty Data Set Elements** **Member Enrollment File**	

Field #	*Field Name*	*Former Field Name*
1	MCE PIDSL	Claim Payer
22	PCC Provider ID	IPA/PMG ID
31	PCC Provider ID Type	IPA/PMG ID_Type
35	ACO PIDSL	
36	Provider ID Address Location Code	
37	PCC ID Address Location Code	
38	Provider Network ID TYPE	
39	Provider Network ID Address Location Code	

Field#	*Field Name NEW*	*Former Field Name*
1	MCE PIDSL	Claim Payer
6	ACO PIDSL	
7	Provider ID Address Location Code	

Field#	*Field Name NEW*	*Former Field Name*
1	MCE PIDSL	Claim Payer
7	ACO PIDSL	
8	Provider ID Address Location Code	

Field #	*Field Name*	*Former Field Name*
1	MCE PIDSL	Claim Payer
12	PCC Provider ID Address Location Code	

<table>
<tr><th>Date</th><th>Description</th><th>Author</th></tr>
<tr><td></td><td>
<table>
<tr><td>13</td><td>PCC Practice ID Address Location Code</td><td></td></tr>
<tr><td>14</td><td>ACO PIDSL</td><td></td></tr>
</table>
</td><td></td></tr>
<tr><td>06/06/2017</td><td>
III. Error Handling
<table>
<tr><td>New error codes added 72*</td><td>Denial Code not in Denied Claims file - Claim Number/Suffix in Denied Claims Reason Code file not in Denied Claims file</td></tr>
<tr><td>73*</td><td>Claim Number/Suffix in Denied Claims file not in Denied Claims Reason Code file</td></tr>
<tr><td>74</td><td>Correction to a claim that is not in MH DW</td></tr>
</table>
* Specific for denied claims only
</td><td>Alla Kamenetsky</td></tr>
<tr><td>01/25/2017</td><td>
In Service Data segment
a) Field # 7 renamed to “Place Holder for Pricing Indicator” (Former “Filler”)
b) Field # 13 renamed to “Submission Clarification Code”– (Former “Filler”)
c) Field # 31 “Revenue Code” less than 4 digit codes should be entered with leading zeros.
d) “Place of Service” and “Type of Bill” values are submitted in separate fields now:
#32 “Place Of Service”;
#33 “Type of Bill” – (Former “Place of Service Type”)
e) Field #33 “Type of Bill” should be sent in 3 digit format including Frequency as 3rd digit.
f) Field # 35 renamed to “FILLER” (Former “Type of Service”, which is no longer required).
g) Added Value “Other” to Field #9 “”Recipient Gender” in Encounter Data Set Elements;
Field # 9 “Member Gender” in Member File Layout ”
</td><td>Alla Kamenetsky</td></tr>
<tr><td>09/09/2016</td><td>
<u>I. In Data Elements Clarifications (section 2.0):</u>
1. Introduced new Inpatient Claim logic for the claims with DOS on or after October 1, 2016.
<u>II. In Table I-B “Service Category (Using the SCO reporting groups)”</u>
Replaced “100” series values with
‘300’ series values.
New Service Categories are in Table I-B1;
Old Service Categories are in Table I-B2.
</td><td>Alla Kamenetsky</td></tr>
<tr><td>01/11/2016</td><td>
I. In Additional Reference Data Set Elements (Section 3.4):
Table Services Data Set Elements Added 5 new fields – MBHP specific.
Additional Reference Data Layout (Section 4.5)
Table Services Data Set Layout
Added 5 new fields – MBHP specific.
II. Added information about new BMC SCO to the list of all SCOs throughout the document.
III. Replaced ICD-9-CM with ICD throughout the document.
</td><td>Alla Kamenetsky</td></tr>
<tr><td>09/29/2015</td><td>
I. In Data Elements Clarifications (section 2.0):
1. Changed Inpatient Claim logic back to the old definition.
II. In Encounter Data Set Elements (section 3.0):
1. Changed field #7 description back to “Filler”.
2. “New Member ID” (field#76) - missing or invalid value in this field will be considered as a fatal error resulting in rejection of the record.
III. In 3.1 Provider Data Set:
1. Edited File Processing section
2. Added a list of the fields that are 100% required to be complete with valid values on all the records.
</td><td></td></tr>
</table>

Date	Description	Author
	3. Removed proposed "Health Policy Commission Registered Provider Organization ID (RPO)" (field#35). 4. Updated definition of "APCD ORG ID" (field#34) **IV**. ***In 4.0 Encounter Record Layout*** The length of "Recipient ZIP Code"(field #10) remains 5 N. **V**. ***In 8.0 Quantity and Quality Edits, Reasonability and Validity Checks*** **Updated definitions of MassHealth Standards in**: -"Admission Date'' (field#15) -"Discharge Date''(field#16) -''Type of Admission" (field#24) -"Source of Admission" (field#25) -"Place of Service" (field#32) -"Patient Discharge Status" (field#34) -"Days Supply" (field#39) -"Refill Indicator" (field#40) -"Dispense as Written Indicator" (field#41) -"Admitting Diagnosis" (field#85) -"ICD Version Qualifier" (field#193)	
08/31/2015	***I. In Data Elements Clarifications (section 2.0):*** 1. Added Capitation Payments clarification. **2**. Updated Inpatient Claim clarification ***II. In Encounter Data Set Elements (section 3.0):*** **1**. "Claim Category" (field #2) removed option "7 = Other (should be rarely used)" **2.** Changed definition of "Plan Identifier" (field #4) o. **3**. Replaced "Filler" (field #7) with "Header / Detail Claim Line Indicator" **6**.**Updated definitions of** : "Admission Date"(field#15) "Discharge Date" (field#16) "Type of Admission" (field#24) "Source of Admission"(field#25) ''Procedure Code'' (field #26), ''Procedure Code Indicator" (field #30)'' "Revenue Code" (field# 31) "Place of Service" (field # 32) Place of Service Type" (field#33) "Patient Discharge Status" (field#34) "Quantity" (field#36) "NDC Number" (field# 37) "Metric Quantity" (field #38) "Dispense As Written Indicator'' (field#41) "DRG" (field#72) "Prescribing Prov. ID" (field#81) "DRG Severity of Illness Level" (field#122) "DRG Risk of Mortality Level" (field#123) **III.** I***n 3.2 Provider Data Set:*** 1, Added "File Processing" paragraph. 2. Updated definitions of: "Provider ID" (field#2) "Medicaid Number" (field#5) "Provider Last Name" (field#6) "Provider Fist Name" (field#7) "Provider Type" (field16) "Social Security Number" (field#28) "Tax ID Number" (field#30) **Added two new fields:** "APCD ORG ID" (field#34) and "Health Policy Commission Registered Provider Organization ID (RPO)" (field#35). ***IV. In 4.0 Encounter Record Layout***	Rima Kayyali Alla Kamenetsky

Date	Description	Author
	1. Replaced "Filler" (field #7) with "Header / Detail Claim Line Indicator". 2. Increased fields length: "Recipient ZIP Code" (field#10) from 5 N to 9 N; "Quantity" (field#36) from 5 N to 9 N; "Metric Quantity" (field#38) from 5N to 9 N ***V. In 4.1 Provider Record Layout*** 1. Increased fields length: "Provider Last Name" (Field # 6) from 30 C to 200 C "Provider Fist Name" (Field#7) from 30 C t0 100 C 2. Added two new fields: "APCD ORG ID" (field 34) – 6 C "Health Policy Commission registered Provider Organization ID (RPO)" (field#35) – 30 C ***In Table B* "Source of Admission (UB)"** Added values A-F ***In Table G* "*Servicing Provider type"*** removed option "-4 -Incomplete/No information". **VI**. ***In 8.0 Quantity and Quality Edits, Reasonability and Validity Checks*** 1.Replaced "Filler" with "Header / Detail Claim Line Indicator" (field#7) 2, Updated definitions of MassHealth Standards in: "Admission Date'' (field#15) '\Discharge Date''(field#16) ''From Service Date''(field#17) ''To Service Date" (field#18) ''Primary Diagnosis" (field#19) ''Type of Admission" (field24) "Source of Admission" (field25) "Procedure Code" (field26) "Revenue Code" (field 31) "Place of Service" (field 32) "Place of Service Type" (field 33) "Patient Discharge Status" (field 34) "Quantity" (field#36) "Servicing Provider ID" (field#50) ''Billing Provider ID'' (field#58) "DRG" (field#72) "New Member ID" (field#76) "Prescribing Prov. ID" (field#81) "Date Script Written" (field#82) "Admitting Diagnosis" (field#85) "Frequency" (field#91) "ICD Version Qualifier" (field#193)	
04/15/2015	1. Updated a name of Monthly Financial Report in the examples with the current dates on pgs. 62-63.	Alla Kamenetsky
10/30/2014	1. Added reference to One Care-ICO 2. Changed Instructions on Monthly Financial Report. pg62-63 3.Changed format of Provider_IDs paragraph on pg.10 4. Changed length value in field #86 to 9. pg.47 5. Changed length value in field #12 to 10. pg.55. 6. Changed format of zip file name. pgs. 59-60 7. Added Table I-C "Service Category (Using the One Care - ICO reporting groups)" pg.92	Alla Kamenetsky

Date	Description	Author
4/23/2014	1. Added clarification in section 2.0 (Diagnosis Codes). 2. Added clarification in section 8.0 on validation of ICD Version Qualifier (Field # 193), ICD Diagnosis and ICD Procedure codes	Rima Kayyali
12/31/2013	Deleted ICO Reference	Rima Kayyali
12/17/2013	Added value "5" for CarePlus population to field Group Number (field # 71)	Rima Kayyali
11/26/2013	Updated Appendix C (Section 9.3) for Member Enrollment File Specifications	Rima Kayyali
8/13/2013	Added Appendix C in Section 9.3 for Member Enrollment File Specifications	Rima Kayyali
4/26/2013	1. Changed Encounter Data files submission requirement from fixed-length files to Pipe-delimited text files (delimiter=|) - Section 6.0 2. Modified Table I – B (SCO Service Category) – Section 7.0 3. Added an appendix for Provider Data File Guidelines – Section 9.0 4. Modified "Inpatient Claim" Clarification – Section 2.0 5. Added "Administrative Fees" Clarification – Section 2.0 6. Added a value of '0' to "Primary Care Eligibility Indicator" field # 33 in Provider Data set – Section 3.1 7. Added a clarifying note to "Rate Increase Indicator" Field # 200 – Section 3.0 8. Clarified that the monthly financial report should include both MH and Compare Populations (Section 1.1), and that it should be submitted subsequent to submission of Manual Override (Section 6.0)	Rima Kayyali
2/21/2013	Modified Provider Data Record Layout, MCE Internal Provider Type and Metadata	Rima Kayyali
1/17/2013	Modified based on feedback received from MCE in 1/17/2013 meeting	Rima Kayyali
1/15/2013	Added Flags for "ACA 1202 Rate Increase" eligibility	Rima Kayyali
11/05/2012	Final Updates	Rima Kayyali
8/16/2012	Updates Based on Meeting Discussions	Rima Kayyali
6/6/2012	Updated Encounter Data Set Elements with additional fields. Updated Tables.	Rima Kayyali
11/22/2010	Added more detailed descriptions	Kelly Zeeh

Table of Contents

Acronyms

ACO	Accountable Care Organization
DW	Data Warehouse
EOHHS	Executive Office of Health and Human Services
MBHP	Mass Behavioral Health Plan
MCE	Managed Care Entity (MCO, SCO, One Care, and MBHP collectively)
MCO	Managed Care Organization
MH	MassHealth
PCC	Primary Care Center
PIDSL	Provider ID Service Location
SCO	Senior Care Organization

1.0 Introduction

MassHealth Data Warehouse was required to build and maintain a database of health care services provided to Massachusetts Medicaid recipients enrolled in managed care programs. EHS is using the database for a number of different projects including Centers for Medicare and Medicaid Services (CMS, formerly HCFA) reporting, program evaluation, and rate development. It is critical that each Managed Care Entity (ACO/MCO, MBHP, SCO, and One Care) provides EHS DW with records accurately reflecting all encounters provided to Medicaid recipients enrolled in MCEs' managed care program. Only with complete and accurate encounter data MassHealth is able to assess the effectiveness of the managed care program.

With the implementation of the ACO project, all MCEs are required to submit extended encounter information on paid claims and related data. Encounters for both, MCO and ACO, should be submitted in the same file.

For denied claims submissions, please see denied claims specifications document.

All the plans, including SCO and One Care plans should follow the new file format in their submissions.

MassHealth expects the MCEs to provide new, replacement, and void claims in each submission. MassHealth processes the data and returns rejected claims to the MCEs with the appropriate error codes. MCEs are expected to correct the offending claims and send them in a correction file within a week. **The submission-rejection-resubmission cycle has to be completed within a month of submission**. The number of rejected claims must be below a MassHealth defined threshold.
If you cannot submit data in this fashion, or if you have any questions about any of these documents, please contact Alla Kamenetsky at *Alla.Kamenetsky@state.ma.us*

1.1 Data Requirements

- The data referred to in this document are encounter data - records of health care services performed for Massachusetts Medicaid managed care beneficiaries. An encounter is defined as a unique service or procedure performed for a recipient. Multiple encounters can occur during a single visit to a provider, and each encounter should have a separate encounter record.

  - Send all fully adjudicated paid claims. All claims should reflect the final status of the claim on the date it is pulled.

  - Submit one encounter record for each service performed (i.e., if a claim consisted of five services, each service should have a separate encounter record).

  - Data should conform to the Record Layout specified later in this document. Any deviations from this format must be approved by EHS.

  - **Each row in a submitted file should have a unique Claim Number + Suffix combination.**

  - Only Paid claim lines should be submitted.

  - A feed should consist of new (original) claims, amendments, replacements and voids.
    The replacements and voids should have a former claim number and former suffix to associate them with the claim+suffix they are voiding or replacing.

  - The association of the adjustments and voids to the ACO claims will be based on the date of service, so there will not be a situation where the original claim is associated with an ACO and the adjustment - with an MCO and vice versa.
  -
  - MCO claims where "From Service Date" is prior to 03/01/2018, the value of MCO PIDSL should be entered in "Entity PIDSL" field (#3)

  - While processing the submission, MassHealth scans the files for the errors and returns error reports in the format of the input file with extra two columns to indicate an error code and the field with the error. MCEs should correct the errors and resubmit the records within a week from the date the file was loaded.

1.2 How to Use this Document

This *Encounter Data Set Request* is intended as a reference document. Its purpose is to identify the data elements that MassHealth needs to load into encounter database. The goal of this document is to clarify the standard record layout, format, and values that MassHealth will accept.

Data Element Clarifications

In 2.0 "Data Set Clarification" section provides clarifications and expectations on data elements like DRG, Diagnosis Codes, Procedure Codes, and Provider IDs.

Data Elements

The information contained in the Data Elements sections defines each of the fields included in the record layout. When appropriate, a list of valid values is included there. Nationally recognized coding schemes have been used whenever they exist.

Encounter Record Layout

Section 4.0 "Encounter Record Layout" specifies encounter file layout. All the MCEs must use that format when compiling the Encounter Data file that might contain all or any Claim Category (facility, professional, dental, etc.). MassHealth requests that the encounter data file is provided in a pipe-delimited text file with each service on a separate line.
Contact MassHealth if you need further clarification.

Media Requirements and Data Formats

Section 6.0 "Media Requirements and Data Formats" contains complete information about all the files that should be submitted to EHS DW. MCEs submit their data to MassHealth through a secure FTP server. Each MCE has a home directory on this server and is given an ID with public key/private key-based login. Please also note the security requirements for Internet transmissions noted in the Media Requirements section.

Standard Data Values

Section 7.0 "Standard Data Values" contains tables referenced in the specific fields of the Data Elements section (Tables A through H).

Data Quality Checks

This section within 8.0 "Quantity and Quality Edits, Reasonability and Validity Checks" provides the validity and quality criteria that encounter data are expected to meet.

2.0 Data Element Clarifications

MassHealth has identified several data elements that require further clarification with respect to the expectations for those elements. The information in this section details MassHealth's expectations for Recipient Identifiers, Provider IDs, DRG, Diagnosis Codes (primary through fifth), and Procedure Codes.

Member Ids
Encounter data records must include MassHealth member IDs that are "active" as of the time of data submission.

Provider Ids
MassHealth is asking plans to provide an identifier that is unique to the plan. The acceptable ID types are:

ID Type	ID Description	Comments
1	NPI	Accepted for any provider including Referring and Prescribing Provider IDs. Note: MassHealth expects MCEs to submit MCE Internal ID in Provider IDs and use NPI as a Provider ID only when necessary and when an internal ID is not available. When NPI is used in Provider ID fields, provider file must have it entered in Field #2 (Provider ID) and in field #26 (NPI). Field #26 (NPI) must also be populated for all other Provider ID types except when it's not available, like in the case of atypical providers.
6	MCE Internal ID	Accepted for any provider
8	DEA Number	Should be used with pharmacy claims only
9	NABP Number	Should be used with pharmacy claims only

- All the provider attributes should be filled out in the provider file as much as possible.
- The Provider ID, Provider ID Type, and Provider ID Location Code should be 100 % present on all provider records.
- 100% of Pharmacy and Physician-Administered Drugs claims must have Billing Provider NPI numbers in provider file
- At least 80% of all the records in submission should have NPI numbers included
- At least 80% of all the records in submission should have Provider Type entered.
- All the provider records in provider file, which are part of the PCC enrollment with MCE, need to have PCC details on the same line**.**

NPI
The Centers for Medicare & Medicaid Services (CMS) require all Medicare and Medicaid providers and suppliers of medical services that qualify for a National Provider Identifier (NPI) to include NPI on all claims. Type 1 NPI is for Health care providers who are individuals, including physicians, psychiatrists and all sole proprietors. Type 2 NPI is for Health care providers that are organizations, including physician groups, hospitals, nursing homes, and the corporations formed when an individual incorporates him/herself.

MCEs should submit the individual NPI (Type1) for Servicing/Rendering, Referring, Prescribing, and Primary Care Providers in Provider file. MCEs should submit individual (Type 1) or group (Type 2) NPI for billing providers and PCCs.

MH DW will closely monitor submission of servicing/rendering, billing, and referring provider NPI numbers in Provider File. With a change of the business rules, claims with missing NPI numbers in Provider File might be rejected. Plans will be notified about the change ahead of time.
The above does not apply to "atypical" providers.

DRG
The DRG field (field #72) is a field requested by CMS. Not all plans collect DRGs so MassHealth has developed a preferred course of action:

1. A plan that collects DRGs- should provide DRG values in data submissions.
2. A plan that does not collect DRGs, should ensure that primary, secondary, and tertiary diagnosis values are as complete and accurate as possible, so that MassHealth may use a DRG grouper if necessary. Accurate procedure codes are also required for DRG assignment.
3. In the future, MassHealth may request that all plans provide DRGs.
4. MassHealth requests from MCEs that report DRGs to also report in DRG related fields: DRG Type, DRG Version, Severity of Illness level, and Risk of Mortality.

Diagnosis Codes
Requirements for validity and completeness are detailed in the ICD clinical guide that is published by the American Medical Association. Current validating process at MH DW requires that diagnosis codes contain the required number of digits outlined in the ICD code books.

At least one diagnosis code (in Primary Diagnosis field #19) is required for all provider type encounters as specified in section 8.0.
The values in all other Diagnosis fields listed in Data Elements section should be submitted when available.

Procedure Code
Many plans accept and use non-standard codes such as State specific and MCE specific codes. Current validating process at EHS DW looks for standard codes only - CPT, HCPCS, and ADA.

HIPPAA regulations require that only standard HCPCS Level I (CPT) and II be used for reporting and data exchange.
The only field containing procedure codes is the Procedure Code field (field #26).

Capitation Payments
Capitation payment arrangement refers to a periodic payment per member, paid in advance to health care providers for the delivery of covered services to each enrolled member assigned to them. The same amount is paid for each period regardless of whether the member receives the services during that period or not.
Note: Capitation payment is not "Bundled" payment, which is usually paid for Episodes of care or other bundled services.

Dollar Amounts
MassHealth wants to ensure that the dollar amounts on the individual lines of the claim represent the actual or computed amounts associated with each encounter. Therefore, whenever dollar amounts are not included at the detail level, and the summary-level line is not available, the MCE should add an extra detail line with a Record Indicator of 0 and report all summary-level amounts/quantities on that line. If the summary-level line is already available in the MCE's source system and is not artificially created, then it should have a Record Indicator 6 (Bundled Summary-Level line) **unless** other Record Indicator values apply (like, for example, 5 for DRG).
All detail lines with 0 dollar amounts (that are **not** artificially created and are **not** summary-level lines) should have any value **other than 0 or 6** placed in Record Indicator field. In such case, MCE decides on the value based on the definition of the Record Indicator in the table below.

For the claims covered by the capitation payments, MCEs must report either FFS equivalent amounts or amounts reported by the provider/vendor on their claims and use Record Indicator values 2 or 3 to indicate the type of payment arrangement.

Record Indicator Table:

Record Indicator	Dollar Amount Split
0: Artificial Line	Dollar amounts / quantities represent numbers that are available only at a summary level.
1: Fee-For-Service	Dollar amounts should be available at the detail line level in the source system.
2: Encounter Record with FFS equivalent	Dollar amounts should be available at the detail line level in the source system for a service provided under a capitation arrangement
3: Encounter Record w/out FFS equivalent	Dollar amount, if any, as reported by the provider or vendor to the MCE for a service provided under a capitation arrangement
4: Per Diem Payment	Total dollar amount for the entire stay. This is not the per-diem rate but the per-diem rate multiplied by the Quantity [numbers of days of inpatient admission. See Quantity]. If the amount applies to all lines on the claim, the claim must bring in a record with indicator = 0.
5: DRG Payment	Total dollar amount for the entire stay. If the amount applies to all lines on the claim, the claim must bring in a record with indicator = 0.
6: Bundled Summary-Level Line	Total dollar amount for a bundled summary-level claim line where the dollar amounts represent numbers that are available only at a summary line level in the source system and is not artificially created. A record with indicator = 6 for a **summary-level line of a bundled claim is used when none of the above payment arrangements apply**
7: Bundled detail line with 0 dollar amount	A bundled detail claim line where the dollar amounts are 0 or not available at the detail level. A record with indicator = 7 is used for a **detail-level line of a bundled claim when none of the above payment arrangements apply**

Below are few examples of possible scenarios for Record Indictor values:

Example 1 - Artificial Line 0 and Detail Lines with Record Indicator 4:

Claim Number	Claim Suffix	Record Indicator	Payment Amount
44444444444	1	4 - Per Diem Payment	0
44444444444	2	4 - Per Diem Payment	0
44444444444	3	4 - Per Diem Payment	0
44444444444	4	4 - Per Diem Payment	0
44444444444	5	0 - Artificial Line: dollar amounts available at summary level only	260

Example 2 - Artificial Line 0 and Detail Lines with Record Indicator 7:

Claim Number	Claim Suffix	Record Indicator	Payment Amount
55555555555	1	7 - Bundled detail line with 0 dollar amount	0
55555555555	2	7 - Bundled detail line with 0 dollar amount	0
55555555555	3	0 - Artificial Line: dollar amounts available at summary level only	100

Example 3 – Bundled Summary Line 6 and Detail Lines with Record Indicator 7:

Claim Number	Claim Suffix	Record Indicator	Payment Amount
66666666666	1	7 - Bundled detail line with 0 dollar amount	0
66666666666	2	7 - Bundled detail line with 0 dollar amount	0
66666666666	3	6 - Bundled Summary-Level Line	500

Example 4 – Bundled Summary Line 6 and Detail Lines with Record Indicator 1:

Claim Number	Claim Suffix	Record Indicator	Payment Amount
22222222222	1	1 - Fee-For-Service	0
22222222222	2	1 - Fee-For-Service	0
22222222222	3	6 - Bundled Summary-Level Line	500

Claim Number & Suffix
Every Original / Void or Replacement claim submitted to MassHealth should have a new claim number + suffix combination. There can be no duplicate claim number + claim suffix in one feed

Former Claim Number & Suffix
In order to void or replace old transactions, MassHealth requires for all the MCEs to add former claim number and former claim suffix to the claim lines of record type 'R', 'V'. The objective is to get a snapshot of the claims at the end of each period after all debit or credit transactions have been applied to them.

Examples:

Adjustments:

Claim Payer	Claim Number	Claim Suffix	Claim Category	Record Type	Former Claim Number	Former Claim Suffix	Payment Amount
XXX	11111111111	4	1	O			10
XXX	33333333333	4	1	R	11111111111	4	20
XXX	88888888888	4	1	R	33333333333	4	25

Voids:

Claim Payer	Claim Number	Claim Suffix	Claim Category	Record Type	Former Claim Number	Former Claim Suffix	Payment Amount
XXX	66666666666	1	1	O			15
XXX	77777777777	2	1	V	66666666666	1	10
XXX	99999999999	1	1	O			30

Record Creation Date
This is the date on which the claim was created in the MCE's database. If a replacement record represents the final result of multiple adjustments to a claim between submissions, Record Creation Date is the date of the last adjustment to that claim. For encounter records where Record Indicator value is 2 or 3, Record Creation Date should be the same as the Paid Date.

Inpatient Claim

Old, pre-November 2016, DW Logic
MassHealth applies a modified logic on encounter data to identify "Inpatient" claims. This new logic is an internal change that does not affect the encounter data submission process and only applies to the claims with "**From Service Date**" (field# 17) on or after October 1, 2016.

New DW Logic
Claims with Claim Category = 1 (Facility except LTC) and **Type of Bill** values **11x and 41x** are defined as "Inpatient". All other claims with Claim category = 1 are defined as "Outpatient".

LTC Claims
Claims with Claim Category = 6 (Long Term Care - Nursing Home, Chronic Care & Rehab) are defined as "**LTC**". MCEs should ***continue*** sending all "Long Term Care" claims with Claim Category='6'.

Physician-Administered Drug Claim Definition
Claims with Claim Category 1 (Facility except LTC) or 2 (Professional) and value in "NDC Number" field (#37).

Administrative Fees

Administrative Fees such as PBM fees should not be reported in the encounter data as part of the "Net Payment Amount". MCEs should inform EOHHS of any arrangement where these fees are included in their claims processing, and should work with their PBM or other agencies to separate out the administrative fees from the encounter cost component in their claim processing**.**

Bundle Indicator, Claim Number & Suffix

The Bundle indicator is a Y/N field to indicate that the claim line is part of a bundle. This indicator should always be 'Y' for **all** bundled claims (see example 1 and 2). The Bundle Claim Number and Suffix refer to the claim number and the claim suffix of the claim line with the bundled payment. The examples below illustrate how these two fields should be populated. Example 1 illustrates a scenario with one bundle within a claim, Example 2 illustrates a scenario with multiple bundles within a claim, and Example 3 illustrates a scenario with one bundle across multiple claims.

The assumption is that when a bundled claim line gets adjusted, all bundled claim lines for that claim would be adjusted as well. Please see Examples 4 and 5 below for scenarios where there is an adjustment of a bundled claim. MCE should leave the Bundle claim number and suffix blank when this assumption is inaccurate and when they do not have this information. However, these two fields are expected when MCE have this information in their system. Bundle Indicator should be provided on all bundled claims with no exception.

Example 1 – One Bundle per Claim Number:

Claim Payer	Claim Number	Claim Suffix	Bundle Ind	Bundle Claim Number	Bundle Claim Suffix	Payment Amount
XXX	AAAAAAAA	1	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	2	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	3	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	4	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	5	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	6	Y	AAAAAAAA	6	120

Example 2 – Two Bundles per Claim Number:

Claim Payer	Claim Number	Claim Suffix	Bundle Ind	Bundle Claim Number	Bundle Claim Suffix	Payment Amount
XXX	CCCCCCCC	1	Y	CCCCCCCC	3	0
XXX	CCCCCCCC	2	Y	CCCCCCCC	3	0
XXX	CCCCCCCC	3	Y	CCCCCCCC	3	60
XXX	CCCCCCCC	4	Y	CCCCCCCC	6	0
XXX	CCCCCCCC	5	Y	CCCCCCCC	6	0
XXX	CCCCCCCC	6	Y	CCCCCCCC	6	80

Example 3 One Bundle for Two Claim Numbers:

Claim Payer	Claim Number	Claim Suffix	Bundle Claim Number	Bundle Claim Suffix	Payment Amount
XXX	DDDDDDDD	1	NNNNNNNN	1	0
XXX	DDDDDDDD	2	NNNNNNNN	1	0
XXX	DDDDDDDD	3	NNNNNNNN	1	0
XXX	NNNNNNNN	1	NNNNNNNN	1	50

Example 4 – Adjustment/Void of Bundled Claims with Record Indicator 0:

Claim Payer	Claim Number	Claim Suffix	Record Type	Former Claim Number	Former Claim Suffix	Bundle Claim Number	Bundle Claim Suffix	Payment Amount	Record Indicator	Procedure Code
XXX	44444444444	1	O			44444444444	4	0	4	96360
XXX	44444444444	2	O			44444444444	4	0	4	96375
XXX	44444444444	3	O			44444444444	4	0	4	96376
XXX	44444444444	4	O			44444444444	4	260	0	96366
XXX	55555555555	1	R	44444444444	1	55555555555	4	0	4	96360
XXX	55555555555	2	V	44444444444	2	55555555555	4	0	4	96375
XXX	55555555555	3	R	44444444444	3	55555555555	4	0	4	96376
XXX	55555555555	4	R	44444444444	4	55555555555	4	200	0	96366

Example 5 – Adjustment/Void of Bundled Claims with Record Indicator 6:

Claim Payer	Claim Number	Claim Suffix	Record Type	Former Claim Number	Former Claim Suffix	Bundle Claim Number	Bundle Claim Suffix	Payment Amount	Record Indicator	Procedure Code
XXX	66666666666	1	O			66666666666	3	0	7	96375
XXX	66666666666	2	O			66666666666	3	0	7	96376
XXX	66666666666	3	O			66666666666	3	500	6	96366
XXX	77777777777	1	R	66666666666	1	77777777777	3	0	7	96375
XXX	77777777777	2	V	66666666666	2	77777777777	3	0	7	96376
XXX	77777777777	3	R	66666666666	3	77777777777	3	400	6	96366

Submission Clarification Code

420-DK-Code indicating that the pharmacist is clarifying the submission.
MassHealth recognizes that submission clarification code value 20 indicates that prior to providing service, the pharmacy has determined the product being billed is purchased pursuant to right available under Section 340B of the Public Health Act of 1992 including sub-celling purchases authorized by section 340B(a)(10) and those made though the Prime Vendor Program 340B(a)(8).

For additional information about submission clarification code values, please refer to the NCPDP standards.

Provider ID submission in Encounter and Provider Files

Among several new elements introduced in Version 4.6 of the current document were Provider ID Address Location Code fields.

The values in the Provider ID, Provider ID Type, and Provider ID Address Location fields entered in claims file should match the values in corresponding fields of the provider file.

Example:

Claims File

Entity PIDSL	Claim Number	Claim Suffix	Servicing Provider ID	Servicing Provider ID Type	Servicing Provider ID Address Location Code
999999999R	98765432WS	1	1234569	6	A
999999999R	23568974RV	1	1234568	6	B
999999999R	741852969K	1	1234567	6	C
999999999R	369874123L	1	1234566	6	D

Provider File

Entity PIDSL	Provider ID	Provider ID Type	Address Location Code	Provider Bundle ID	Provider Last Name
999999999R	1234569	6	A	65656	Smith
999999999R	1234568	6	B	65656	Smith
999999999R	1234567	6	C	65656	Smith
999999999R	1234566	6	D	65656	Smith

3.0 Encounter Data Set Elements with Record Layout

Data Elements

This section contains field names and definitions for the encounter record. It is divided into five sections:

- Demographic Data
- Service Data
- Provider Data
- Financial Data
- Medicaid Program-Specific Data

For the fields that contain codified values (e.g. Patient Status), we use national standard (e.g. UB92 coding standards) values whenever possible.
In the table below 'X' indicates a Claim Category the data element is applicable in. The columns are labeled as:

- H – Facility (*except Long Term Care*)
- P – Professional
- L – Long Term Care
- R – Prescription Drug
- D – Dental

Programs with withhold amount
Some Managed Care programs include withhold risk-sharing arrangements with their providers when a portion of the approved payment amount is withheld from the provider payment amount and placed in a risk-sharing pool for later distribution. In such case, the withheld amount should be recorded in a separate field "Withhold Amount" (#69) and included in the amounts in the Eligible Charges and "Net Payment" (#68) fields.

Demographic Data

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization. **Code that identifies your Organization :** **ACO/MCO** 465 Fallon Community Health Plan 469 Neighborhood Health Plan 997 Boston Medical Center HealthNet Plan 998 Network Health 999 Massachusetts Behavioral Health Partnership 470 CeltiCare 471 Health New England **SCO** 501 Commonwealth Care Alliance 502 UnitedHealthCare 503 NaviCare 504 Senior Whole Health 505 Tufts Health Plan 506 BMC HealthNet Plan **One Care** 601 Commonwealth Care Alliance 602 Network Health 603 Fallon Total	X	X	X	X	X	3	N

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
2	Claim Category	A code indicating the category of this claim. Valid values are: 1 = Facility (*except Long Term Care*) 2 = Professional (includes transportation claims) 3 = Dental 4 = Vision 5 = Prescription Drug 6 = Long Term Care *(Nursing Home, Chronic Care & Rehab)*	X	X	X	X	X	1	C
3	Entity PIDSL	ACO PIDSL on the ACO claims (an ACO with which a PCC is contracted with) or MCO PIDSL on the MCO claims or One Care Plan PIDSL on One Care claims or SCO PIDSL for SCO claims *Example*: 999999999A	X	X	X	X	X	10	C
4	Record Indicator	This information refers to the payment arrangement under which the rendering provider was paid. Value identifies whether the record was a fee-for-service claim, or a service provided under a capitation arrangement (encounter records). For encounter records, indicate whether or not there are Fee-For-Service (FFS) equivalents and payment amounts on the record. 0 Artificial record – Refers to a line item inserted to hold amounts / quantities available only at a summary (claim) level. 1 Claim Record – Refers to a claim paid on a Fee-For-Service (FFS) basis 2 Encounter Record with FFS equivalent - Refers to services provided under a capitation arrangement and for which a FFS equivalent is given 3 Encounter Record w/out FFS equivalent - Refers to services provided under a capitation arrangement but for which no FFS equivalent is available 4 Per Diem Payment - Refers to a record for an inpatient stay paid on a per diem basis. 5 DRG Payment - Refers to a record for an inpatient stay paid on a DRG basis 6 Bundled Summary-Level Line – Refers to a record with a bundled summary-level amounts/quantities as available in the MCE source system. Use this value when none of the above values apply. 7 Bundled detail line with 0 dollar amount – Refers to a bundled detail claim line where the dollar amounts are 0 or not available at the detail level. Use this value when none of the above values apply	X	X	X	X	X	1	C

		See discussion under Dollar Amounts in the Data Elements Clarification Section.							
#	**Field Name**	**Definition/Description**	**H**	**P**	**L**	**R**	**D**	**Length**	**Data Type**
5	Claim Number	A unique number assigned by the administrator to this claim (e.g., ICN, TCN, DCN). It is very important to include a Claim Number on each record since this will be the key to summarizing from the service detail to the claim level. ***See discussion under Claim Number/Suffix in the Data Elements Clarification Section***	X	X	X	X	X	15	C
6	Claim Suffix	This field identifies the line or sequence number in a claim with multiple service lines. ***See discussion under Claim Number/Suffix in the Data Elements Clarification Section***	X	X	X	X	X	4	C
7	Pricing Indicator	Pricing Indicator; currently it is a subject of internal discussion. MCEs will be notified when decision is made.						20	C
8	Recipient DOB	The birth date of the patient expressed as YYYYMMDD. For example, August 31, 1954 would be coded "19540831".	X	X	X	X	X	8	D/YYYYMMDD
9	Recipient Gender	The gender of the patient: 1 = Male 2 = Female 3 = Other	X	X	X	X	X	1	C
10	Recipient ZIP Code	The ZIP Code of the patient's residence as of the date of service.	X	X	X	X	X	5	N
11	Medicare Code	A code indicating if Medicare coverage applies and, if so, the type of Medicare coverage. Medicare code should indicate what part of Medicare is being used to cover the services billed within the claim, NOT all of the parts of Medicare that the member is enrolled in. 0= No Medicare 1 = Part A Only 2 = Part B Only 3 = Part A and B **4 = Part D Only** **5 = Part A and D** **6 = Part B and D** **7 = Part A, B, and D**	X	X	X	X	X	1	N

Service Data

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
12	Other Insurance Code	A Yes/No flag that indicates whether or not third party liability exists. 1 = Yes; 2 = No	X	X	X	X	X	1	C
13	Submission Clarification Code	420-DK- Code indicating that the pharmacist is clarifying the submission. Please refer to *Segment "2.0 Data Element Clarifications"* for the details.				X		7	N
14	Claim Type	MBHP Specific field	X	X	X	X	X	18	C
15	Admission Date	For facility services, the date the recipient was admitted to the facility. The format is YYYYMMDD.	X		X				
16	Discharge Date	For facility services, the date the recipient was discharged from the facility. The format is YYYYMMDD. Cannot be prior to Admission Date.	X		X			8	D/YYYY MMDD
17	From Service Date	The actual date the service was rendered; if services were rendered over a period of time, this is the date of the first service for this record. The format is YYYYMMDD.	X	X	X	X	X	8	D/YYYY MMDD
18	To Service Date	The last date on which a service was rendered for this record. The format is YYYYMMDD.	X	X	X		X	8	D/YYYY MMDD
19	Primary Diagnosis	The ICD diagnosis code chiefly responsible for the hospital confinement or service provided. The code should be left justified, coded to the fifth digit when applicable (blank filled when less than five digits are applicable). *DO NOT include decimal points in the code.* ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		X	7	C/ No decimal points (780.31 must be entered as 78031)
20	Secondary Diagnosis	The ICD diagnosis code explaining a secondary or complicating condition for the service. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/ No decimal points
21	Tertiary Diagnosis	The tertiary ICD diagnosis code. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/ No decimal points
22	Diagnosis 4	The fourth ICD diagnosis code. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/ No decimal points
23	Diagnosis 5	The fifth ICD diagnosis code. See above for format. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/ No decimal points
24	Type of Admission	Should be valid and present on all Hospital and Long Term Care claims with hospital admission. For the UB standard values see Table A.	X		X			1	C
25	Source of Admission	Should be valid and present on all Hospital and Long Term Care claims with hospital admission. For the UB standard values see Table B	X		X			1	C

Service Data (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
26	Procedure Code	A code explaining the procedure performed. This code may be any valid code included in the coding systems identified in the Procedure Type field below. *Any internal coding systems used must be translated to one of the coding systems identified in field* ***#30*** *below.* Should not contain ICD procedure codes. All ICD procedure codes should be submitted in the surgical procedure code fields (#101 – #113) ***including the ICD-treatment procedure codes*** ***See discussion in Data Element Clarifications section.***	X	X	X		X	6	C
27	Procedure Modifier 1	A current procedure code modifier (CPT or HCPCS) corresponding to the procedure coding system used, when applicable.	X	X	X		X	2	C
28	Procedure Modifier 2	Second procedure code modifier, required, if used.	X	X	X		X	2	C
29	Procedure Modifier 3	Third procedure code modifier, required, if used.	X	X	X		X	2	C
30	Procedure Code Indicator	A code identifying the type of procedure code used in field#26: 2= CPT or HCPCS Level 1 Code 3= HCPCS Level II Code 4= HCPCS Level III Code (State Medicare code). 5= American Dental Association (ADA) Procedure Code (Also referred to as CDT code.) 6= State defined Procedure Code 7= Plan specific Procedure Code ICD procedure codes should go in Surgical Procedure code fields (Field # 103 – 111) *State defined procedure codes should be used, when coded, for services such as EPSDT procedures.* ***See discussion in the Data Element Clarifications section.***	X	X	X		X	1	N
31	Revenue Code	For facility services, the UB Revenue Code associated with the service. *Only standard UB92 Revenue Codes values are allowed; plans may* ***not*** *use "in house" codes. Values should be sent in 4 digit format. Revenue codes less than 4 digits long should be submitted with leading zeros. For Example:* *a. Revenue code -1 - as '0001';* *b. Revenue Code 23 - as '0023;* *c. Revenue code 100 - as '0100';* *d. Revenue Code 2100 – as '2100'.*	X		X			4	C
32	Place of Service	This field hosts Place of Service (POS) that comes on the Professional claim). See Table C for CMS 1500 standard		X			X	2	C

Service Data (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
33	Type Of Bill	For encounter data supporting UB claims submission the Type of Bill is submitted as a 3-digit bill type in accordance with national billing guideline. The first two digits denote the place of services and the third digits denotes the frequency. See Table D for UB Type of Bill values indicating place. ***Note*:** for UB Type of Bill, use the 1st and 2nd positions only.) Frequency values can be found in Table K and are documented in field # ***91 as well.***	X		X			3	C
34	Patient Discharge Status	This is 2-digit Discharge Status Code (UB Patient Status) for hospital admissions. Values from 1 to 9 should always be entered with leading '0'. Examples: a. Patient Discharge Status '1' should be submitted as '01'; b. Patient Discharge Status '19' should be submitted as '19'.	X		X			2	C
35	Filler							2	C
36	Quantity	This value represents the actual quantity and should be submitted with decimal point when applicable. For inpatient admissions, the number of days of confinement. Count the day of admission but not the day of discharge (for admission and discharge on the same day, Quantity is counted as 1). For all other procedures, the number of units performed for this procedure. For most procedures, this number should be "1". In some cases, a procedure may be repeated, in which case this number should reflect the number of times the procedure was performed. For anesthesia services, this should be the total number of minutes that make up the beginning and ending clock time of anesthesia service administered. Please make sure that the Quantity corresponds to the procedure code. For example, if the psychiatric code 90844 is used (Individual psychotherapy, 45-50 minutes), the Quantity should be "1" NOT "45" or "50". For Inpatient records, it should represent number of days of care. Values of 30, 60 or 1 00 are most common on drug records. *Note*: Length of this field has been increased to accommodate the actual quantity. Quantity=10 should be submitted as 10; Quantity=10.5 should be submitted as 10.5; Quantity=10.55 should be submitted as 10.55	X	X	X		X	9	SN

Service Data (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
37	NDC Number	For prescription drugs, the valid National Drug Code number assigned by the Food and Drug Administration (FDA). For Compound drugs claims submit NDC Number for the primary drug, If primary drug is unknown, submit NDC Number for most expensive drug. NDC codes having less than 11 digits should be submitted with leading 0's. For Example NDC "603373932" should be submitted as "00603373932".	X	X		X		11	N
38	Metric Quantity	For prescription drugs, the total number of units or volume (e.g., tablets, milligrams) dispensed. Should be submitted with decimal point when applicable. Note: Length of this field has been increased to accommodate the actual Metric Quantity. Metric Quantity=10 should be submitted as 10; Metric Quantity=10.5 should be submitted as 10.5; Metric Quantity=10.55 should be submitted as 10.55	X	X		X		9	N
39	Days Supply	The number of days of drug therapy covered by this prescription.				X		3	N
40	Refill Indicator	A number indicating whether this is an original prescription (0) or a refill number (e.g., 1, 2, 3, etc.) on Pharmacy claims.				X		2	N
41	Dispense As Written Indicator	An indicator specifying why the product dispensed was selected by the pharmacist and should be entered in a 2 digit format with leading zero: 00 = No DAW 01 = Physician DAW 02 = Patient DAW 03 = Pharmacist DAW 04 = Generic Not In Stock 05 = Brand Dispensed as Generic 06 = Override 07 = Brand Mandated by Law 08 = No Generic Available 09 = Other				X		2	N
42	Dental Quadrant	One of the four equal sections into which the dental arches can be divided; begins at the midline of the arch and extends distally to the last tooth. 1 = Upper Right 2 = Upper Left 3 = Lower Left 4 = Lower Right					X	1	N
43	Tooth Number	The number or letter assigned to a tooth for identifications purposes as specified by the American Dental Association. A - T (for primary teeth) 1 - 32 (for secondary teeth)					X	2	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
44	Tooth Surface	The tooth surface on which the service was performed: M = Mesial D = Distal O = Occlusal L = Lingual I = Incisal F = Facial B = Buccal A = All 7 surfaces This field can list up to six values. When multiple surfaces are involved, please list the value for each surface without punctuation between values. For example, work on the mesial, occlusal, and lingual surfaces should be listed as "MOL "(three spaces following the third value).					X	6	C
45	Paid Date	For encounter records, the date on which the record was processed. For services performed on a fee-for-service basis, the date on which the claim was paid. The format is YYYYMMDD.	X	X	X	X	X	8	D/YYYYMMDD
46	Service Class	MBHP Specific field	X	X	X	X	X	23	C

Provider Data

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
47	PCP Provider ID	A unique identifier for the Primary Care Physician selected by the patient as of the date of service. ***See discussion in the Data Element Clarifications section.***	X	X	X		X	15	C
48	PCP Provider ID Type	A code identifying the type of ID provided in PCP Provider ID above. For example, 6 = Internal ID (Plan Specific)	X	X	X		X	1	N
49	PCC Internal Provider ID	PCC Internal ID	X	X	X	X	X	15	C
50	Servicing Provider ID	A unique identifier for the provider performing the service. ***See discussion in the Data Element Clarifications section.***	X	X	X	X	X	15	C
51	Servicing Provider ID Type	A code identifying the type of ID provided in Servicing Provider ID above. For example, 6 = Internal ID (Plan Specific) 9 = NAPB Number (for pharmacy claims only)	X	X	X	X	X	1	N
52	Referring Provider ID	A unique identifier for the provider. ***See discussion in the Data Element Clarifications section.***	X	X	X	X	X	15	C
53	Referring Provider ID Type	A code identifying the type of ID provided in Referring Provider ID above. For example, 1 = NPI 6 = Internal ID (Plan Specific) 8 = DEA Number (for pharmacy claims only)	X	X	X	X	X	1	N
54	Servicing Provider Class	A code indicating the class for this provider: 1 = Primary Care Provider 2 = In plan provider, non PCP 3 = Out of plan provider Note: This code relates to the class of the provider and a PCP does not necessarily indicate the recipient's selected or assigned PCP. PCP class should be assigned only to those physicians whom the plan considers to be a participating PCP.	X	X	X	X	X	1	C
55	Servicing Provider Type	A code indicating the type of provider rendering the service represented by this encounter or claim. (Use Servicing Provider Type values, see Table G)	X	X	X	X	X	3	N
56	Servicing Provider Specialty	The specialty code of the servicing provider. (Use CMS 1500 standard, see Table H)	X	X	X		X	3	C
57	Servicing Provider ZIP Code	The servicing provider's ZIP code. The ZIP code where the service occurred is preferred.	X	X	X	X	X	5	N
58	Billing Provider ID	A unique identifier for the provider billing for the service.	X	X	X	X	X	15	C
59	Authorization Type	MBHP Specific field	X	X	X	X	X	25	C

Financial Data

Most of the fields below apply to services for which reimbursement is made on a fee-for-service basis. For capitated services, the record should include fee-for-service equivalent information when available. Line item amounts are required for these fields.

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
60	Billed Charge	The amount the provider billed for the service.	X	X	X	X	X	9	SN
61	Gross Payment Amount	The amount that the provider was paid in total by all sources for this service. *NOTE: This field should include any withhold amount, if applicable.*	X	X	X	X	X	9	SN
62	TPL Amount	Any amount of third party liability paid by another medical coverage carrier for this service. If the TPL amount is available only at the summary level, it must be recorded on a special line on the claim which will have a record indicator value of 0. See Dollar Amounts.	X	X	X	X	X	9	SN
63	Medicare Amount	Any amount paid by Medicare for this service.	X	X	X	X	X	9	SN
64	Copay/ Coinsurance	Any co-payment amount the member paid for this service.	X	X	X	X	X	9	SN
65	Deductible	Any deductible amount the member paid for this service.	X	X	X	X	X	9	SN
66	Ingredient Cost	The cost of the ingredients included in the prescription.				X		9	SN
67	Dispensing Fee	The dispensing fee charged for filling the prescription.				X		9	SN
68	Net Payment	The amount the Medicaid MCE paid for this service. (Should equal Eligible Charges less COB, Medicare, Copay/Coinsurance, and Deductible.)	X	X	X	X	X	9	SN
69	Withhold Amount	Any amount withheld from fee-for-service payments to the provider to cover performance guarantees or as incentives.	X	X	X		X	9	SN
70	Record Type	A code indicating the type of record: O = Original V = Void or Back Out R = Replacement A = Amendment ***See discussion under 'Former Claim Number / Suffix' in the Data Elements Clarification Section***	X	X	X	X	X	1	C
71	Group Number	For non-MHSA MCEs 1 = MCO MassHealth 2 = MCO Commonwealth Care 3 = SCO 5 = CarePlus 6 = One Care (ICO) 7 = ACO-A 8 = ACO-B 9 = ACO-C	X	X	X	X	X	25	C

Medicaid Program-Specific Data

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
72	DRG	The DRG code used to pay for an inpatient confinement and should always be submitted in 3-digit format. One and two digit codes should be completed with leading zeros to comply. For example: a. DRG code '1' should be submitted as '001'; b. DRG code '25' should be submitted as '025'; c. DRG code '301' should be submitted as '301'. ***See discussion in the Data Element Clarifications section***.	X		X			3	C
73	EPSDT Indicator	A flag that indicates those services which are related to EPSDT: 1 = EPSDT Screen 2 = EPSDT Treatment 3 = EPSDT Referral		X			X	1	N
74	Family Planning Indicator	A flag that indicates whether or not this service involved family planning services, which may be matched by CMS at a higher rate: 1 = Family planning services provided 2 = Abortion services provided 3 = Sterilization services provided 4 = No family planning services provided (see Table I)	X	X		X		1	C
75	MSS/IS	*Please leave this field blank, it will be further defined at a later date.* A flag that indicates services related to MSS/IS: 1 = Maternal Support Services 2 = Infant Support Services		X				1	N
76	New Member ID	The ***"Active" Medicaid*** identification number assigned to the individual. This number is assigned by MassHealth and may change.	X	X	X	X	X	25	C

Other Fields

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
77	Former Claim Number	If this is not an Original claim [Record Type = 'O'], then the previous claim number that this claim is replacing/voiding. ***See discussion under Former Claim Number / Suffix in the Data Elements Clarification Section***	X	X	X	X	X	15	C
78	Former Claim Suffix	If this is not an Original claim [Record Type = 'O'], then the previous claim suffix that this claim is replacing/voiding. ***See discussion under Former Claim Number / Suffix in the Data Elements Clarification Section***	X	X	X	X	X	4	C
79	Record Creation Date	The date on which the record was created. ***See discussion under Record Creation Date in the Data Elements Clarification Section.***	X	X	X	X	X	8	D
80	Service Category	Service groupings from financial reports like 4B (see Table I)	X	X	X	X	X	3	C
81	Prescribing Prov. ID	Federal Tax ID or UPIN or other State assigned provider ID for the prescribing provider on the Pharmacy claim.				X		15	C
82	Date Script Written	Date prescribing provider issued the prescription.				X		8	D/YYYY MMDD
83	Compound Indicator	Indicates that the prescription was a compounded drug. 1 = Yes 2 = No				X		1	C
84	Rebate Indicator	PBM received rebate for drug dispensed. 1 = Yes 2 = No				X		1	C
85	Admitting Diagnosis	Diagnosis upon admission. May be different from principal diagnosis. Should not be External Injury codes. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
86	Allowable Amount	Amount allowed under the Health Plan formulary.	X	X	X	X	X	9	N
87	Attending Prov. ID	Provider ID of the provider who attended at facility. Federal Tax ID or UPIN or other State assigned provider ID.	X					15	C
88	Non-covered Days	Days not covered by Health Plan.	X		X			3	N
89	External Injury Diagnosis 1	If there is an External Injury Diagnosis code 1 (ICD E-Code) present on the claim, it should be submitted in this field. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C
90	Claim Received Date	Date claim received by Health Plan, if processed by a PBM.				X		8	D/YYYY MMDD
91	Frequency	The third digit of the UB92 Bill Classification field. Submitted as a third digit in Type of Bill (#33)	X		X			1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
92	PCC Internal Provider ID_Type	One code identifying the type of ID provided in the PCC Internal Provider ID in Field # 49 above For example, 6 = Internal ID (Plan Specific) 8 = DEA Number 9 = NABP Number 1 = NPI	X	X	X	X	X	1	N
93	Billing Provider ID _Type	A code identifying the type of ID provided in Billing Provider ID above. For example, 6 = Internal ID (Plan Specific) *9 = NABP Number* (for pharmacy claims only)	X	X	X	X	X	1	N
94	Prescribing Prov. ID _Type	A code identifying the type of ID provided in Prescribing Provider ID above. For example, 1 = NPI 6 = Internal ID (Plan Specific) 8 = DEA Number				X		1	N
95	Attending Prov. ID _Type	A code identifying the type of ID provided in Attending Prov. ID above. For example, *6 = Internal ID (Plan Specific)*	X					1	N
96	Admission Time	For inpatient facility services, the time the recipient was admitted to the facility. If not an inpatient facility, the value should be missing. This field ***must*** be in HH24MI format. For example, 10:30AM would be 1030 and 10:30PM would be 2230.	X		X			4	N/HH24MI
97	Discharge Time	For inpatient facility services, the time the recipient was discharged from the facility. If not an inpatient facility, the value should be missing. This field ***must*** be in HH24MI format. For example, 10:30AM would be 1030 and 10:30PM would be 2230.	X		X			4	N/HH24MI
98	Diagnosis 6	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/No decimal points
99	Diagnosis 7	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/No decimal points
100	Diagnosis 8	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/No decimal points
101	Diagnosis 9	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/No decimal points
102	Diagnosis 10	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/No decimal points
103	Surgical Procedure code 1	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
104	Surgical Procedure code 2	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
105	Surgical Procedure code 3	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications***	X					7	C

		section, including clarification on ICD-10							
#	**Field Name**	**Definition/Description**	**H**	**P**	**L**	**R**	**D**	**Length**	**Data Type**
106	Surgical Procedure code 4	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
107	Surgical Procedure code 5	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
108	Surgical Procedure code 6	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
109	Surgical Procedure code 7	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
110	Surgical Procedure code 8	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
111	Surgical Procedure code 9	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
112	Employment	Is the patient's condition related to Employment Y N	X	X	X	X	X	1	C
113	Auto Accident	Is the patient's condition related to an Auto Accident Y N	X	X	X	X	X	1	C
114	Other Accident	Is the patient's condition related to Other Accident Y N	X	X	X	X	X	1	C
115	Total Charges	This field represents the total charges, covered and uncovered related to the current billing period.	X	X	X	X	X	9	N
116	Non Covered charges	This field represents the uncovered charges by the payer related to the revenue code. This is the amount, if any, that is not covered by the primary payer for this service.	X	X	X	X	X	9	N
117	Coinsurance	Any coinsurance amount the member paid for this service.	X	X	X	X	X	9	N
118	Void Reason Code	The reason the claim line was voided 1 TPL 2 accident recovery 3 provider audit recoveries 4 Other	X	X	X	X	X	1	C

119	DRG Description	Description of DRG Code	X		X			132	C
#	**Field Name**	**Definition/Description**	**H**	**P**	**L**	**R**	**D**	**Length**	**Data Type**
120	DRG Type	*Values:* 1=Medicare CMS-DRG 2=Medicare MS-DRG 3=Refined DRGs (R-DRG) 4=All Patient DRGs (AP-DRG) 5=Severity DRGs (S-DRG) 6=All Patient, Severity-Adjusted DRGs (APS-DRG) 7=All Patient Refined DRGs (APR-DRG) 8=International-Refined DRGs (IR-DRG) 9=Other ***Please use the accurate and specific DRG type and avoid using the value "Other". Please communicate to MassHealth any DRG types you are using that are missing from the above list***	X		X			1	C
121	DRG Version	DRG Version number associated with DRG type	X		X			3	C/ No decimal points (26.1 must be entered as 261)
122	DRG Severity of Illness Level	A code that describes the Severity of the claim with the assigned DRG: Valid values are: 1 = minor 2 = moderate 3 = major 4 = extreme ***Associated with DRG Type=APR-DRG (DRT Type =7) or any other DRG that has these fields***	X		X			1	C
123	DRG Risk of Mortality Level	A code that describes the Mortality of the patient with the assigned DRG code. Valid values are: 1 = minor 2 = moderate 3 = major 4 = extreme ***Associated with DRG Type=APR-DRG (DRT Type =7) or any other DRG that has these fields.***	X		X			1	C
124	Patient Pay Amount	Patient paid amount for nursing facility stays and hospitals	X		X			9	SN
125	Patient Reason for Visit Diagnosis 1	ICD diagnosis code describing the patient's (or patient representative's) stated reason for seeking care at the time of outpatient (ER) visit ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
126	Patient Reason for Visit Diagnosis 2	ICD diagnosis code describing the patient's (or patient representative's) stated reason for seeking care at the time of outpatient (ER) visit ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
127	Patient Reason for Visit Diagnosis 3	ICD diagnosis code describing the patient's (or patient representative's) stated reason for seeking care at the time of outpatient (ER) visit	X		X			7	C/ No decimal points

		See discussion in Data Element Clarifications section, including clarification on ICD-10							(26.1 must be entered as 261)
#	**Field Name**	**Definition/Description**	**H**	**P**	**L**	**R**	**D**	**Length**	**Data Type**
128	Present on Admission (POA) 1	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
129	Present on Admission (POA) 2	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
130	Present on Admission (POA) 3	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
131	Present on Admission (POA) 4	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
132	Present on Admission (POA) 5	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
133	Present on Admission (POA) 6	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
134	Present on Admission (POA) 7	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
135	Present on Admission (POA) 8	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
136	Present on Admission (POA) 9	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
137	Present on Admission (POA) 10	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
138	Diagnosis 11	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/ No decimal points (26.1 must be entered as 261)
139	Present on Admission (POA) 11	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
140	Diagnosis 12	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/ No decimal points (26.1 must be entered as 261)
141	Present on Admission (POA) 12	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
142	Diagnosis 13	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be

									entered as 261)
143	Present on Admission (POA) 13	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
#	**Field Name**	**Definition/Description**	**H**	**P**	**L**	**R**	**D**	**Length**	**Data Type**
144	Diagnosis 14	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
145	Present on Admission (POA) 14	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
146	Diagnosis 15	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
147	Present on Admission (POA) 15	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
148	Diagnosis 16	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
149	Present on Admission (POA) 16	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
150	Diagnosis 17	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
151	Present on Admission (POA) 17	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
152	Diagnosis 18	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
153	Present on Admission (POA) 18	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
154	Diagnosis 19	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1

									must be entered as 261)
155	Present on Admission (POA) 19	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
156	Diagnosis 20	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
157	Present on Admission (POA) 20	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
158	Diagnosis 21	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
159	Present on Admission (POA) 21	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
160	Diagnosis 22	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
161	Present on Admission (POA) 22	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
162	Diagnosis 23	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
163	Present on Admission (POA) 23	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
164	Diagnosis 24	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
165	Present on Admission (POA) 24	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
166	Diagnosis 25	The ICD diagnosis code. ***See discussion in Data Element Clarifications section,***	X		X			7	C/ No decimal

		including clarification on ICD-10							points (26.1 must be entered as 261)
167	Present on Admission (POA) 25	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
#	**Field Name**	**Definition/Description**	**H**	**P**	**L**	**R**	**D**	**Length**	**Data Type**
168	Diagnosis 26	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
169	Present on Admission (POA) 26	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
170	Present on Admission (POA) EI 1	This is an indicator associated with External Injury Diagnosis 1 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
171	External Injury Diagnosis 2	If there is an External Injury Diagnosis code 2 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
172	Present on Admission (POA) EI 2	This is an indicator associated with External Injury Diagnosis 2 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
173	External Injury Diagnosis 3	If there is an External Injury Diagnosis code 3 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
174	Present on Admission (POA) EI 3	This is an indicator associated with External Injury Diagnosis 3 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
175	External Injury Diagnosis 4	If there is an External Injury Diagnosis code 4 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
176	Present on Admission (POA) EI 4	This is an indicator associated with External Injury Diagnosis 4 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
177	External Injury	If there is an External Injury Diagnosis code 5 (ICD-	X		X			7	C/ No

	Diagnosis 5	E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***							decimal points (26.1 must be entered as 261)
178	Present on Admission (POA) EI 5	This is an indicator associated with External Injury Diagnosis 5 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
#	**Field Name**	**Definition/Description**	**H**	**P**	**L**	**R**	**D**	**Length**	**Data Type**
179	External Injury Diagnosis 6	If there is an External Injury Diagnosis code 6 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
180	Present on Admission (POA) EI 6	This is an indicator associated with External Injury Diagnosis 6 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
181	External Injury Diagnosis 7	If there is an External Injury Diagnosis code 7 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
182	Present on Admission (POA) EI 7	This is an indicator associated with External Injury Diagnosis 7 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
183	External Injury Diagnosis 8	If there is an External Injury Diagnosis code 8 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
184	Present on Admission (POA) EI 8	This is an indicator associated with External Injury Diagnosis 8 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
185	External Injury Diagnosis 9	If there is an External Injury Diagnosis code 9 (ICD E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
186	Present on Admission (POA) EI 9	This is an indicator associated with External Injury Diagnosis 9 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
187	External Injury Diagnosis 10	If there is an External Injury Diagnosis code 10 (ICD- E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered

									as 261)
188	Present on Admission (POA) EI 10	This is an indicator associated with External Injury Diagnosis 10 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
189	External Injury Diagnosis 11	If there is an External Injury Diagnosis code 11 (ICD- E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
#	**Field Name**	**Definition/Description**	**H**	**P**	**L**	**R**	**D**	**Len gth**	**Data Type**
190	Present on Admission (POA) EI 11	This is an indicator associated with External Injury Diagnosis 11 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
191	External Injury Diagnosis 12	If there is an External Injury Diagnosis code 12 (ICD- E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
192	Present on Admission (POA) EI 12	This is an indicator associated with External Injury Diagnosis 12 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
193	ICD Version Qualifier	ICD9 or ICD10. The value "ICD9" must be populated on claim records with either ICD-9-CM diagnosis codes or ICD-9-CM procedure codes. The value "ICD10" must be populated on claim records with either ICD-10-CM diagnosis codes or ICD-10-CM procedure codes. One claim record must ***never*** have a combination of ICD9 and ICD10 codes. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		X	5	C
194	Procedure Modifier 4	4th procedure code modifier, required, if used.	X	X	X		X	2	C
195	Service Category Type	This field describes the Type of Financial reports the service category is based on. The values are: '4B' for MCO Service Categories 'ACO' for ACO Categories 'SCO' for SCO Service Categories 'ICO' for Care One (ICO) Service Categories	X	X	X	X	X	3	C
196	Ambulance Patient Count	AMBULANCE PATIENT COUNT. REQUIRED WHEN MORE THAN ONE PATIENT IS TRANSPORTED IN THE SAME VEHICLE FOR AMBULANCE OR NON-EMERGENCY		X				3	N

		TRANSPORTATION SERVICES.							
197	Obstetric Unit Anesthesia Count	The number of additional units reported by an anesthesia provider to reflect additional complexity of services.		X				5	N
198	Prescription Number	Rx Number.				X		15	C
199	Taxonomy Code	This is the Taxonomy code for Servicing Provider identified on the claim. Taxonomy codes are National specialty codes used by providers to indicate their specialty. These codes can be found on the Website of Centers for Medicare & Medicaid Service (CMS)	X	X	X		X	10	C
#	**Field Name**	**Definition/Description**	**H**	**P**	**L**	**R**	**D**	**Length**	**Data Type**
200	Rate Increase Indicator	Indicates if the provider is eligible to receive the enhanced primary care rate ***for this service***, as specified in the Affordable Care Act – Section 1202 final regulations. 1=Yes 2=No 3=Unknown 4=Not Applicable **Note: If a service is considered eligible based on the ACA regulations, then the value should be equal to "1" even if the MCE is already paying the provider at the higher rate.**	X	X	X			1	C
201	Bundle Indicator	Indicates if the claim line is part of a bundle. Values: Y=Yes, the claim line is part of a bundle. All bundled lines including the line with the bundled payment should have a value of 'Y' N=No, the claim line is not part of a bundle.	X	X	X	X	X	1	C
202	Bundle Claim Number	This is the claim number of the claim line with the bundled payment. ***See discussion in Data Element Clarifications section,***	X	X	X	X	X	15	C
203	Bundle Claim Suffix	This the claim suffix of the claim line with the bundled payment. ***See discussion in Data Element Clarifications section,***	X	X	X	X	X	4	C
204	Value Code	Code used to relate values to identify data elements necessary to process a UB92 claim. Submit only when the value=54 for Newborn claims	X					2	AN
205	Value Amount	Weight of a newborn in grams. Must be present on all newborn claims when the value code "54"is submitted in Field #204	X					9	N
206	Surgical Procedure Code 10	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
207	Surgical Procedure Code 11	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C

208	Surgical Procedure Code 12	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
209	Surgical Procedure Code 13	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
210	Surgical Procedure Code 14	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
#	**Field Name**	**Definition/Description**	**H**	**P**	**L**	**R**	**D**	**Length**	**Data Type**
211	Surgical Procedure Code 15	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
212	Surgical Procedure Code 16	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
213	Surgical Procedure Code 17	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
214	Surgical Procedure Code 18	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
215	Surgical Procedure Code 19	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
216	Surgical Procedure Code 20	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
217	Surgical Procedure Code 21	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
218	Surgical Procedure Code 22	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
219	Surgical Procedure Code	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not	X					7	C

	23	applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***							
220	Surgical Procedure Code 24	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
221	Surgical Procedure Code 25	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
222	Attending Prov. ID Address Location Code	Code to identify address location of Attending Provider ID in field #87	X					15	C
#	**Field Name**	**Definition/Description**	**H**	**P**	**L**	**R**	**D**	**Length**	**Data Type**
223	Billing Provider ID Address Location Code	Code to identify address location of Billing Provider ID in field # 58	X	X	X	X	X	15	C
224	Prescribing Prov. ID Address Location Code	Code to identify address location of Prescribing Provider ID in field # 81				X		15	C
225	PCP Provider ID Address Location Code	Code to identify address location of PCP Provider ID in field # 47	X	X	X	X	X	15	C
226	Referring Provider ID Address Location Code	Code to identify address location of Referring Provider ID in filed # 52	X	X	X			15	C
227	Servicing Provider ID Address Location Code	Code to identify address location of Servicing Provider ID in field # 50	X	X	X	X	X	15	C
228	PCC Provider ID Address Location Code	Code to identify address location of PCC Internal Provider ID In field **# 49**	X	X	X	X	X	15	C
229	Submission Clarification Code 2	420-DK- Code indicating that the pharmacist is clarifying the submission. Please refer to *Segment "2.0 Data Element Clarifications"* for the details.				X		7	N
230	Submission Clarification Code 3	420-DK- Code indicating that the pharmacist is clarifying the submission. Please refer to *Segment "2.0 Data Element Clarifications"* for the details.				X		7	N
231	Unit of Measure	To be provided on all Pharmacy and Physician-Administered Drugs claims. A unit of the value entered in "Metric Quantity" field (# 38). Please refer to Table O for the allowed values, standard references and available links	X	X		X		2	C
232	Provider Payment	The Gross Amount that the Plan/PBM paid to the pharmacy for the claim						9	SN
233	Filler							9	SN

*** Key to Data Types**

C *Character*

Includes space, A-Z (upper or lower case), 0-9

Left justified with trailing blanks.

Unrecorded or missing values are blank

N *Numeric*

Include 0-9.

Right justified, lead-zero filled.

Unrecorded or missing values are blank

D *Date Fields*

Dates should be in a numeric format. The format for all dates is eight digits in YYYYMMDD format, where YYYY represents a four digit year, MM = numeric month indicator (01 - 12); DD = numeric day indicator (01 - 31).
Example: November 22, 1963 = 19631122

Financial Fields

MassHealth prefers to receive both dollars and cents, with an **implied decimal point** before the last two digits in the data.
Example: the data string "1234567" would represent $12,345.67
Please do not include the actual decimal point in the data.

Please see Key to Data Types on the next page

3.1 Provider Data Set with Record Layout

Data Elements

This section contains field names and definitions for the provider record. To be able to link providers across the MCEs, it is essential to accurately report as many data elements as possible.

Provider file has to contain a snapshot of complete provider data at the time the provider file is created for encounter data submission.

All locations for Provider ID and Provider ID Type are expected to be sent in the provider file, and service location - in the encounter file. For Billing Providers the primary address location should be included in the encounter file.

To reflect the changes in provider contract status, an MCE should provide one record per provider/location with the effective and term dates populated accurately. In this case, the effective and term dates per Provider ID/Provider ID Type/location will not overlap.

Effective and Term dates should ***not*** be blank. Providers, who are enrolled with the MCE at the time of the data submission, are expected to have "End of Time" as a Term date in that submission. The preferred value for the "End of Time" field is '99991231'.

Providers with multiple servicing sites or addresses ***must*** have different IDs for each location.

File Processing

I. The values should be submitted in all fields when available including:
   1. Tax Id Number when available (filed#30)
   2. APCD ORG ID when available in APCD data (filed#34)

II. 100% of providers on Pharmacy and Physician-Administered Drugs claims must have:
   1. NPI (Field #2) value

III. Reject the file if:
   1. NPI is missing on more than 20% of the records. At least 80% of the records should have NPI
   2 Provider Type is missing on more than 20% of the records.
   At least 80% of the records should have Provider Type entered
   3 Provider ID, or Provider ID Type, or Provider ID Location Code are missing

The following fields are 100% required on all records:

1. Org. Code (Field #1)
2. Provider ID (Field #2)
3. Provider ID Type (Field #3)
4. Provider last Name (Field #4)
5. Provider First Name (Field #5)
6. Provider Office Address Street (Field #8)
7. Provider Office Address City (Field #9)
8. Provider Office Address State (Field #10)
9. Provider Office Address Zip (Field #11)
10. Provider Mailing Address Street (Field #12)
11. Provider Mailing Address City (Field #13)
12. Provider Mailing Address State (Field #14)
13. Provider Mailing Address zip (Field #15)
14. Provider Effective Date (Field #18)
15. Provider Term Date (Field #19)
16. Provider DEA Number when applicable (Field #24)
17. Provider ID Address Location Code (Field#36)
18. Provider Bundle ID (Field #40)
19. Entity PIDSL (Field# 35)

#	Field Name	Definition/Description	Length	Data Type
1	Org.Code	Unique ID assigned by MH DW to each submitting organization. **This code identifies your Organization :** 465 Fallon Community Health Plan 469 Neighborhood Health Plan 997 Boston Medical Center HealthNet Plan 998 Network Health 999 Massachusetts Behavioral Health Partnership 470 CeltiCare 471 Health New England 501 Commonwealth Care Alliance 502 UnitedHealthCare 503 NaviCare 504 Senior Whole Health 505 Tufts Health Plan 506 BMC HealthNet Plan 601 Commonwealth Care Alliance 602 Network Health 603 Fallon Total	3	N
2	Provider ID	Multiple formats for the same Provider ID must be avoided. For example, ID '00001111' and '001111' should be submitted with one consistent format if it indicates the same ID for the same provider.	15	C
3	Provider ID Type	A code identifying the type of ID provided in the Provider ID above. For example, 1 = NPI 6 = Internal Plan ID 8 = DEA Number (For Pharmacy claims ONLY) 9 = NABP Number (For Pharmacy claims ONLY)	1	C
4	License Number	State license number.	9	C
5	Medicaid Number	State Medicaid number (MassHealth/MMIS Provider ID).	10	C
6	Provider Last Name	Last name of provider. In case of an organization or entity or hospital, name should be entered in this field only. Please avoid using abbreviations and enter names consistently. For example, enter "Massachusetts General Hospital" instead of "MGH". Length increased to 200 characters	200	C
7	Provider First Name	First name of the provider Please submit First Name consistently. In case of an organization or entity or hospital, name should be entered in "Provider Last Name" field above and **not** in this field. Length increased to 100 characters	100	C
8	Provider Office Address Street	Street address where services were rendered. This field has to be a street address. It cannot be a post office or lock box if the provider is the billing provider	45	C
9	Provider Office Address City	City where services were rendered.	20	C
10	Provider Office	State where services were rendered.	2	C

	Address State			
11	Provider Office Address ZIP	Zip where services were rendered. ZIP+4	9	C
12	Provider Mailing Address Street	Street address where correspondence is received. This field has to be a street address. It cannot be a post office or lock box if the provider is the billing provider	45	C
13	Provider Mailing Address City	City where correspondence is received.	20	C
14	Provider Mailing Address State	State where correspondence is received.	2	C
15	Provider Mailing Address ZIP	Zip where correspondence is received. ZIP+4	9	C
16	Provider Type	Please use the values from Table G. **Note** that value "-4" for "Incomplete/No Information" option has been removed.	3	N
17	Filler		3	C
18	Provider Effective Date	Date provider becomes eligible to perform services.	8	D
19	Provider Term Date	Date provider is no longer eligible to perform services.	8	D
20	Provider Non-par Indicator	Non-participating provider indicator. 2 non-participating provider 3 participating provider	1	C
21	Provider Network ID	The network the provider is affiliated to by the Health Plan (internal plan ID).	15	C
22	PCC Provider ID	Required for PCCs enrolled with the MCE.	15	C
23	Panel Open Indicator	Is the provider accepting new patients? 1 Accepting new patients 2 Not accepting new patients	1	C
24	Provider DEA Number	Provider DEA Number	11	C
25	Provider Type Description	Description of the provider type	50	C
26	National Provider Identifier (NPI)	National Provider Identifier issued by the National Plan and Provider Enumeration System (NPPES). It is required on all claims.	10	C
27	Medicare ID Number		15	C
28	Social Security Number	Provider's SSN is 9 digits field and should be entered with no dashes (e.g.04-3333333 should be entered as 043333333 and 099-99-9999 should be entered as 099999999). Values less that 9-character long are invalid.	9	C
29	NABP Number	National Association of Boards of Pharmacy number	9	C
30	Tax ID Number	Tax ID Number is primarily the Federal Employee Identification Number (FEIN); however, when Providers don't have Tax ID Number for the reasons like being sole proprietors or small business owners without employees, provider's SSN should be entered in both fields, # 28 and #30, in same 9 digits format with no dashes (e.g.04-3333333 should be entered as 043333333 and 099-99-9999 should be entered as 099999999). Values less	9	C

		that 9-character long are invalid.		
31	PCC Provider ID Type	Required for PCCs enrolled with the MCE.	1	C
32	Gender Code	”M” for Male, “F” for Female, and “O” for Other	1	C
33	Primary Care Eligibility Indicator	Provider is eligible to receive enhanced Medicare rate for their primary care services. This indicator should follow the CMS and MassHealth regulations on provider eligibility for Affordable Care Act – Section 1202. 0=Yes, Eligible based on 60% Attestation 1=Yes, Eligible based on Board Certification 2=No, Not Eligible 3=Unknown 4=Not Applicable **Note:** The values ‘0’ and ‘1’ indicating provider eligibility for the “ACA Section 1202” Rate Increase should be only applicable when providers have active contracts with MCEs. If a provider contract gets terminated then the provider would no longer be eligible for the rate increase, and the value for this flag would be ‘2’ (Not Eligible). The assumption is that eligible providers are either eligible based on Board Certification or 60% attestation. In the case where the MCE receives a 60% attestation from a provider that has already been determined to be eligible based on Board Certification then MCE should use value “1”.	1	C
34	APCD ORG ID	This is a new field added to get the APCD Provider Organization ID (OrgID) for the provider. Length is 6 characters. It should be submitted for all providers whose Org ID had been submitted to APCD.	6	C
35	Entity PIDSL	MCO/ACO providers - if the provider is enrolled with MCO only (not with ACO) - MCO PIDSL - if the provider is enrolled with ACO only - ACO PIDSL - if the provider is enrolled with both, ACO and MCO, then ACO PIDSL - if provider is enrolled with multiple ACOs (e.g. a specialist), and a plan is an active MCO - MCO PIDSL - if provider is enrolled with multiple ACOs (e.g. a specialist) and a plan is not an active MCO - old MCO PIDSL SCO PIDSL for SCO providers One Care PIDSL for One Care providers Example: 999999999A	10	C
36	Provider ID Address Location Code	Code to identify address location of Provider ID in Field # 2.	15	C
37	PCC Provider ID Address Location Code	Code to identify address location of PCC Provider ID in Field # 22.	15	C
38	Provider Network ID Type	Type of Provider Network ID in Field # 21.	1	N
39	Provider Network ID Address Location Code	Code to identify address location of Provider Network ID in Field # 21.	15	C
40	Provider Bundle ID	ID to tie together all the IDs for a particular provider	15	C

41	Provider ID Primary Address Location Indicator	Y/N value to indicate primary address location	1	C

Example of Provider Bundle ID

This example shows the case when Provider ID is different for every location.
In most cases Provider ID is unique per each provider within the organization and will be the same on every line

Org. Code	Provider ID	Provider ID Type	Address Location Code	Provider Bundle ID	Provider ID Primary Address Location Indicator	Provider Last Name	Provider First Name
888	1234569	6	A	65656	N	Smith	John
888	1234568	6	B	65656	N	Smith	John
888	1234567	6	C	65656	Y	Smith	John
888	1234566	6	D	65656	N	Smith	John

Provider Error Process:

1. Provider records with null ID and/or null ID Type do not get loaded into MH DW. Such records get rejected and returned in the provider error response file.

2. If duplicate records per provider ID, Provider ID Type, Provider Address Location, and Provider Term Date are ***erroneously*** submitted, one record will be accepted based on "best fit" logic and all other records will be rejected and returned in the provider error file.

3. "Best" fit logic picks one record per provider ID, provider ID Type and provider Term Date in a provider file, based on the record that has the most populated information (NPI, provider name, address, tax ID, license number, and Medicaid Number, respectively).

4. Records sent with "null" or missing effective/term dates, will also be returned to the MCEs in the provider error response file. The MCE is expected to correct and resubmit these records in the Correction file data submissions.

5. A Correction file for provider records rejected for any of the reasons above should be submitted with a zipped Correction file for the ***same*** submission.

3.2 MCE Internal Provider Type Data Set Elements with Record Layout

Data Elements

This section contains field names and definitions for the provider type record that is based on the Provider Types that are **internally** used by the MCE. This is different from MassHealth Provider Types submitted in the Provider Data Set defined above***. This table should only have providers who have an internal provider type code. In other words, this table should not have providers with missing internal provider type code.***

#	Field Name	Definition/Description	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization. **This code identifies your Organization :** 465 Fallon Community Health Plan 469 Neighborhood Health Plan 997 Boston Medical Center HealthNet Plan 998 Network Health 999 Massachusetts Behavioral Health Partnership 470 CeltiCare 471 Health New England 501 Commonwealth Care Alliance 502 UnitedHealthCare 503 NaviCare 504 Senior Whole Health 505 Tufts Health Plan 506 BMC HealthNet Plan 601 Commonwealth Care Alliance 602 Network Health 603 Fallon Total	3	N
2	Provider ID	Provider ID.	15	C
3	Provider ID Type	A code identifying the type of ID provided in Provider ID above: One code identifying the type of ID provided in the Provider ID above. For example, 6 = Internal ID (Plan Specific)) 8 = DEA Number 9 = NABP Number 1 = NPI	1	N
4	Internal Provider Type Code	Provider Type code as defined internally by the MCE	6	C
5	Internal Provider Type Description	Description of Provider Type code as defined internally by the MCE	120	C
6	Provider ID Address Location Code	Code to identify address location of Provider ID in Field # 2	15	C

3.3 Provider Specialty Data Set Elements

Data Elements

This section contains field names and definitions for the provider specialty record. If a provider has multiple specialties, please provide one record for each specialty per provider.

#	Field Name	Definition/Description	Length	Data Type
1	Org.Code	Unique ID assigned by MH DW to each submitting organization. **This code identifies your Organization :** 465 Fallon Community Health Plan 469 Neighborhood Health Plan 997 Boston Medical Center HealthNet Plan 998 Network Health 999 Massachusetts Behavioral Health Partnership 470 CeltiCare 471 Health New England 501 Commonwealth Care Alliance 502 UnitedHealthCare 503 NaviCare 504 Senior Whole Health 505 Tufts Health Plan 506 BMC HealthNet Plan 601 Commonwealth Care Alliance 602 Network Health 603 Fallon Total	3	N
2	Provider ID	Provider ID, Federal Tax ID, UPIN or Health Plan ID.	15	C
3	Provider Specialty	Please use the values contained in Table H. If there are provider specialties not contained in table H, assign them a new three digit number. List the description of the new values in the Provider Specialty Description field.	3	C
4	Provider Specialty Date	Date provider becomes eligible to perform specialty services.	8	D
5	Provider ID Type	A code identifying the type of ID provided in Provider ID above: One code identifying the type of ID provided in the Provider ID above. For example: 6 = Internal ID (Plan Specific)) 8 = DEA Number 9 = NABP Number 1 = NPI	1	C
6	Provider Specialty Description	Description of the Provider Specialty	50	C
7	Provider ID Address Location Code	Code to identify address location of Provider ID in Field # 2.	15	C

3.4 Additional Reference Data Set Elements

These files currently apply only to MBHP.

Authorization Type Data Set Elements

#	Field Name	Description	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization.	3	N
2	ATHTYP	Two digit code identifying the type of service.	6	C
3	ATHTYP DESCRIPTION	Description for the ATHYTYP codes.	100	C

Claim Type Data Set Elements

#	Field Name	Description	Length	Data Type
1	Org. Code	Unique ID assigned in MassHealth DW to each submitting organization	3	N
2	CLATYP	Code identifying a service.	6	C
3	CLATYP DESCRIPTION	Description for the CLATYP codes.	100	C

Group Number Data Set Elements

#	Field Name	Description	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization.	3	N
2	Member Rating Category	Description for the Member Rating Category.	50	C
3	DMA/DMH Indicator	Description for the DMA/DMH Indicator.	50	C
4	Eligibility Group Name	Description for the Eligibility Group Name.	100	C
5	Eligibility Group Number	Six digit number identifying the Eligibility Group.	10	N
6	MMIS Plan Type	Two digit code identifying the MMIS Eligibility Plan Type.	2	C

Service Class Data Set Elements

#	Field Name	Description	Length	Data Type
1	Org. Code	Unique ID assigned in MassHealth DW to each submitting organization	3	N
2	Service Class	Code identifying a service class.	10	C
3	Description	Description of service class codes	100	C

Services Data Set Elements				
#	Field Name	Description	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization.	3	N
2	SVCLVLE	Description of Service Level I.	60	C
3	SVCLVLMHSA	Description of Service Level II.	90	C
4	SVCGRP	Description of Service Level III.	100	C
5	SVCDESC	Description of Service Level IV.	120	C
6	UNITTYP	Description of Unit Type.	4	C
7	UNITCONVE	Unit Conversion Value. This must be a positive number greater than zero.	12	N
8	ATHTYP	Authorization Type Code.	1	C
9	SVCCOD_REF SERVICES	Service Code.	6	C
10	CLATYP_REF SERVICES	Claim Type Code.	2	C
11	MOD1_REFSE RVICES	Modifier Code.	2	C
12	ID_SERVICES	ID Services Value.	10	N
13	CBHI_FLAG	An indicator to distinguish CBHI Services	10	C
14	SERVICE_24_ HOUR	Specifies if it was 24-Hour or Non-24-Hour Service (or other descriptions such as P4P)	11	C
15	INTERMEDIAT E_SVCLVLE	Specifies what kind of Intermediate Service Level was provided	50	C
16	SVCLVLI	Specifies service level provided	60	C
17	MHSAEM	Service provided: whether it was EM, or MH, or NA, or SA	2	C
18	SVCDIRECTO RY	Service Directory	82	C

4.0 Encounter Record Layout Amendment Process and Layout

1. Amendment processing has been created to allow MCEs to make retroactive changes to the existing claims. "Existing" are the claims that have been accepted and loaded in MH DW.

2. MH DW expects that amendments are used to reflect retroactive dimension changes, such as Member ID, Servicing Category, etc.

3. There are no constraints on timing for submissions of the amendments.

4. Amendments can be sent as a part of a regular submission or as one-off submission. The one-off submission should contain claims file in the format outlined in segment 3.0 "Encounter Data Set Elements" and a metadata file in the format outlined in segment 6.0 "Media Requirements" of this document.

5. Amendments should be submitted with the Type of Feed 'ENC'

6. In submission amendment record is identified by Record Type 'A'. When inserted in MH DW, it inherits the record type of the record it is amending.

7. If the Claim Number + Claim Suffix combination of the 'A' record is not found in MH DW, the record will be rejected with error code 11"Active Original Claim No-Claim Suffix Not Found"

8. If the claim that has to be amended already has Former Claim Number information on a line, that Former Claim Number information should be repeated precisely on the amendment claim

9. All columns should be populated according to the standards like any other submitted claim and should contain post-change values

10. All provider data on the claim must point to a provider reference data.

11. A claim submitted prior to the introduction of Commonwealth Care must have valid data in the Group Number field.

12. Multiple amendments to the same record in the same feed are not allowed and will be rejected with error code "10 - Duplicate Claim No-Claim Suffix -- in same feed".

13. The amendment file loads with the same iterative error process as the regular submission.

14. Dollar amount changes on the claims that happen in the source system, like adjustments and voids, should be handled via existing process set up to handle those kinds of transactions.

5.0 Error Handling

MassHealth will validate the feeds received from the MCEs and MBHP and return files containing erroneous records back to the MCEs and MBHP for correction and resubmission. The error rate in the initial submission should be no more than 3% for the data to be considered complete and accurate. The format of the error files will be the same as the input record layout described above with 2 fields appended as the last 2 fields on the record layout. These will be the erroneous field number and the error code for that field. Section 8.0 Quantity & Quality Edits lays out the expectation for each field in the record format for the feed. In addition to these edits, MassHealth will also subject the records to some intra-record validation tests. These may include validation checks like "net amount <= gross amount", "non-unique claim number + claim suffix combination", etc. Error checking is likely to evolve with time therefore a complete list of all pseudo-columns and error codes will accompany the rejected records returned to the MCEs and MBHP. A list is published below.

Error Codes

Error Code	Description
1	Incorrect Data Type
2	Invalid Format
3	Missing value
4	Code missing from reference data
5	Invalid Date
6	Admissions Date is greater than Discharge Date
7	Discharge Date is less than Admissions Date
8	Paid Date is less than Admission or Discharge or Service Dates
9	Date is prior to Birth Date
10	Duplicate Claim No-Claim Suffix -- in same feed
11	Active Original Claim No-Claim Suffix Not Found
12	Bad Zip Code
13	Replacement received for a voided record
14	Date is in the future
15	From Service Date is greater than To Service Date
16	To Service Date is less than From Service Date
17	Cannot be Negative
18	Non HIPAA/Standard code.
19	Bad Metadata File.
20	Local Code Not present in MassHealth DW.
21	Cannot be Zero.
22	Former Claim No-Claim Suffix fields should not contain data for Original Claim
23	Only Original claims allowed in the Initial feed
24	Duplicate Claim No-Claim Suffix -- from prior submission
25	Filler
26	Original Claim No-Claim Suffix, Former Claim No-Claim Suffix -- in same feed
27	Metadata - No metadata file found or file is empty.
28	Metadata - MCE_Id incorrect for the plan.
29	Metadata - MCE_ID not found in metadata file.
30	Metadata - Date_Created not found in metadata file.
31	Metadata - Date_Created is not a valid date.

32	Metadata - Data_File_Name not found in metadata file.
33	Metadata - Data_File_Name does not exist or is not a regular file.
34	Metadata - Pro_file_Name not found in metadata file.
35	Metadata - Pro_file_Name does not exist or is not a regular file.
36	Metadata - Pro_Spec_Name not found in metadata file.
37	Metadata - Pro_Spec_Name does not exist or is not a regular file.
38	Metadata - Total_Records not found in metadata file.
39	Metadata - Total_Records does not match actual record count.
40	Metadata - Total_Net_Payments not found in metadata file.
41	Metadata - Total_Net_Payments does not match actual sum of dollar amount.
42	Metadata - Time_Period_From not found in metadata file.
43	Metadata - Time_Period_From is not a valid date.
44	Metadata - Time_Period_To not found in metadata file.
45	Metadata - Time_Period_To is not a valid date.
46	Metadata - Return_To not found in metadata file.
47	Metadata - Type_Of_Feed not found in metadata file.
48	Metadata - Type_Of_Feed contains invalid value. Refer to the spec for valid values.
49	Metadata - Metadata - Ref_Services_File_Name not found in metadata file.
50	Metadata - Ref_Services_File_Name does not exist or is not a regular file.
51	Metadata - ATHTYP_File_Name not found in metadata file.
52	Metadata - ATHTYP_File_Name does not exist or is not a regular file.
53	Metadata - GRPNUM_File_Name not found in metadata file.
54	Metadata - GRPNUM_File_Name does not exist or is not a regular file.
55	Metadata - SVCCLS_File_Name not found in metadata file.
56	Metadata - SVCCLS_File_Name does not exist or is not a regular file.
57	Metadata - CLATYP_File_Name not found in metadata file.
58	Metadata - CLATYP_File_Name does not exist or is not a regular file.
59	RefService not found.
60	If former claim number filled in, so must former_claim_suffix.
70	ICD Version Qualifier ICD9 used on a claim post ICD10 implementation (To Service Date >=10/01/2015)
71	ICD Version Qualifier ICD9 used on a claim post ICD10 implementation (Discharge Date>=10/01/2015)
*72**	(Denial Code not in Denied_Claims file) Claim Number/Suffix in Denied_Claims_Reason_Code file not in Denied_Claims file
*73**	*Claim Number/Suffix in Denied_Claims file not in Denied_Claims_Reason_Code file*
74	Correction to a claim that is not in MH DW
61	*Missing Provider NPI – Not used at present*
62	Metadata - Pro_MCEType_Name not found in metadata file.
63	Metadata - Pro_MCEType_Name does not exist or is not a regular file.

*Applies to the Denied Claims submissions only

All the MCEs including MBHP should resubmit corrected records within a week of receiving the error files from MassHealth. This process will be repeated until the number of validation errors falls below a MassHealth defined threshold. Refer to the "**Encounter Data" section** of the **MassHealth Contract** for more details on the action required when data submission is not in compliance with Encounter Data requirements.

6.0 Media Requirements

Format

File Type: PKZIP/WINZIP compressed plain text file
Character Set: ASCII

All submitted files should be ***pipe-delimited.*** Please compress the data file using PKZIP/WINZIP or compatible program. All records in the data file should follow the record layout specified in section 4.0 where the length represents the maximum length of each field. Padding fields with 0s or spaces is ***not*** required.

Each record should end with the standard MS Windows text file end-of-line marker ("\r\n" - a carriage control followed by a new line).

Filename

The Zip file name should conform to the following naming convention
MCE_Claims_YYYYMMDD.zip

Example:

"BMC_Claims_20010701.zip", where
YYYYMMDD -the date of file creation (4 digit year, 2 digit month, 2 digit day) and
MCE identifies the Plan according to the following:

MCOs:
BMC - Boston Medical Center HealthNet Plan
CHA - Cambridge Network Health
FLN- Fallon Community Health Plan
MBH - Massachusetts Behavioral Health Partnership
NHP - Neighborhood Health Plan
HNE - Health New England
CAR - CeltiCare

SCOs:
CCA - Commonwealth Care Alliance
UHC – United HealthCare
NAV - Navicare
SWH - Senior Whole Health
TFT – Tufts Health Plan
BHP – BMC HealthNet Plan

One Care (ICO):
CCI - Commonwealth Care Alliance
NWI – Cambridge Network Health
FTC – Fallon Total Care

Project Related Filename

1. Names of the files submitted for the special projects should have an extension up to 6 characters after the date part of the name. For example, the files submitted for the J-Code project might have an extension "JCODE" in the name of the file.

Example:

"MCE_Claims_YYYYMMDD_JCODE.zip"

2. MH DW will give the MCEs specific instructions on the file naming standards related to specific
   - projects

The Manual Override File
The manual override file should be named MCE_Claims_YYYYMMDD_**MO**. The "_MO" files should be sent only after the error file has been returned to the MCEs, and the MCEs have re-submitted a corrected file. The manual override file should have a file type of EMO in the metadata file.

The Zip File should contain:
The Encounter Data file
The Provider data file
The Provider specialty file
The MCE Internal Provider Type file
The Manual Override file (if applicable)
The Service Reference file (MBHP Only)
The Service Class Codes file (MBHP Only)
The Authorization Type Codes file (MBHP Only)
The Claim Type Codes file (MBHP Only)
The Group Number Codes file (MBHP Only)
Additional Documentation File or Metadata file

Metadata file
Please submit an additional file called **metadata.txt** which contains the following Key Value Pairs. A regular submission or error submission file should have a file type of ENC. The manual override file should have a file type of EMO in the metadata file.

	ENC/EMO
MCE_Id="Value" (MCO: FLN, NHP, BMC, CHA, MBH, HNE, CAR) (SCO: CCA, UHC, NAV, SWH, TFT, BHP) (One Care-ICO: CCI, NWI, FTC)	Mandatory
Date_Created=" YYYYMMDD"	Mandatory
Data_File_Name="Value"	Mandatory
Pro_File_Name="Value"	Mandatory
Pro_Spec_Name="Value"	Mandatory
Pro_MCEType_Name="Value"	Mandatory
Total_Records="Value"	Mandatory
Total_Net_Payments="Value"	Mandatory
Time_Period_From="Value" (YYYYMMDD)	Mandatory
Time_Period_To="Value" (YYYYMMDD)	Mandatory
Return_To="email address"	Mandatory
Type_Of_Feed="Value" (ENC/EMO)	Mandatory
Ref_Services_File_Name ="Value"	Optional
SVCCLS_File_Name ="Value"	Optional
ATHTYP_File_Name ="Value"	Optional
CLATYP_File_Name ="Value"	Optional
GRPNUM_File_Name ="Value"	Optional

a) Names of the files in the metadata file must match the names of the actual files in submission
b) Send a zero byte None.txt for missing files - provider or specialty and set corresponding field value to "None.txt"
c) A file posted on SFTP server must have a unique name
d) Discrepancy between the actual feed and the values in Metadata file fields Total_Net_Payments and/or Total_Records results in rejection of the entire feed.
e) The names of the fields in Metadata file should match the spelling suggested in the spec (Example: Total_Net_Payments)
f) From a processing perspective there is no difference between the original submission file, a correction file, and an Amendment file. All these types of submissions should have Type_ Of_ Feed = ”ENC” in metadata file

Monthly Financial Report - CURRENTLY DECOMISSIONED!

some additional updates might be introduced later

This is a stand-alone text file submitted monthly separate from encounter data submission; however, it must be always submitted ***after*** the manual override file. Please follow instructions in Section 1.1 "Data Requirements".

Monthly Financial Report is submitted as a pipe-delimited text file based on the following specifications:

1. File name should conform to the following naming convention:
   MCE_FinReport_YYYYMMDD.txt where the date reflects the date of a file submission.

   Example:
   A report submitted by Boston Medical Center HealthNet Plan in May of 2015 for the month of March of 2015 would be named: **BMC_FinReport_20150531.txt**

2. Along with the report file, a confirmation file named **"mce_fin_done.txt"** should be submitted. This file should contain one field only indicating the name of the financial report submitted.

   Example:
   mce_fin_done.txt submitted along with **BMC_FinReport_20150531.txt** file will have the following content:
   "MCE_FINREP_FILE="BMC_FinReport_20150531.txt"

   First report record is a mandatory header record with the following details:
   MCE_ID|Reporting_YearMonth|Date_Created|Total_Records|Return_To

   Example:

   BMC|201503|20150531|25|abc.xyz@bmchp.org

3. Definition of header record by data element:

#	Field Name	Definition
1	MCE_ID	One of the following values: MCO: FLN,NHP,BMC,CHA,MBH,HNE,CAR; SCO: CCA, UHC, NAV, SWH, TFT, BHP; One Care-ICO: CCI, NWI, FTC.
2	Reporting_YearMonth	Must be the year and the month of the reporting month in "YYYYMM" format. (Same as "YearMonth" in the report).
3	Date_Created	Must be the date of submission with format "YYYYMMDD"
4	Total_Records	Number of records in the report excluding the header record.
5	Return_To	Must have the email address of the MCE contact person(s).

4. Data records should follow the header record with the layout described below:

#	Field Name	Definition	Length	Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization.	3	Number
2	Service Category	Service Category as defined in Tables I-A, I-B, I-C	3	Text
3	Description	Description of Service Category	120	Text
4	Total_Number_Of_Claim_Lines	Total number of claim lines per Service Category	10	Number
5	Total Net Payment	Total expenses per Service Category	15	*Number/No Decimal Point
6	YearMonth	The Year and Month of the report based on the dates of service on the claims. There is only one value per monthly report. See example below for August 2014 report.	6	Text

*MassHealth prefers to receive dollars and cents with an **implied decimal point** before the last two digits in the data. Actual decimal point must not be included in dollar amounts.

For example, a data string "1234567" would represent $12,345.67.

Report Example:

BMC|201503|20150531|25|abc.xyz@bmchp.org
997|5|Behavioral Health - Emergency Services|148|12365400|201408
997|9|Facility - Medical/Surgical|321|987456|201408
997|13|Laboratory|654|321456|201408
……

Note: No Pipes are allowed in the values of any above mentioned elements

Secure FTP Server

MassHealth has set up a Secure FTP server for exchanging data with the MCEs. Details of the server are below:

Sever: virtualgateway**dw**.ehs.state.ma.us ID currently set up for MCOs: fln, nhp, bmc, cha, mbhp, gu02 (CAR), gu04 (HNE).
ID currently set up for SCOs: swh, uhc, nav, cca, tft, bhp.
ID currently set up for One Care (ICOs): cci, nwi, ftc.
Home directory :/<mce>: example /nhp.

- Each home directory currently contains following sub directories *ehs_dw* : production folder for exchanging encounter data and error reports.
- *test_masshealth*: used by MassHealth for testing purpose.
- *test_mco*: available for mce to send any test files or adhoc data to MassHealth.

Sending Encounter data

Transfer encounter data file in a format and content as described in sections above to the production folder on the server. After the data transfer is complete, include a zero byte file called *mce_done.txt.*

- Please refrain from sending several files with the same name.
- Please make sure to post only one encounter or member file at the same time.
- If a second file is a project specific, please work with MH DW to follow the instructions on file submission related to the project

Receiving Error reports

After the data has been processed, an error zip file (beginning with err) will be posted to the production folder. A notification email will be sent to the email address provided in the Metadata feed. Please note that the error file will be available on the server for a period of 30 days. MassHealth may need to revise the retention period in the future, based on available disk space on the server. If you post a file and do not receive email message about the error file back in 7 business days, please contact MassHealth.

CMS Internet Security Policy

DATE OF ISSUANCE: November 24, 1998

SUBJECT:
Internet Communications Security and Appropriate Use Policy and Guidelines for CMS Privacy Act-protected and other Sensitive CMS Information.

1. Purpose.

This bulletin formalizes the policy and guidelines for the security and appropriate use of the Internet to transmit CMS Privacy Act-protected and other sensitive CMS information.

2. Effective Date.

This bulletin is effective as of the date of issuance.

3. Expiration Date.

This bulletin remains in effect until superseded or canceled.

4. Introduction.

The Internet is the fastest growing telecommunications medium in our history. This growth and the easy access it affords has significantly enhanced the opportunity to use advanced information technology for both the public and private sectors. It provides unprecedented opportunities for interaction and data sharing among health care providers, CMS contractors, CMS components, State agencies acting as CMS agents, Medicare and Medicaid beneficiaries, and researchers.
However, the advantages provided by the Internet come with a significantly greater element of risk to the confidentiality and integrity of information. The very nature of the Internet communication mechanisms means that security risks cannot be totally eliminated. Up to now, because of these security risks and the need to research security requirements vis-a-vis the Internet, CMS has prohibited the use of the Internet for the transmission of all CMS Privacy Act-protected and other sensitive CMS information by its components and Medicare/Medicaid partners, as well as other entities authorized to use this data.

The Privacy Act of 1974 mandates that federal information systems must protect the confidentiality of individually-identifiable data. Section 5 U.S.C. 552a (e) (10) of the Act is very clear; federal systems must: "...establish appropriate administrative, technical, and physical safeguards to insure the security and confidentiality of records and to protect against any anticipated threats or hazards to their security or integrity which could result in substantial harm, embarrassment, inconvenience, or unfairness to any individual on whom information is maintained." One of CMS's primary responsibilities is to assure the security of the Privacy Act-protected and other sensitive information it collects, produces, and disseminates in the course of conducting its operations. CMS views this responsibility as a covenant with its beneficiaries, personnel, and health care providers. This responsibility is also assumed by CMS's contractors, State agencies acting as CMS agents, other government organizations, as well as any entity that has been authorized access to CMS information resources as a party to a Data Release Agreement with CMS.

However, CMS is also aware that there is a growing demand for use of the Internet for inexpensive transmission of Privacy Act-protected and other sensitive information. CMS has a responsibility to accommodate this desire

as long as it can be assured that proper steps are being taken to maintain an acceptable level of security for the information involved.

This issuance is intended to establish the basic security requirements that must be addressed for use of the Internet to transmit CMS Privacy Act-protected and/or other sensitive CMS information.

The term "CMS Privacy Act-protected Data and other sensitive CMS information" is used throughout this document. This phrase refers to data which, if disclosed, could result in harm to the agency or individual persons. Examples include:

All individually identifiable data held in systems of records. Also included are automated systems of records subject to the Privacy Act, which contain information that meets the qualifications for Exemption 6 of the Freedom of Information Act; i.e., for which unauthorized disclosure would constitute a "clearly unwarranted invasion of personal privacy" likely to lead to specific detrimental consequences for the individual in terms of financial, employment, medical, psychological, or social standing.

Payment information that is used to authorize or make cash payments to individuals or organizations. These data are usually stored in production application files and systems, and include benefits information, such as that found at the Social Security Administration (SSA), and payroll information. Such information also includes databases that the user has the authority and capability to use and/or alter. As modification of such records could cause an improper payment, these records must be adequately protected.

Proprietary information that has value in and of itself and which must be protected from unauthorized disclosure.

Computerized correspondence and documents that are considered highly sensitive and/or critical to an organization and which must be protected from unauthorized alteration and/or premature disclosure.

5. Policy

This Guide establishes the fundamental rules and systems security requirements for the use of the Internet to transmit CMS Privacy Act-protected and other sensitive CMS information collected, maintained, and disseminated by CMS, its contractors, and agents.

It is permissible to use the Internet for transmission of CMS Privacy Act-protected and/or other sensitive CMS information, as long as an acceptable method of encryption is utilized to provide for confidentiality and integrity of this data, and that authentication or identification procedures are employed to assure that both the sender and recipient of the data are known to each other and are authorized to receive and decrypt such information. Detailed guidance is provided below in item 7.

6. Scope.

This policy covers all systems or processes which use the Internet, or interface with the Internet, to transmit CMS Privacy Act-protected and/or other sensitive CMS information, including Virtual Private Network (VPN) and tunneling implementations over the Internet. Non-Internet
Medicare/Medicaid data communications processes (e.g., use of private or value added networks) are not changed or affected by the Internet Policy.

This policy covers Internet data transmission only. It does not cover local data-at-rest or local host or network protections. Sensitive data-at-rest must still be protected by all necessary measures, in conformity with the guidelines/rules which govern the entity's possession of the data. Entities must use due diligence in exercising this responsibility.

Local site networks must also be protected against attack and penetration from the Internet with the use of firewalls and other protections. Such protective measures are outside the scope of this document, but are essential to providing adequate local security for data and the local networks and ADP systems which support it.

7. Acceptable Methods

CMS Privacy Act-protected and/or other sensitive CMS information sent over the Internet must be accessed only by authorized parties. Technologies that allow users to prove they are who they say they are (authentication or identification) and the organized scrambling of data (encryption) to avoid inappropriate disclosure or modification must be used to insure that data travels safely over the Internet and is only disclosed to authorized parties. Encryption must be at a sufficient level of security to protect against the cipher being readily broken and the data compromised. The length of the key and the quality of the encryption framework and algorithm must be increased over time as new weaknesses are discovered and processing power increases.

User authentication or identification must be coupled with the encryption and data transmission processes to be certain that confidential data is delivered only to authorized parties. There are a number of effective means for authentication or identification which are sufficiently trustworthy to be used, including both in-band authentication and out-of-band identification methods. Passwords may be sent over the Internet only when encrypted.

(footnote)1 We note that the Health Insurance Portability and Accountability Act of 1966 (HIPAA) calls for stringent security protection for electronic health information both while maintained and while in transmission. The proposed Security Standard called for by HIPAA was published in the Federal Register on August 12, 1998. The public had until October 13, 1998, to comment on the proposed regulation. Based on public comments, a final regulation is planned for late 1999. Policy guidance contained in this bulletin is consistent with the proposed HIPAA security requirements.

ENCRYPTION MODELS AND APPROACHES

Figure 1 depicts three generalized configurations of connectivity to the Internet. The generic model is not intended to be a literal mirror of the actual Internet interface configuration, but is intended to show that the encryption process takes place prior to information being presented to the Internet for transmission, and the decryption process after reception from the Internet. A large organization would be very likely to have the Internet Server/Gateway on their premises while a small organization would likely have only the Internet Client, e.g., a browser, on premises with the Internet Server at an Internet Service Provider (ISP). The Small User and Large User examples offer a more detailed depiction of the functional relationships involved.

The Encryption/Decryption process depicted graphically represents a number of different approaches. This process could involve encryption of files prior to transmittal, or it could be implemented through hardware or software functionality. The diagram does not intend to dictate how the process is to be accomplished, only that it must take place prior to introduction to the
Internet. The "Boundary" on the diagrams represents the point at which security control passes from the local user. It lies on the user side of the Internet Server and may be at a local site or at an Internet Service Provider depending upon the configuration.

FIGURE 1: INTERNET COMMUNICATIONS EXAMPLES in PDF.

Acceptable Approaches to Internet Usage

The method(s) employed by all users of CMS Privacy Act-protected and/or other sensitive
CMS information must come under one of the approaches to encryption and at least one of the authentication or identification approaches. The use of multiple authentication or identification approaches is also permissible. These approaches are as generic as possible and as open to specific implementations as possible, to provide maximum user flexibility within the allowable limits of security and manageability.

Note the distinction that is made between the processes of "authentication" and "identification". In this Internet Policy, the terms "Authentication" and "Identification" are used in the following sense. They should not be interpreted as terms of art from any other source. Authentication refers to generally automated and formalized methods of establishing the authorized nature of a communications partner over the Internet communications data channel itself, generally called an
"in-band process." Identification refers to less formal methods of establishing the authorized nature of a communications partner, which are usually manual, involve human interaction, and do not use the Internet data channel itself, but another "out-of-band" path such as the telephone or US mail.

The listed approaches provide encryption and authentication/identification techniques which are acceptable for use in safeguarding CMS Privacy Act-protected and/or other sensitive CMS information when it is transmitted over the Internet.

In summary, a complete Internet communications implementation must include adequate encryption, employment of authentication or identification of communications partners, and a management scheme to incorporate effective password/key management systems.

ACCEPTABLE ENCRYPTION APPROACHES

Note: As of November 1998, a level of encryption protection equivalent to that provided by an algorithm such as Triple 56 bit DES (defined as 112 bit equivalent) for symmetric encryption, 1024 bit algorithms for asymmetric systems, and 160 bits for the emerging Elliptical Curve systems is recognized by CMS as minimally acceptable. CMS reserves the right to increase these minimum levels when deemed necessary by advances in techniques and capabilities associated with the processes used by attackers to break encryption (for example, a brute-force exhaustive search).

HARDWARE-BASED ENCRYPTION:

1. Hardware encryptors - While likely to be reserved for the largest traffic volumes to a very limited number of Internet sites, such symmetric password "private" key devices (such as link encryptors) are acceptable.

SOFTWARE-BASED ENCRYPTION:

2.Secure Sockets Layer (SSL) (Sometimes referred to as Transport Layer Security - TLS) implementations - At a minimum SSL level of Version 3.0, standard commercial implementations of PKI, or some variation thereof, implemented in the Secure Sockets Layer are acceptable.

3.S-MIME - Standard commercial implementations of encryption in the e-mail layer are acceptable.

4.In-stream - Encryption implementations in the transport layer, such as pre-agreed passwords, are acceptable.

5.Offline - Encryption/decryption of files at the user sites before entering the data communications process is acceptable. These encrypted files would then be attached to or enveloped (tunneled) within an unencrypted header and/or transmission.

ACCEPTABLE AUTHENTICATION APPROACHES

AUTHENTICATION (This function is accomplished over the Internet, and is referred to as an "in-band" process.)

1. Formal Certificate Authority-based use of digital certificates is acceptable.

2. Locally-managed digital certificates are acceptable, providing all parties to the communication are covered by the certificates.

3. Self-authentication, as in internal control of symmetric "private" keys, is acceptable.

4. Tokens or "smart cards" are acceptable for authentication. In-band tokens involve overall network control of the token database for all parties.

ACCEPTABLE IDENTIFICATION APPROACHES

IDENTIFICATION (The process of identification takes place outside of the Internet connection and is referred to as an "out-of-band" process.)

1. Telephonic identification of users and/or password exchange is acceptable.

2. Exchange of passwords and identities by U.S. Certified Mail is acceptable.

3. Exchange of passwords and identities by bonded messenger is acceptable.

4. Direct personal contact exchange of passwords and identities between users is acceptable.

5. Tokens or "smart cards" are acceptable for identification. Out-of-band tokens involve local control of the token databases with the local authenticated server vouching for specific local users.

8. REQUIREMENTS AND AUDITS

Each organization that uses the Internet to transmit CMS Privacy Act-protected and/or other sensitive CMS information will be expected to meet the stated requirements set forth in this document.

All organizations subject to OMB Circular A-130 are required to have a Security Plan. All such organizations must modify their Security Plan to detail the methodologies and protective measures if they decide to use the Internet for transmittal of CMS Privacy Act-protected and/or other sensitive CMS information, and to adequately test implemented measures.

CMS reserves the right to audit any organization's implementation of, and/or adherence to the requirements, as stated in this policy. This includes the right to require that any organization utilizing the Internet for transmission of CMS Privacy Act-protected and/or other sensitive information submit documentation to demonstrate that they meet these requirements.

9. ACKNOWLEDGMENT OF INTENT

Organizations desiring to use the Internet for transmittal of CMS Privacy Act-protected and/or other sensitive CMS information must notify CMS of this intent. An e-mail address is provided below to be used for this acknowledgment. An acknowledgment must include the following information:
Name of Organization
Address of Organization
Type/Nature of Information being transmitted
Name of Contact (e.g., CIO or an accountable official)
Contact's telephone number and e-mail address
For submission of acknowledgment of intent, send an e-mail to: internetsecurity@CMS.gov. Internal CMS elements must proceed through the usual CMS system and project development process.

10. POINT OF CONTACT
For questions or comment, write to:

Office of Information Services, CMS
Security and Standards Group
Division of CMS Enterprise Standards -Internet
7500 Security Boulevard
Baltimore, MD 21244

Also, check out the Security Policy FAQs
Return to Information Clearinghouse Listing

Last Updated January 31, 2001

7.0 Standard Data Values

Contents

This section contains tables that identify the standard coding structures for several of the encounter data fields.

Use of Standard Data Values

The tables list all of the standard data values for the fields, with descriptions.

Standard data values are given for the following tables:

Table A	Admit Type (UB)
Table B	Admit Source (UB)
Table C	Place of Service (CMS 1500)
Table D	Place of Service (from UB Type of Bill)
Table E	Discharge Status (UB Patient Status)
Table G	Servicing Provider Type
Table H	Servicing Provider Specialty (CMS 1500)
Table I	Service Category I-A: MCO I-B: SCO I-C: One Care (ICO)
Table K	Bill Classifications – (UB Bill Classification, 3rd digit)
Table M	Present on Admission (UB)
Table O	UB-4 UNIT OF MEASURE

Note: The abbreviation **NEC** after a description stands for **Not Elsewhere Classified**.

TABLE A
Type of Admission (UB)

Value	Definition
1	Emergency
2	Urgent
3	Elective
4	Newborn
5	Trauma Center
6-8	Reserved for National Assignment
9	Information not available

TABLE B
Source of Admission (UB)

Value	Description
1	Physician Referral
2	Clinic/Outpatient Referral
3	HMO Referral
4	Transfer from Hospital
5	Transfer from SNF
6	Transfer from another Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information not available
A	RESERVED FOR ASSIGNMENT BY THE NUBC (END 10/1/07)
B	TRANSFER FROM ANOTHER HOME HEALTH AGENCY
C	RESERVED FOR ASSIGNMENT BY THE NUBC (END 7/1/10)
D	TRANSFER FROM ONE UNIT TO ANOTHER - SAME HOSP
E	TRANSFER FROM AMBULATORY SURGICAL CENTER
F	TRANSFER FROM HOSPICE/ENROLLED IN HOSPICE PROGRAM

For Newborns

Value	Description
1	Normal Delivery
2	Premature Delivery
3	Sick Baby
4	Extramural Birth

TABLE C
Place of Service (HCFA 1500)

Place of Service Codes for Professional Claims

CMS Database (updated November 2016)

Value	Place of Service Name	Place of Service Description
01	Pharmacy**	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients (effective 10/1/05)
02	Telehealth	The location where health services and health related services are provided or received, through a telecommunication system. (Effective January 1, 2017)
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison-Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (effective 7/1/06)
10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.

Value	Place of Service Name	Place of Service Description
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services. (effective 10/1/03)
14	Group Home*	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.
17	Walk-in Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services. (This code is available for use immediately with a final effective date of May 1, 2010)
18	Place of Employment-Worksite	A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual. (This code is available for use effective January 1, 2013 but no later than May 1, 2013)
19	Off Campus-Outpatient Hospital	A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On Campus-Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Description change effective January 1, 2016)
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

Value	Place of Service Name	Place of Service Description
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance – Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (effective 10/1/03)
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

Value	Place of Service Name	Place of Service Description
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/ Individuals with Intellectual Disabilities	A facility which primarily provides health-related care and services above the level of custodial care to individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (effective 10/1/03)
58-59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician. (effective 10/1/03)

Value	Place of Service Name	Place of Service Description
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other place of service not identified above.

TABLE D
Place of Service (from UB Bill Type – 1st & 2nd digits)

Type of Facility (1st digit)

Value	Description
1	Hospital
2	Skilled Nursing Facility (SNF)
3	Home Health Agency (HHA)
4	Christian Science (Hospital)
5	Christian Science (Extended Care)
6	Intermediate Care
7	Clinic (refer to *Clinics Only* for 2nd digit)
8	Substance Abuse or Specialty Facility
9	Halfway House

Bill Classifications – Facilities (2nd digit)

Value	Description
1	Inpatient (including Medicare Part A)
2	Inpatient (Medicare Part B only)
3	Outpatient
4	Other
5	Basic Care
6	Complementary Inpatient
7	Complementary Outpatient
8	Swing Beds
9	Halfway House

Bill Classifications – Clinics only (2nd digit)

Value	Description
1	Rural Health Clinic
2	Hospital-based or Freestanding End State Renal Dialysis Facility
3	Freestanding Clinic
4	Other Rehab Facility (ORF) or Community Mental Health Center
5	Comprehensive Outpatient Rehab Facility (CORF)
6-8	Reserved for national assignment
9	Other

Bill Classifications – Specialty Facility (2nd digit)

Value	Description
1	Hospice (non-hospital based)
2	Hospice (hospital based)
3	Ambulatory Surgery Center
4	Free Standing Birthing Center
5	Critical Access Hospital
6	Residential Facility
7-8	Reserved for national assignment
9	Other

TABLE E
Discharge Status (UB Patient Status)

Value	Description
01	Discharged alive to home / self-care (routine discharge)
02	Discharged/Transferred to short term general hospital
03	Discharged/Transferred to skilled nursing facility (SNF)
04	Discharged/Transferred to intermediate care facility (ICF)
05	Discharged/Transferred to other facility
06	Discharged/Transferred to home care
07	Left against medical advice
08	Discharged/Transferred to home under care of a home IV drug therapy provider
09	Admitted as an inpatient to this hospital
10 – 19	Discharged to be defined at State level if necessary
20	Expired (Did not recover – Christian Science Patient)
21 – 29	Expired to be defined at State level if necessary
30	Still a patient
31 – 39	Still a patient to be defined at State level if necessary
40	Expired at home (Hospice claims only)
41	Died in a medical facility (Hospice claims only)
42	Place of death unknown (Hospice claims only)
43 – 99	Reserved for National Assignment

TABLE G
Servicing Provider Type

Value	Description
00	Placeholder PCP
01	Acute Care Hospital-Inpatient
02	Acute Care Hospital-Outpatient
03	Chronic Hospital-Inpatient
04	Chronic Hospital-Outpatient
05	Ambulatory Surgery Centers
06	Trauma Center
10	Birthing Center
15	Treatment Center
20	Mental Health/Chemical Dep. (NEC)
21	Mental Health Facilities
22	Chemical Dependency Treatment Ctr.
23	Mental Health/Chem Dep Day Care
25	Rehabilitation Facilities
30	Long-Term Care (NEC)
31	Extended Care Facility
32	Geriatric Hospital
33	Convalescent Care Facility
34	Intermediate Care Facility
35	Residential Treatment Center
36	Cont. Care Retirement Community
37	Day/Night Care Center
38	Hospice
40	Facility (NEC)
41	Infirmary
42	Special Care Facility (NEC)
50	Physician
51	Medical Doctor MD
52	Osteopath DO
53	Allergy & Immunology
54	Anesthesiology
55	Colon & Rectal Surgery
56	Dermatology
57	Emergency Medicine
58	Family Practice
59	Geriatric Medicine
60	Internist (NEC)
61	Cardiovascular Diseases
62	Critical Care Medicine
63	Endocrinology/Metabolism
64	Gastroenterology
65	Hematology
66	Infectious Disease
67	Medical Oncology
68	Nephrology
69	Pulmonary Disease
70	Rheumatology
71	Neurological Surgery
72	Nuclear Medicine
73	Obstetrics/Gynecology

TABLE G
Servicing Provider Type

Value	Description
74	Ophthalmology
75	Orthopedic Surgery
76	Otolaryngology
77	Pathology
78	Pediatrician (NEC)
79	Pediatric Specialist
80	Physical Medicine and Rehabilitation
81	Plastic Surgery/Maxillofacial Surgery
82	Preventative Medicine
83	Psychiatry/Neurology
84	Radiology
85	Surgeon
86	Surgical Specialist
87	Thoracic Surgery
88	Urology
95	Dentist
96	Dental Specialist
99	Podiatry
100	Unknown Clinic
120	Chiropractor
125	Dental Health Specialists
130	Dietitian
135	Medical Technologists
140	Midwife
145	Nurse Practitioner
146	Nursing Services
150	Optometrist
155	Pharmacist
160	Physician's Assistant
165	Therapy (physical)
170	Therapists (supportive)
171	Psychologist
175	Therapists (alternative)
180	Acupuncturist
185	Spiritual Healers
190	Health Educator
200	Transportation
205	Health Resort
210	Hearing Labs
215	Home Health Organization
220	Imaging Center
225	Laboratory
230	Pharmacy
235	Supply Center
240	Vision Center
245	Public Health Agency
246	Rehab Hospital-Inpatient
247	Rehab Hospital-Outpatient
248	Psychiatric Hospital-Inpatient
249	Psychiatric Hospital-Outpatient
250	Community Health Center

301	General Hospital

TABLE G
Servicing Provider Type

Value	Description
302	Certified Clinical Nurse Specialist
303	Infusion Therapy
304	Palliative Care Medicine
305	Adult Day Health
306	Adult Foster Care / Group Adult Foster Care
307	Fiscal Intermediary Services (FIS)
308	Personal Care Management Agency
309	Independent Living Centers
310	Day Habilitation
311	Durable Medical Equipment
312	Oxygen And Respiratory Therapy Equip
313	Prosthetics
314	Orthotics
315	Renal Dialysis Clinics
316	Respite Care
317	Intensive Residential Treatment Program (IRTP)
318	Complex Care Management
319	Special Programs
320	Recovery Learning Community (RLCs)
321	Certified Peer Specialist
322	Emergency Services Program (ESP)
323	Community Health Worker
324	Hospital Licensed Health Center
325	Aging Services Access Point (ASAP)
326	Geriatric Mental Health
327	Child Mental Health
328	Deaf and Hard of Hearing Independent Living Services Programs
329	Home Modification Service Providers
330	Transitional Assistance (across settings) Providers
331	Medication Management Providers
332	Substance Abuse Treatment Center
333	Magnetic Resonance Centers
334	Psych Day Treatment
335	QMB (Qualified Medicare Beneficiaries) Only Provider
336	Group Practice Physicians
337	School-Based Clinic or Health Center
338	Billing Agent

TABLE H
Servicing Provider Specialty (from CMS 1500)

Value	Description
01	General Practice
02	General Surgery
03	Allergy / Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative therapy
13	Neurology
14	Neurosurgery
15	Speech Language Pathologists
16	Obstetrics / Gynecology
17	Hospice and Palliative Care
18	Ophthalmology
19	Oral Surgery (Dentists Only)
20	Orthopedic Surgery
22	Pathology
23	Sports Medicine
24	Plastic & Reconstructive Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Geriatric Psychiatry
28	Colorectal Surgery
29	Pulmonary Disease
30	Diagnostic Radiology
31	Intensive Cardiac Rehabilitation
32	Anesthesiologist Assistant
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery
41	Optometrist
42	Certified Nurse Midwife
43	CRNA, Anesthesia Assistant
44	Infectious Diseases
45	Mammography Screening Center
46	Endocrinology
48	Podiatrist
49	Ambulatory Surgery Center
50	Nurse Practitioner
51	Med Supply Co w/Certified Orthotist
52	Med Supply Co w/Certified Prosthetist
53	Med Supply Co w/Certified Prosthetist/Orthotist
54	Med Supply Co not included in 51, 52 or 53
55	Individual Certified Orthotist

56	Individual Certified Prosthetist

TABLE H

Servicing Provider Specialty

Value	Description
57	Individual Certified Prosthetist/Orthotist
58	Individuals not included in 55, 56 or 57
59	Ambulance Service Supplier
60	Public Health or Welfare Agency (Federal, State & Local Govt)
61	Voluntary Health Agency (ex: Planned Parenthood)
62	Psychologist
63	Portable X-Ray Supplier
64	Audiologist
65	Physical Therapist
66	Rheumatology
67	Occupational Therapist
68	Clinical Psychologist
69	Clinical Laboratory
70	Multispecialty Clinic or Group Practice
71	Registered Dietician/Nutrition Professional
72	Pain Management
73	Mass Immunization Roster Biller
74	Radiation Therapy Centers
75	Slide Preparation Facilities
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
80	Licensed Clinical Social Worker
81	Critical Care (Intensivists)
82	Hematology
83	Hematology/Oncology
84	Preventive Medicine
85	Maxillofacial Surgery
86	Neuropsychiatry
87	All Other Suppliers (i.e. Drug, & Department Stores)
88	Unknown Supplier/Provider Specialty
89	Certified Clinical Nurse Specialist
90	Medical Oncology
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Interventional Radiology
95	Independent Physiological Lab
96	Optician
97	Physician Assistant
98	Gynecologist/Oncologist
99	Unknown Physician Specialty

Value	Description
A0	Hospital
A1	SNF
A2	Intermediate Care Facility
A3	Nursing Facility, Other
A4	HHA
A5	Pharmacy
A6	Medical Supply Co w/Respiratory Therapist
A7	Department Store
A8	Grocery Store
A9	Dentist
B2	Pedorthic Personnel
B3	Medical Supply Company with Pedorthic Personnel
B4	Rehabilitation Agency
B5	Ocularist

TABLE I – A
Service Category (Using the 4B reporting groups)

Value	Description
1	Capitated Physician Services
2	Fee For Service Physician Services
3	Behavioral Health –Inpatient Services
4	Behavioral Health –Diversionary Services *
5	Behavioral Health –Emergency Services Program (ESP) Services
6	Behavioral Health –Mental Health Outpatient Services *
7	Behavioral Health –Substance Abuse Outpatient Services *
8	Behavioral Health –Other Outpatient Services *
9	Facility- Medical/Surgical
10	Facility- Pediatric/Sick Newborns
11	Facility- Obstetrics
12	Facility- Skilled Nursing Facility/Rehab
13	Facility- Other Inpatient
14	Facility- Emergency Room
15	Facility –Ambulatory Care
16	Prescription Drug
17	Laboratory
18	Radiology
19	Home Health
20	Durable Medical Equipment
21	Emergency Transportation
22	Therapies
23	Other (Please use this for Vision and Dental claims)
24	Other Alternative Care
25	Mental Health and Substance Abuse Outpatient Services(MBHP Only)*
26	Outpatient Day Services (MBHP Only) *
27	Non-ESP Emergency Services (MBHP Only) *
28	Behavioral Health –Diversionary Services – 24-Hour
29	Behavioral Health – Diversionary Services – Non-24-Hour
30	Behavioral Health –Standard Outpatient Services
31	Behavioral Health –Other Services
32	Behavioral Health – Intensive Home or Community Based Outpatient Services for Youth (Please note this new category is where all CBHI services, except youth mobile crisis intervention would be listed. Youth mobile crisis intervention would be considered part of the Emergency Services Program Services.)

*** Use these categories *only* for the claims with Dates of Service before 07/01/2010.**

TABLE I – B1

Service Category (Using the SCO reporting groups)

Note: For the Claims with Date of Service **on or after October 1, 2016**

Value	Description
301	Hospital Inpatient
302	Behavioral Health (BH) Hospital Inpatient
303	Hospital Outpatient
304	Behavioral Health (BH) Hospital Outpatient
305	Professional
306	Vision
307	Dental
308	Therapy
309	Pharmacy/Drugs
309B	Pharmacy/Drugs (non-Part D)
310	Laboratory, Radiology, Testing
311	Institutional Long Term Care
312	Community Long Term Care
313	Home and Community Based Waiver
314	Transportation
315	Medical Equipment
316	Hospice
317	Case Management
318	Other Miscellaneous

TABLE I – B2

Service Category (Using the SCO reporting groups)

Note: For the Claims with Date of Service **before October 1, 2016**

Value	Description
101	Acute Inpatient
102	Chronic Inpatient
103	Outpatient Clinic
104	Mental Health/Substance Abuse
105	Physicians
106	Nonphysician Practitioners
107	Vision Care
108	Dental Care
109	Therapies
110	Pharmacy
111	Laboratory, radiology, testing
112	Institutional Long Term Care
113	Community Long Term Care
114	Waiver Services
115	Transportation
116	Supplies/ Durable Medical Equipment
117	Hospice
118	Care Management
119	Miscellaneous

TABLE I – C
Service Category (Using the One Care - ICO reporting groups)

Value	Description
201	Acute Inpatient
202	Inpatient – MH/SA
203	Hospital Outpatient
204	Outpatient – MH/SA
205	Professional
210	Pharmacy
212	Long-Term Care (LTC) Facility
213	Home and Community Based Services (HCBS)/Home Health
215	Transportation
216	Durable Medical Equipment (DME) and Supplies
217	*All Other

*Should follow the definition in the “Quarterly Financial Report” submitted to EOHHS Budget Unit

TABLE K
Bill Classifications - Frequency (3rd digit)

Value	Description
0	Nonpayment/Zero Claims
1	Admit thru discharge claim
2	Interim-first claim
3	Interim –continuing claim
4	Interim-last claim
5	Late charges only claim
6	Adjustment of prior claim
7	Replacement of prior claim
8	Void/back out of prior claim
9	Final claim for Home Health PPS episode
A	Admission/Election Notice
B	Hospice termination revocation notice
C	Hospice change of provider notice
D	Hospice Void/back out
E	Hospice change of ownership
F	Beneficiary Initiated adjustment claim-other
G	CWF Initiated adjustment claim-other
H	CMS Initiated adjustment claim-other
I	Intermediary adjustment claim (other than PRO or Provider)
J	Initiated adjustment claim-other
K	OIG initiated adjustment claim
L	Reserved for national assignment
M	MSP initiated adjustment claim
N	PRO adjustment Claim
O	Nonpayment/Zero Claims
P-W	Reserved for national assignment
X	Void/back out a prior abbreviated encounter submission
Y	Replacement of a prior abbreviated encounter submission
Z	New abbreviated encounter submission

TABLE M
Present on Admission (UB)
CMS POA Indicator Options and Definitions

Code	Reason for Code
Y	Diagnosis was present at time of inpatient admission
N	Diagnosis was not present at time of inpatient admission.
U	Documentation was insufficient to determine if the condition was present at the time of inpatient admission.
W	Clinically undetermined, Provider was unable to clinically determine whether the condition was present at the time of inpatient admission.
1	Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04, however; it was determined that blanks are undesirable when submitting this data via the 4010A.

CMS Updated on June 2008

TABLE O
UNIT OF MEASURE

#	Unit	Description	POPS Suggested Rules
1	F2	International Unit (for example, anti-hemophilia factor)	Physician Administered Drug claims only
2	GR	Gram (for creams, ointments, and bulk powder)	Physician Administered Drug claims only
3	ME	Milligrams (for creams, ointments, and bulk powder)	Physician Administered Drug claims only
4	UN	Unit (for tablets, capsules, suppositories, and powder filled vials)	Physician Administered Drug claims
5	ML	Milliliters (for liquids, suspensions, and lotions)	Physician Administered Drug claims **and** Pharmacy
6	EA	Each	Pharmacy claims only
7	GM	Gram	Pharmacy claims only

Unit of Measure Reference

#	Unit	Standard Referenced	Available Link
1	F2	ANSI 5010 837P and ANSI 5010 837I	
2	GR	ANSI 5010 837P and ANSI 5010 837I	
3	ME	ANSI 5010 837P and ANSI 5010 837I	
4	UN	ANSI 5010 837P and ANSI 5010 837I	
5	ML	ANSI 5010 837P, ANSI 5010 837I, and NCPDP	NCPDP: http://www.ncpdp.org/NCPDP/media/pdf/BUS_fact_sheet.pdf
6	EA	NCPDP	NCPDP: http://www.ncpdp.org/NCPDP/media/pdf/BUS_fact_sheet.pdf
7	GM	NCPDP	NCPDP: http://www.ncpdp.org/NCPDP/media/pdf/BUS_fact_sheet.pdf

8.0 Quantity and Quality Edits, Reasonability and Validity Checks

Raw Data

- File layout format
- Length and data type of the fields
- Reasonability of data
- ***ICD Version Qualifier*** (field # 193) is populated on every encounter claim record that has either ICD diagnosis codes or ICD procedure codes.
- All ICD diagnosis and ICD procedure codes on a claim record are consistent with ICD Version Qualifier.

Data Quality

- Each field is checked for quantity and quality
- Distribution reports
- Percentage reports
- Valid value reports
- Reasonability reports

Claims File

#	Field Name	MassHealth Standard
1	Org. Code	100% present
2	Claim Category	100% present and valid, as found in Data Elements table.
3	Entity PIDSL	100% present on all encounters
4	Record Indicator	100% present
5	Claim Number	100% present
6	Claim Suffix	100% present
7	Pricing Indicator	Directions will be provided later, validation standards TBD
8	Recipient DOB	100% present and valid, as compared to encounter service dates
9	Recipient Gender	100% present and valid, as found in Data Elements table
10	Recipient ZIP Code	100% present
11	Medicare Code	Provide if applicable
12	Other Insurance Code	100% present and valid, as found in Data Elements table
13	Submission Clarification Code	Provide on Pharmacy and Provider-Administered Drug claims
14	Claim Type	100% present and valid for MBHP only
15	Admission Date	100% present and valid value on all Inpatient claims, Long Term Care claims and all hospital (institutional) claims with admission.
16	Discharge Date	100% present and valid value on all Hospital discharges and Long Term Care discharges.
17	From Service Date	100% present and valid date on all claims; dates should be

		evenly distributed across time
18	To Service Date	100% present and valid date on all claims.
#	**Field Name**	**MassHealth Standard**
19	Primary Diagnosis	100% present and valid ICD codes on all Professional, Institutional (including Long Term Care) , Vision, and Transportation claims. • On Transportation claims for the services like "a ride to the grocery store", MCEs should use generic diagnosis codes such as: V46.3 – Wheelchair dependence; V49.9 – Unspecified problem with limbs and other problems; V58.9 – Unspecified aftercare. • Should be submitted on Dental claims when available. • Not required on Pharmacy claims. • E-codes not valid as primary diagnosis. • Consistent with ICD Version Qualifier.
20	Secondary Diagnosis	60% present and valid ICD codes on inpatient facility and 20% present and valid on other records, excluding drug and vision. Not routinely coded on Dental records and LTC. Consistent with ICD Version Qualifier.
21	Tertiary Diagnosis	Provide if available. Consistent with ICD Version Qualifier.
22	Diagnosis 4	Provide if available. Consistent with ICD Version Qualifier.
23	Diagnosis 5	Provide if available. Consistent with ICD Version Qualifier.
24	Type of Admission	100% present and valid value *(Admit Type, Table A) on all inpatient claims,* Long Term Care claims, and all hospital (institutional) claims with admission.
25	Source of Admission	100% present and valid value (*Admit Source, Table B*) *on all inpatient claims,* Long Term Care claims, and all hospital (institutional) claims with admission.
26	Procedure Code	98% present and valid in general but should be 100% present on all professional claims .Procedure Code Indicator match (i.e., if the code is a "CPT or HCPCS Level 1 Code" then the Procedure code indicator should be "2").
27	Procedure Modifier 1	Provide if available
28	Procedure Modifier 2	Provide if available
29	Procedure Modifier 3	Provide if available
30	Procedure Code Indicator	100% present and valid if Procedure Code field is filled
31	Revenue Code	98% present and valid on Hospital and Long Term Care claims only and should be 100% present on all Inpatient claim detail lines
32	Place of Service	100% present and valid value *on all professional claims.*
33	Type Of Bill	100% present and valid on all Inpatient and Long Term Care claims
34	Patient Discharge Status	100% present and valid value on all Inpatient claims, LTC claims, all hospital (institutional) claims with admission.
35	FILLER	
36	Quantity	100% present on all claim categories.
37	NDC Number	98% present and valid values, on Pharmacy claims; and on Hospital and Professional claims when applicable
38	Metric Quantity	100% present and valid values, only on Pharmacy claims, reasonability of values (total number of units or volume) and on Hospital and Professional claims when applicable.
39	Days Supply	100% present and valid values, only on all prescription drug Pharmacy claims.
40	Refill Indicator	100% present and valid values, only on all prescription drug Pharmacy claims.
41	Dispense As Written Indicator	100% present and valid values, only on all prescription drug Pharmacy claims.

#	Field Name	MassHealth Standard
42	Dental Quadrant	100% present and valid values (1-4), only on dental claims , where applicable
43	Tooth Number	100% present, only on dental claims, where applicable
44	Tooth Surface	100% present, only on dental claims, where applicable
45	Paid Date	100% present and valid date, falls within submitted date range, falls after “Admit, Discharge, To, and From Dates”
46	Service Class	100% present and valid for MBHP only
47	PCP Provider ID	100% present should be an enrolled provider listed in provider enrollment file. Not applicable to MBHP.
48	PCP Provider ID Type	100% present and valid based on PCP Provider ID field. Not applicable to MBHP.
49	PCC Internal Provider ID	If applicable, should be an enrolled provider listed in provider enrollment file.
50	Servicing Provider ID	100% present and valid on all claims except Pharmacy. Should be an enrolled provider listed in provider enrollment file.
51	Servicing Provider ID Type	100% present and valid on all claims except Pharmacy, Based on Servicing Provider ID field
52	Referring Provider ID	If applicable, should be an enrolled provider listed in provider enrollment file.
53	Referring Provider ID Type	100% present and valid, only when Referring Provider ID is present
54	Servicing Provider Class	100% present and valid on all records, as found in the Data Elements table.
55	Servicing Provider Type	100% present and valid value (*Servicing Provider Type, Table G*)
56	Servicing Provider Specialty	100% present and valid value (*Servicing Provider Specialty, Table H*)
57	Servicing Provider ZIP Code	100% present and valid
58	Billing Provider ID	100% present and valid on all claims; should be an enrolled provider listed in provider enrollment file.
59	Authorization Type	100% present and valid for MBHP only
60	Billed Charge	100% present financial field with implied 2 decimals, mathematical check with other dollar amounts
61	Gross Payment Amount	100% present financial field with implied 2 decimals, mathematical check with other dollar amounts
62	TPL Amount	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
63	Medicare Amount	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
64	Copay/Coinsurance	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
65	Deductible	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
66	Ingredient Cost	100% present and valid on prescription drug records, financial field with implied 2 decimals, mathematical check with other dollar amounts only on Pharmacy claims
67	Dispensing Fee	100% present and valid on prescription drug records, financial field with implied 2 decimals, mathematical check with other dollar amounts only on Pharmacy claims
68	Net Payment	100% present financial field with implied 2 decimals, mathematical check with other dollar amounts
69	Withhold Amount	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
70	Record Type	100% present and valid on all records, as found in the Data Elements table, dollar amount checks
71	Group Number	100% present and valid

#	Field Name	MassHealth Standard
72	DRG	100% present and valid value (001 - 495), on Acute Inpatient Hospital claims, when collected by plan.
73	EPSDT Indicator	Not coded at the present time
74	Family Planning Indicator	Not coded at the present time
75	MSS/IS	Not coded at the present time
76	New Member ID (consistent with above data)	100% Present and valid on all claims; not allowed to be missed or invalid.
77	Former Claim Number	100% present and valid, only when Record Type is not O
78	Former Claim Suffix	100% present and valid, only when Record Type is not O
79	Record Creation Date	100% present and valid date
80	Service Category	100% present and valid (*Service Category, Table I*)
81	Prescribing Prov. ID	100% present and valid on Pharmacy claims. Should be an enrolled provider listed in provider enrollment file.
82	Date Script Written	100% present and valid on Pharmacy claims.
83	Compound Indicator	100% present and valid on prescription drug records
84	Rebate Indicator	100% present and valid on prescription drug records
85	Admitting Diagnosis	100% present and valid value on all Inpatient claims, Long Term Care claims, and all hospital (institutional) claim with admission.
86	Allowable Amount	100% present and valid, financial field with implied 2 decimals, mathematical check with other dollar amounts
87	Attending Prov. ID	100% present should be an enrolled provider listed in provider enrollment file. Inpatient Claims only.
88	Non-covered Days	Provide if applicable
89	External Injury Diagnosis 1	Provide if available. Consistent with ICD Version Qualifier.
90	Claim Received Date	100% present and valid date
91	Frequency	100% present and valid on Inpatient claims.
92	PCC Internal Provider ID Type	100% present and valid, when PCC Provider ID is present
93	Billing Provider ID _Type	100% present, and valid on all claims.
94	Prescribing Prov. ID _Type	100% present and valid on Pharmacy claims.
95	Attending Prov. ID _Type	100% present, and valid
96	Admission Time	100% present and valid value on Hospital and Long Term Care claims
97	Discharge Time	100% present and valid value on Hospital and Long Term Care claims
98	Diagnosis 6	Provide if available. Consistent with ICD Version Qualifier.
99	Diagnosis 7	Provide if available. Consistent with ICD Version Qualifier.
100	Diagnosis 8	Provide if available. Consistent with ICD Version Qualifier.
101	Diagnosis 9	Provide if available. Consistent with ICD Version Qualifier.
102	Diagnosis 10	Provide if available. Consistent with ICD Version Qualifier.
103	Surgical Procedure code 1	Provide if available. Consistent with ICD Version Qualifier.
104	Surgical Procedure code 2	Provide if available. Consistent with ICD Version Qualifier.
105	Surgical Procedure code 3	Provide if available. Consistent with ICD Version Qualifier.
106	Surgical Procedure code 4	Provide if available. Consistent with ICD Version Qualifier.
107	Surgical Procedure code 5	Provide if available. Consistent with ICD Version Qualifier.
108	Surgical Procedure code 6	Provide if available. Consistent with ICD Version Qualifier.
109	Surgical Procedure code 7	Provide if available. Consistent with ICD Version Qualifier.
110	Surgical Procedure code 8	Provide if available. Consistent with ICD Version Qualifier.
111	Surgical Procedure code 9	Provide if available. Consistent with ICD Version Qualifier.
112	Employment	Provide if available
113	Auto Accident	Provide if available
114	Other Accident	Provide if available
115	Total Charges	Provide if available
116	Non Covered charges	Provide if available
117	Coinsurance	Provide if available

118	Void Reason Code	Provide if available
119	DRG Description	Provide if applicable
120	DRG Type	Provide if applicable
121	DRG Version	Provide if applicable
122	DRG Severity of Illness Level	Provide if applicable
123	DRG Risk of Mortality Level	Provide if applicable
#	**Field Name**	**MassHealth Standard**
124	Patient Pay Amount	Provide if applicable
125	Patient Reason for Visit Diagnosis 1	Provide if applicable. Consistent with ICD Version Qualifier.
126	Patient Reason for Visit Diagnosis 2	Provide if applicable. Consistent with ICD Version Qualifier.
127	Patient Reason for Visit Diagnosis 3	Provide if applicable. Consistent with ICD Version Qualifier.
128	Present on Admission (POA) 1	100% present on Hospital and Long Term Care claims
129	Present on Admission (POA) 2	Provide if Diagnosis 2 is available on Hospital and Long Term Care claims
130	Present on Admission (POA) 3	Provide if Diagnosis 3 is available on Hospital and Long Term Care claims
131	Present on Admission (POA) 4	Provide if Diagnosis 4 is available on Hospital and Long Term Care claims
132	Present on Admission (POA) 5	Provide if Diagnosis 5 is available on Hospital and Long Term Care claims
133	Present on Admission (POA) 6	Provide if Diagnosis 6 is available on Hospital and Long Term Care claims
134	Present on Admission (POA) 7	Provide if Diagnosis 7 is available on Hospital and Long Term Care claims
135	Present on Admission (POA) 8	Provide if Diagnosis 8 is available on Hospital and Long Term Care claims
136	Present on Admission (POA) 9	Provide if Diagnosis 9 is available on Hospital and Long Term Care claims
137	Present on Admission (POA) 10	Provide if Diagnosis 10 is available on Hospital and Long Term Care claims
138	Diagnosis 11	Provide if available. Consistent with ICD Version Qualifier.
139	Present on Admission (POA) 11	Provide if Diagnosis 11 is available on Hospital and Long Term Care claims
140	Diagnosis 12	Provide if available. Consistent with ICD Version Qualifier.
141	Present on Admission (POA) 12	Provide if Diagnosis 12 is available on Hospital and Long Term Care claims
142	Diagnosis 13	Provide if available. Consistent with ICD Version Qualifier.
143	Present on Admission (POA) 13	Provide if Diagnosis 13 is available on Hospital and Long Term Care claims
144	Diagnosis 14	Provide if available. Consistent with ICD Version Qualifier.
145	Present on Admission (POA) 14	Provide if Diagnosis 14 is available on Hospital and Long Term Care claims
146	Diagnosis 15	Provide if available. Consistent with ICD Version Qualifier.
147	Present on Admission (POA) 15	Provide if Diagnosis 15 is available on Hospital and Long Term Care claims
148	Diagnosis 16	Provide if available. Consistent with ICD Version Qualifier.
149	Present on Admission (POA) 16	Provide if Diagnosis 16 is available on Hospital and Long Term Care claims
150	Diagnosis 17	Provide if available. Consistent with ICD Version Qualifier.
151	Present on Admission (POA) 17	Provide if Diagnosis 17 is available on Hospital and Long Term Care claims
152	Diagnosis 18	Provide if available. Consistent with ICD Version Qualifier.
153	Present on Admission (POA) 18	Provide if Diagnosis 18 is available on Hospital and Long Term Care claims

154	Diagnosis 19	Provide if available. Consistent with ICD Version Qualifier.
155	Present on Admission (POA) 19	Provide if Diagnosis 19 is available on Hospital and Long Term Care claims
156	Diagnosis 20	Provide if available. Consistent with ICD Version Qualifier.
157	Present on Admission (POA) 20	Provide if Diagnosis 20 is available on Hospital and Long Term Care claims
158	Diagnosis 21	Provide if available. Consistent with ICD Version Qualifier.
159	Present on Admission (POA) 21	Provide if Diagnosis 21 is available on Hospital and LTC claims
#	**Field Name**	**MassHealth Standard**
160	Diagnosis 22	Provide if available. Consistent with ICD Version Qualifier.
161	Present on Admission (POA) 22	Provide if Diagnosis 22 is available on Hospital and Long Term Care claims
162	Diagnosis 23	Provide if available. Consistent with ICD Version Qualifier.
163	Present on Admission (POA) 23	Provide if Diagnosis 23 is available on Hospital and Long Term Care claims
164	Diagnosis 24	Provide if available. Consistent with ICD Version Qualifier.
165	Present on Admission (POA) 24	Provide if Diagnosis 24 is available on Hospital and Long Term Care claims
166	Diagnosis 25	Provide if available. Consistent with ICD Version Qualifier.
167	Present on Admission (POA) 25	Provide if Diagnosis 25 is available on Hospital and Long Term Care claims
168	Diagnosis 26	Provide if available. Consistent with ICD Version Qualifier.
169	Present on Admission (POA) 26	Provide if Diagnosis 26 is available on Hospital and Long Term Care claims
170	Present on Admission (POA) EI 1	Provide if External Injury Diagnosis 1 is available on Hospital and Long Term Care claims
171	External Injury Diagnosis 2	Provide if available. Consistent with ICD Version Qualifier.
172	Present on Admission (POA) EI 2	Provide if External Injury Diagnosis 2 is available on Hospital and Long Term Care claims
173	External Injury Diagnosis 3	Provide if available. Consistent with ICD Version Qualifier.
174	Present on Admission (POA) EI 3	Provide if External Injury Diagnosis 3 is available on Hospital and Long Term Care claims
175	External Injury Diagnosis 4	Provide if available. Consistent with ICD Version Qualifier.
176	Present on Admission (POA) EI 4	Provide if External Injury Diagnosis 4 is available on Hospital and Long Term Care claims
177	External Injury Diagnosis 5	Provide if available. Consistent with ICD Version Qualifier.
178	Present on Admission (POA) EI 5	Provide if External Injury Diagnosis 5 is available on Hospital and Long Term Care claims
179	External Injury Diagnosis 6	Provide if available. Consistent with ICD Version Qualifier.
180	Present on Admission (POA) EI 6	Provide if External Injury Diagnosis 6 is available on Hospital and Long Term Care claims
181	External Injury Diagnosis 7	Provide if available. Consistent with ICD Version Qualifier.
182	Present on Admission (POA) EI 7	Provide if External Injury Diagnosis 7 is available on Hospital and Long Term Care claims
183	External Injury Diagnosis 8	Provide if available. Consistent with ICD Version Qualifier.
184	Present on Admission (POA) EI 8	Provide if External Injury Diagnosis 8 is available on Hospital and Long Term Care claims
185	External Injury Diagnosis 9	Provide if available. Consistent with ICD Version Qualifier.
186	Present on Admission (POA) EI 9	Provide if External Injury Diagnosis 9 is available on Hospital and Long Term Care claims
187	External Injury Diagnosis 10	Provide if available. Consistent with ICD Version Qualifier.
188	Present on Admission (POA) EI 10	Provide if External Injury Diagnosis 10 is available on Hospital and Long Term Care claims
189	External Injury Diagnosis 11	Provide if available. Consistent with ICD Version Qualifier.
190	Present on Admission (POA) EI 11	Provide if External Injury Diagnosis 11 is available on Hospital and Long Term Care claims
191	External Injury Diagnosis 12	Provide if available. Consistent with ICD Version Qualifier.

192	Present on Admission (POA) EI 12	Provide if External Injury Diagnosis 12 is available on Hospital and Long Term Care claims
193	ICD Version Qualifier	100 % Present on all Professional and Institutional claims. 100% required on all other claims when at least one ICD diagnosis code or ICD surgical procedure code is submitted..
194	Procedure Modifier 4	Provide if available
195	Service Category Type	100% present and valid
196	Ambulance Patient Count	Provide if applicable
197	Obstetric Unit Anesthesia Count	Provide if applicable
#	**Field Name**	**MassHealth Standard**
198	Prescription Number	100% present on Pharmacy claims
199	Taxonomy Code	Provide if available
200	Rate Increase Indicator	Provide if applicable
201	Bundle Indicator	100% present on bundled claims
202	Bundle Claim Number	Provide if available. Follow instructions in Section 2.0 - Data Element Clarifications
203	Bundle Claim Suffix	Provide if available. Follow instructions in Section 2.0 - Data Element Clarifications
204	Value Code	Provide on the new-born claim lines
205	Value Amount	Provide when Value Code is present in field # 203
206	Surgical Procedure Code 10	Provide if available. Consistent with ICD Version Qualifier.
207	Surgical Procedure Code 11	Provide if available. Consistent with ICD Version Qualifier.
208	Surgical Procedure Code 12	Provide if available. Consistent with ICD Version Qualifier.
209	Surgical Procedure Code 13	Provide if available. Consistent with ICD Version Qualifier.
210	Surgical Procedure Code 14	Provide if available. Consistent with ICD Version Qualifier.
211	Surgical Procedure Code 15	Provide if available. Consistent with ICD Version Qualifier.
212	Surgical Procedure Code 16	Provide if available. Consistent with ICD Version Qualifier.
213	Surgical Procedure Code 17	Provide if available. Consistent with ICD Version Qualifier.
214	Surgical Procedure Code 18	Provide if available. Consistent with ICD Version Qualifier.
215	Surgical Procedure Code 19	Provide if available. Consistent with ICD Version Qualifier.
216	Surgical Procedure Code 20	Provide if available. Consistent with ICD Version Qualifier.
217	Surgical Procedure Code 21	Provide if available. Consistent with ICD Version Qualifier.
218	Surgical Procedure Code 22	Provide if available. Consistent with ICD Version Qualifier.
219	Surgical Procedure Code 23	Provide if available. Consistent with ICD Version Qualifier.
220	Surgical Procedure Code 24	Provide if available. Consistent with ICD Version Qualifier.
221	Surgical Procedure Code 25	Provide if available. Consistent with ICD Version Qualifier.
222	Attending Prov. ID Address Location Code	Provide when Attending Prov. ID is present
223	Billing Provider ID Address Location Code	Provide when Billing Provider ID is present
224	Prescribing Prov. ID Address Location Code	Provide when Prescribing Prov. ID is present
225	PCP Provider ID Address Location Code	Provide when PCP Provider ID is present
226	Referring Provider ID Address Location Code	Provide when Referring Provider ID is present
227	Servicing Provider ID Address Location Code	Provide when Servicing Provider ID is present
228	PCC Provider ID Address Location Code	Provide when PCC Internal Provider ID is present
229	Submission Clarification Code 2	Provide on Pharmacy and Provider-Administered Drug claims

230	Submission Clarification Code 3	Provide on Pharmacy and Provider-Administered Drug claims
231	Unit of Measure	100 % Provide on Pharmacy and/or Physician-Administered Drug claims
232	Provider Payment	Provide when available
233	Filler	

9.0 Appendices

Appendix C – *Member Enrollment File Specifications*

1. ***Overview:***

MCEs are required to submit member enrollment data on a monthly basis along with Encounter data submission. Member level enrollment data are needed for multiple EHS projects.
For example, the updated Member Enrollment File captures member enrollment with a PCP and member demographics.
In addition, MassHealth would like to start obtaining Care Coordination and/or Care Management providers' information for the analysis of this aspect of care delivery.

2. ***Technical Specifications:***

MCEs should submit a full refresh of the following three files on a monthly basis.

Member File

1. Each MCE should submit a full refresh of Member File of all MassHealth and CommCare members who have been enrolled with the MCE on or after 1/1/2010 including members who ended their enrollment after 1/1/2010.
2. The Member File contains the **member** MassHealth ID and demographic information.
3. The Member File is a snapshot as of the end of the month prior to the submission date. For example, the "as of" date for data submitted end of September 2013 is August 31, 2013.
4. The Member File always contains the most current member demographic information.
5. Member records submitted by the MCEs stay in EHS DW unless the MCE sends a "delete" file with the member records that have to be removed from EHS DW system. ***This file will only be sent when the MCE determines that the member should never have been part of EOHHS population and had been erroneously sent to MassHealth.*** In this case, the member in the delete file will be deleted from both the Member File and the Member Enrollment File (See section 3 –Submission Process).

Member Enrollment File

1. Each MCE should submit a full refresh of all MassHealth and CommCare members who have been enrolled with a **PCP and/or CM Provider** (Care Coordinator, Care Coordination Program, Care Manager, or Care Management Program) on or after 1/1/2010 including members who ended their enrollment after 1/1/2010.
2. The file should include ***all*** enrollments since 1/1/2010. For example, if a member had three PCP enrollments during this period then all three enrollments will be reported in the file.
3. Begin and End Enrollment dates must reflect changes in member ***enrollment*** with a PCP, CM Provider and changes in Practice affiliation.
4. Members who are enrolled with an MCE and are in the Member File, but do not have PCP or CM Provider enrollment should ***not*** be included in Member Enrollment file.
5. All members included in the Member Enrollment File should also be included in the Member File.
6. Any member enrollment record that existed in prior files and is not submitted in current files get "soft" deleted from MassHealth system.

A. Member Enrollment File Providers and Practices

1. Care Coordinators, Care Managers, Care Coordination and Management Programs are referred to as **CM Providers**.
2. PCPs and CM Providers are considered **"Providers**", and their IDs should be submitted in the Provider ID field.
3. The Practice that the above providers are associated with is referred to as "**Practice**", and the Practice Provider ID should be submitted in the Practice ID field.
4. If one Practice location cannot be identified for the member enrollment with a PCP then MCEs should provide the ID for the PCP's head contracting entity in the Practice ID field.
5. A "Provider Enroll Type" field indicates whether the Provider ID is for a PCP or a CM Provider.
6. A "Care Level" field indicates whether the **CM Provider IDs** are submitted **at the MCE or Practice/Provider level**.
7. If a member is enrolled with two types of providers (e.g. PCP and Care Manager), two records will be submitted with two different Provider Enroll Types for that member even if the PCP happens to be the same provider as the Care Manager.
8. MCEs would need to submit unique identifiers for the **CM Providers**. These unique identifiers must be maintained by the MCE and must be included in the **Care Management Provider File** (see below)
9. The only information required in the Member Enrollment File for a Provider and Practice is Provider ID/Provider ID Type and Practice ID/Practice ID Type.
10. Every Provider ID **for a PCP** and every Practice ID must exist in the Provider File submitted in the Encounter file.
11. Every Provider ID **for a CM Provider** must exist in the **Care Management Provider File** (see Care Management Provider File below)
12. Any change in ***Provider or Practice*** demographic information would ***not*** require the submission of any new records in the Member Enrollment File. Demographic information will be maintained in the Encounter Provider File or the Care Management Provider File.

B. Member Enrollment File Begin and End Enrollment Dates

1. The Member Enrollment File will have "Begin" and "End" Enrollment Dates to identify all enrollments with a PCP or CM Providers.
2. Any change in the member enrollment with a provider would require additional records with new "Begin" and "End" Enrollment dates.
3. "Begin" and "End" enrollment dates must be submitted with each record. End Enrollment Date for "active" enrollments with a provider will be submitted as "End of Time" (EOT – 99991231)

Care Management Provider File

1. MCE will submit a Care Management Provider File that includes all **CM Providers** (Care Coordinators, Care Managers, Care Coordination and Management Programs) ***who are not inlcuded in the Encounter Provider File.***
2. The Care Management Provider File will have "Effective" and "Term" dates for CM Providers that must be submitted with each record. Term Date for "active" records should be submitted as "End of Time" (EOT – 99991231)

3. Submission Process:

1. Member ZIP File must be named "MCE_MEMBER_YYYYMMDD.zip" (e.g. BMC_MEMBER_20130831.zip).
2. Member ZIP File must include Member File, Member Enrollment File, Care Management Provider File and Member Metadata File.
3. Member File, Member Enrollment File, and Care Management Provider File must be submitted as "Pipe" delimited text files.
4. The member metadata file in the Member ZIP File must be named MEM_metadata.txt.
5. Member ZIP File must be submitted at the same time the Encounter data is submitted. It should be placed on SFTP server **after** the claims zip file is posted.
6. A zero byte file "**mem_mce_done.txt**" must be placed on SFTP server along with the Member Zip file. The file "mem_mce_done.txt" is only needed when the Member Zip file is submitted.

Member Metadata File

Metadata Field	**Submission**
MCE_Id="Value"	Mandatory
Date_Created=" YYYYMMDD"	Mandatory
Member_File_Name="Value"	Mandatory
MemEnroll_File_Name="Value"	Mandatory
CareMgmt_File_Name="Value"	Mandatory
Total_Member_Records="Value"	Mandatory
Total_MemEnroll_Records="Value"	Mandatory
Total_CareMgmt_Records="Value"	Mandatory
Time_MemEnroll_From="Value" (YYYYMMDD)	Mandatory
Return_To="Email Address"	Mandatory

Notes:

i. Total_Member_Records is the total number of records in the Member File
ii. Total_MemEnroll_Records is the total number of records in the Member Enrollment File.
iii. Time_MemEnroll_From is the earliest "Begin" Enrollment Date in the Member Enrollment File.
iv. Total_CareMgmt_Records is the total number of records in the Care Management Provider File.
v. For files missing from a submission set corresponding field value to "none.txt"

Member Delete File

1. Member Delete File has the same format as Member File but will only have the member records that need to be deleted from our system. ***This file will only be sent when the MCE determines that the member should never have been part of EOHHS population and had been erroneously sent to MassHealth.***
2. The member in the delete file will be deleted from both the Member File and the Member Enrollment File.
3. Member Delete File will be submitted independently from the Member Zip file and will be named **MCE_DELETE_MEM_YYYYMMDD.txt** (e.g. BMC_DELETE_MEM_20130930.txt).
4. The Member Delete File can be submitted any time, however the MCE must send an email to MassHealth Data Warehouse to notify them about the submission of a delete file.

4. Validation Rules:

Member File

1. All Member IDs submitted in the Member File should exist in MMIS.
2. In the following scenarios, all records for that Member ID will be rejected:
    1. Member ID is missing
    2. Member ID is invalid
    3. Org. Code is missing
    4. Org. Code is not meeting MassHealth Standards
    5. Entity Identifier is not meeting MassHealth Standards
3. Member File data are ***not*** used in the claims validation process. Rejected Member File records do not affect encounter claims data load.

Member Enrollment File

1. All Member IDs submitted in the Member Enrollment File must exist in MMIS
2. All Member IDs submitted in the Member Enrollment File must exist in Member File
3. The records get rejected if:
    - Member ID is missing
    - Member ID is invalid
    - Provider ID is missing
    - Provider ID is not found in MCE Provider Files
    - Provider ID Type is missing
    - Provider ID Type is not found in MCE Provider Files
    - Provider ID address location code is missing
    - Practice ID Type or Practice ID Address Location Code is missing when Practice ID is provided
    - Practice ID Type not found in MCE Provider File
    - Provider Enroll Type is missing
    - Provider Enroll Type is not valid as per specification
    - Care Level is missing
    - Care Level is not valid as per specification
    - Begin Enrollment Date is missing or invalid
    - End Enrollment Date is missing or invalid
    - Org. Code is missing
4. Member Enrollment File data are not used in claims validation process. Rejected Member Enrollment File records do not affect encounter claims data load.

***Care Management Provider File* – Not currently submitted**

1. All records in the Care Management Provider File will be rejected in the following scenarios:

a. Org. Code is missing
b. Org. Code is not meeting MassHealth Standards
c. CM Provider ID is missing

5. Member Error File:

1. All records in the Member File, Member Enrollment File and Care Management Provider File not meeting validation rules described in Section 4 will be rejected.
2. An error file for the Member File will be posted on the FTP server and will be named "ERR_MCE_MEMBER_YYYYMMDD.txt". (e.g. ERR_BMC_MEMBER_20130930.txt)
3. An error file for the Member Enrollment File will be posted on the FTP server and will be named "ERR_MCE_MEMENROLL_YYYYMMDD.txt". (e.g. ERR_BMC_MEMENROLL_20130930.txt)
4. An error file for Care Management Provider File will be posted on the FTP server and will be named "ERR_MCE_CAREMGMT_YYYYMMDD.txt". (e.g. ERR_BMC_CAREMGMT_20130930.txt)
5. Records that get rejected must be corrected and sent back to MassHealth to get into the system.
6. Member and Member Enrollment correction files should follow the same format as the original files
7. Member and Member Enrollment correction files must be submitted with the Encounter correction/manual override file or must be corrected in the following month's member files submission.
8. Corrected records in Member File, Member Enrollment File or Care Management Provider File that still have errors will never go into MassHealth system and will not be overridden even when submitted along with the Manual Override Encounter file.

6. ***Files Layout:***

Member File Layout

#	Field	Description	Length	Type	Required	Comments
1	Org. Code	Unique ID assigned by MH DW to each submitting organization. **This code identifies your Organization :** 465 Fallon Community Health Plan 469 Neighborhood Health Plan 997 Boston Medical Center HealthNet Plan 998 Network Health 999 Massachusetts Behavioral Health Partnership 470 CeltiCare 471 Health New England 501 Commonwealth Care Alliance 502 UnitedHealthCare 503 NaviCare 504 Senior Whole Health 505 Tufts Health Plan 506 BMC HealthNet Plan 601 Commonwealth Care Alliance 602 Network Health 603 Fallon Total	3	N	Required	
2	Member ID	The MassHealth ID for the **member**	12	C	Required	
3	Active Status Indicator	Y/N indicates whether the member has a current “Active” enrollment status with the MCE	1	C	Required	
4	Member Birth Date	Member Date of Birth	8	Date YYYYMMDD	Required	
5	Member Death Date	Member Date of Death	8	Date YYYYMMDD	Required	
6	Member First Name	Member first name	100	C	Required	
7	Member Last Name	Member last name	100	C	Required	
8	Member Middle Initial	Member Middle Initial	1	C	Required	

#	Field	Description	Length	Type	Required	Comments
9	Member Gender	The gender of the member: "Male" ; "Female", or “Other” These values should be spelled out and should not be abbreviated	8	C	Required	
10	Member Ethnicity	Please follow the US Office of Management and Budget (OMB) standards for Classification of Race and Ethnicity	75	C	Provide if available	Values should have descriptions and not codes
11	Member Race	Please follow the US Office of Management and Budget (OMB) standards for Classification of Race and Ethnicity	75	C	Provide if available	Values should have descriptions and not codes
12	Member Primary Language	The Primary Language of the Member	75	C	Provide if available	Values should have descriptions and not codes
13	Member Address 1	Member Street Address 1	100	C	Required	
14	Member Address 2	Member Street Address 2	100	C	Provider if applicable	
15	Member City	Member City	40	C	Required	
16	Member State	Member State	2	C	Required	
17	Member Zip Code	Member Zip Code	5	C	Required	
18	Homeless Indicator	Y/N. Indicates if the member is homeless	1	C	Provide if available	
19	Communication Access Needs Indicator	Y/N. Indicates if the member has special needs for communicator	1	C	Provide if available	
20	Disability Indicator	Y/N. Indicates if the member has a disability	1	C	Provide if available	
21	Disability Type	Identifies the disability type for a member. This is a place holder until the disability types are clearly defined. Values TBD	30	C	Provide if available	

Member Enrollment File Layout

#	Field	Description	Length	Type	Required	Comments
1	Org. Code	Unique ID assigned by MH DW to each submitting organization. **This code identifies your Organization :** 465 Fallon Community Health Plan 469 Neighborhood Health Plan 997 Boston Medical Center HealthNet Plan 998 Network Health 999 Massachusetts Behavioral Health Partnership 470 CeltiCare 471 Health New England 501 Commonwealth Care Alliance 502 UnitedHealthCare 503 NaviCare 504 Senior Whole Health 505 Tufts Health Plan 506 BMC HealthNet Plan 601 Commonwealth Care Alliance 602 Network Health 603 Fallon Total	3	N	Required	
2	Member ID	The MassHealth ID for the member	12	C	Required	

#	Field	Description	Length	Type	Required	Comments
3	Provider Enroll Type	This field indicates the Type of Provider a member is enrolled with. It should reflect the information entered in the Provider ID and ID Type. For example, if Provider Enroll Type is entered as '02' then the Provider ID and ID Type should be for the "Geriatric Coordinator" the member is enrolled with. **The values are as follows:** **01 = PCP** **02 = Geriatric Coordinator** **03 = LTSS Coordinator** **04 = Care Coordinator** **05 = Care Coordination Program (if no assigned care coordinator but member is enrolled in a care coordination program)** **06 = Care Manager** **07 = Care Management Program (if no assigned care manager but member is enrolled in a care management program)**	2	C	Required	This is a key field and it indicates whether the provider fields are for a PCP or CM providers.
4	Provider Enroll Type Description	The Description of the Provider Enroll Type. The description should be consistent with the value selected in Provider Enroll Type. If the value entered in Provider Enroll Type is **"01"** the description should be "PCP" If the value entered in Provider Enroll Type is **"02"** the description should be " Geriatric Coordinator" and so on	40	C	Required	
5	Care Level	This field is required with all CM Providers to indicate whether the Provider ID submitted is at the MCE or Practice/Provider level. If the Provider is a PCP, value "NA" **must** be entered in this field. Values are: "MCE" "PRV" "NA" for "Not Applicable"	3	C	Required	
6	Begin Enrollment Date	This is the beginning enrollment date with a PCP or CM Providers	8	Date YYYYMMDD	Required	

#	Field	Description	Length	Type	Required	Comments
7	End Enrollment Date	This is the end enrollment date with a PCP or CM Providers	8	Date YYYYMMDD	Required	This value should be "99991231" for "active" enrollment which represents End of Time (EOT).
8	Provider ID	Provider ID	15	C	Required	This ID should be consistent with the ID submitted in the Encounter Provider File for a provider. Information provided in this field should be consistent with the information submitted in the “Provider Enroll Type” field above. For example, if the Provider Enroll Type was submitted on a record as “01” then the Provider ID for that record would be for a PCP. This applies to all other values in the Provider Enroll Type.

#	Field	Description	Length	Type	Required	Comments
9	Provider ID Type	Provider ID Type is required when the provider is part of prior and current provider files submitted in the encounter data. The values are: 1 for NPI 6 for MCE Internal ID	1	C	Required	This ID Type should be consistent with the ID Type submitted in the Encounter Provider File for a provider. Information provided in this field should be consistent with the information submitted in the "Provider Enroll Type" field above. For example, if the Provider Enroll Type was submitted on a record as "01" then the Provider ID Type for that record would be the ID Type associated with a PCP. This applies to all other values in the Provider Enroll Type.
10	Practice ID	Practice ID	15	C	Highly important so please provide if available	This ID should be consistent with the ID submitted in the Encounter Provider File for a Practice

#	Field	Description	Length	Type	Required	Comments
11	Practice ID Type	Practice ID Type. The values are: 1 for NPI 6 for MCE Internal ID	1	C	Highly important so please provide if available	This ID Type should be consistent with the ID Type submitted in the Encounter Provider File for a Practice
12	PCC Provider ID Address Location Code	Code to identify address location of Provider ID in Field #8	15	C		
13	PCC Practice ID Address Location Code	Code to identify address location of Practice ID in Field #10.	15	C		
14	Entity PIDSL	ACO PIDSL for the ACO claims and MCO PIDSL for the MCO claims SCO PIDSL on SCO claims One Care PIDSL on One Care claims Example: 999999999A	10	C	Required on all ACO claims	Should be consistent with ACO PIDSL submitted in the encounter provider file

Care Management Provider File Layout – Not currently submitted

#	Field	Description	Length	Type	Required	Comments
1	Org. Code	Unique ID assigned by MH DW to each submitting organization.	3	N	Required	
2	CM Provider ID	The MCE unique identifier for CM Provider	15	C	Required	
3	CM Provider Last Name	CM Provider last name	100	C	Required	
4	CM Provider First Name	CM Provider first name	100	C	Provide if Applicable	
5	CM Provider Gender	M' for Male ; 'F' for Female, and 'O' for "Other"	**1**	C	Optional	
6	CM Provider Address	CM Provider Street Address	120	C	Required	
7	CM Provider City	CM Provider City	40	C	Required	
8	CM Provider State	CM Provider State	2	C	Required	
9	CM Provider Zip Code	CM Provider Zip Code	9	C	Required	
10	CM Provider Phone	CM Provider Telephone number	13	C "9999999999"	Required	Do not include characters like dashes or brackets – e.g. 6178889900
11	CM Provider Effective Date	Begin effective date for the CM Provider	8	C – YYYYMMDD	Required	
12	CM Provider Term Date	End effective date for CM Provider	8	C – YYYYMMDD	Required	This value should be "99991231" for "active" CM Provider IDs which represents End of Time (EOT).
13	Entity PIDSL	ACO PIDSL for the ACO claims and MCO PIDSL for the MCO claims SCO PIDSL on SCO claims One Care PIDSL on One Care claims Example: 999999999A	10	C	Required	
14	CM Provider ID TYPE		1	N		
15	CM Provider ID Location code		5	C		

Exhibit 2.

COMMONWEALTH OF MASSACHUSETTS

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Data Warehouse

Denied Claims Submission Requirements (Expanded Format)

Version 2.1

Date: December 22, 2017

Table of Content

Revision History

Date	Version	Description	Author
12/22/2017		**Changes to the fields:** *Encounter* Field # 1: Org. Code (replaces MCE PIDLS) Format changed to 3/N Field # 3: Entity PIDSL (replaced ACO PIDSL) Field # 49: PCC Internal Provider ID (moved from field # 227 and replaced PCC Provider ID) Field # 92: PCC Internal Provider ID Type (moved from field # 229 and replaced PCC Provider ID Type) Field # 228: PCC Provider ID Address Location Code Field # 229: Adjudication date *Denied Claims Reason Code File* Field # 1: Org. Code (replaces MCE PIDLS) Format changed to 3/N Field # 5: Entity PIDSL (replaced ACO PIDSL) *Denied Claims Reason Code Reference File* Field # 1: Org. Code (replaces MCE PIDLS) Format changed to 3/N	Alla Kamenetsky
10/26/2017	2.0	**Changes in :** **2.3.2 Denied Claims reason code File Format** Field#1: MCE PIDSL (former Claim Payer) Field#5: ACO PIDSL (NEW) **2.3.3 Denied Claims Reason Code File** Field#1: MCE PIDSL (former Claim Payer) **3.0 Error Handling Section** **4.0 Error Reports and Notifications to the Plans** **4.1 Error Denied Claims Summary Report Format** **4.2 Error Denied Claims Details Report Format** **4.3 Error Denial Reason Code Report**	Alla Kamenetsky
09/21/2017	2.0	**Encounter Data Set** *Changes to the existing fields* Field#1: MCE PIDSL (former Claim Payer) Field#3: ACO PIDSL (Former "Plan Identifier") Field#7: - Pricing Indicator (former "Filler") - the length changed from 9 to 20 Field#9: added value of "O" for "Other"	

		Field#13: Submission Clarification Code "(former Filler") Field #33: Type of Bill (former "Place of Service Type") Field # 35 FILLER (Former Type of Service) Field#37: NDC Number (now will be required on Hospital and Professional claims in addition to the Pharmacy claims) Field#38: Metric Quantity (now will be required on Hospital and Professional claims in addition to the Pharmacy claims) Field#49: PCC Provider ID (former IPA/PMG) Field#71:Group Number, Added values of "7 = ACO-A", "8 = ACO-B" and "9= ACO-C" Field#195: Service Category Type, added value 'ACO' for ACO Service Category Type Field #204: Value Code (used to be "Adjudication Date", which is moved to field # 231) **Field # 231: Adjudication Date** *Introducing new fields* Field #204: Value Code Field #205: Value Amount Field # 206 - 221: Surgical Procedure Codes 10-25 Field#222: Attending Prov. ID Address Location Code Field#223: Billing Provider ID Address Location Code Field#224: Prescribing Prov. ID Address Location Code Field#225: PCP Provider ID Address Location Code Field#226: Referring Provider ID Address Location Code Field#227: Servicing Provider ID Address Location Code Address Location Code Field#228: PCC Internal Provider ID Field#229: PCC Internal Provider ID_Type Field#230: PCC Provider ID Address Location Code	
04/27/2017	1.1	**In 2.2.1, 5.1.2 and 5.1.3** to correct inconsistency the folder name was changed from "ehs_dw_denied" to "denied_claims". Now it reads: **2.2.1** The denied claims zip files will be placed on SFTP server in /home/mce/ehs_dw/ **denied_claims** folder. Error reports will be provided at the same location where the files are loaded. **5.1.2** Error reports will be generated and saved in /home/mco/test_mco/ **denied_claims** folders on SFTP servers with every processed submission **5.1.3** MCOs will fix the errors and place the correction files in /home/mco/test_mco/ **denied_claims** folder	Alla Kamenetsky

04/13/2017	1.1	**In 2. Logic and Input** added: • Individual claim lines might have several denial reasons • NPI number can be submitted in Billing Provider ID field with value "1" in Billing Provider ID Type • Claims with no valid "New Member ID" values must not be submitted **In 2.3.4 Denied Claims Data Set Elements** • Added descriptions of the claim categories mentioned in the header of the file • Added reference to the tables in "Encounter Data Set Request" (paid claims file specifications). • Changed the file format to the paid encounter claims file format. Added field #204 "Adjudication Date"	Alla Kamenetsky
03/01/2017	1.0	Creation of specification	Alla Kamenetsky Rima Kayyali Sivakumar Essambattu

Acronyms

ACO	Accountable Care Organization
DW	Data Warehouse
EOHHS	Executive Office of Health and Human Services
MBHP	Mass Behavioral Health Plan
MCE	Managed Care Entity (MCO, SCO, One Care, and MBHP collectively)
MCO	Managed Care Organization
MH	MassHealth
PCC	Primary Care Center
PIDSL	Provider ID Service Location
SCO	Senior Care Organization

1. Introduction

There has been a business need to collect denied claims to allow for accurate analysis of risk adjustment, utilization, and healthcare quality measurement. EHS is adding a requirement to have all MCOs and MBHP submit denied claims.
Denied claim lines should be included, even if they are part of the paid claim. ***Please note that denied claims process is independent of paid claims process. Denied and Paid claims are submitted in separate files and on different schedules. Current process of paid claims continues to exist as usual, where the MCOs submit voids to paid claims loaded in MH DW.***

The intent of this document is to outline formats of the files, data validation, and submission process requirements.
Changes to the Denied Claims Data Set format introduced in Version 2.0 of the document, reflect the changes applied to the Paid Encounter Data Set Expanded file format.

2. Logic and Input:

2.1 DW Design Requirements

2.1.1 DW implements minimal editing logic since denied claims can be denied for many reasons.
2.1.2 Individual claim lines might have several denial reasons.
2.1.3 When Billing Provider internal ID is not known, submit NPI number in place of Billing Provider ID with Billing Provider ID Type = 1. Billing Provider ID field should never be null.
2.1.4 Claims with invalid "New Member ID" values must not be submitted.
2.1.5 The following fields are critical for the load process and must have valid values:

- Org. Code (field # 1)
- Entity PIDSL (field # 3)
- Claim Number (field # 5)
- Claim Suffix (field # 6)
- Billing Provider ID (field # 58)
- Billing Provider ID Type (field # 93)
- Billing Provider ID Address Location Code (field # 223)New Member ID (field # 76)
- Adjudication date (field # 231)

2.1.6 Format standards should be followed for all fields.
2.1.7 Email notifications will be sent to the MCOs know that the file has been processed and the status of submission.

2.2 File Submission Requirements

2.2.1 The denied claims files have to be placed on SFTP server by the 6th day of the submission month

2.2.2 The denied claims zip files should be placed on SFTP server in /mce/ehs_dw/**denied claims** folder.
Error reports will be provided at the same location- /mce/ehs_dw/**denied claims** folder.

2.2.3 An initial production file contained denied claims with From Service Date since 1/1/2014, adjudicated through March 31, 2017 in their most recent state as of the date of submission. All the claims were sent as Original (Record Type = 'O') in July of 2017.

2.2.4 All the subsequent submissions should have denied claims adjudicated in the prior **quarter** with a 3 month lag.
For example, October 6, 2017 submission files contained denied claims with adjudication date from April 1, 2017 through June 30, 2017

2.2.5 All denied claims must have values in the following fields:

Field #	Field Name	Error	Result
1	Org. Code	Null or Invalid	File rejection
3	Entity PIDSL	Invalid	Record rejection
5	Claim Number	Null	Record rejection
6	Claim Suffix	Null	Record rejection
58	Billing Provider ID	Null	Record rejection
223	Billing Provider ID Address Location Code	Null	Record rejection
93	Billing Provider ID Type	Null	Record rejection
76	New Member ID	Null	Record rejection
229	Adjudication Date	Null/Less than DOS/less than DOB/ invalid format	Record rejection

2.2.6 MCOs must re-submit rejected files / records with corrected data within a week from rejection date.

2.2.7 All providers' information must have been previously submitted by the MCOs in the paid claims files and exist in EHS DW provider directory.

2.2.8 All New Member IDs must exist in MH DW reference source.

2.3 Submission Files Format (claims and metadata)

2.3.1 Format

2.3.1.1 MCOs should submit Zip file named in **"MCO_Denied_Claims_YYYYMMDD.zip"** format where "MCO" stands for the plans' name (i.e. "BMC_Denied_Claims_20170405")

2.3.1.2 Zip File must be accompanied by a zero byte file called ***mce_denied_done.txt***.

2.3.1.3 Denied Claims zip files should contain the following:

- Denied Claims File
- Denied Claims Reason Code File
- Denied Reason Codes Reference File
- Metadata File

2.3.1.4 All submitted files should be pipe-delimited and compressed using PKZIP/WINZIP or comparable program. All records in the data file should follow the record layout specified in "Denied Claims Data Set Elements" section, where the length represents the maximum length of each field. Padding fields with zeros or spaces is ***not*** required.

Each record should end with the standard MS Windows text file end-of-line marker ("\r\n" – a carriage control followed by a new line).

File Type: PKZIP/WINZIP compressed plain text file
Character Set: ASCII

2.3.1.5 MCOs will submit zip files on SFTP server in /home/mce/ehs_dw/denied_claims folder.

2.3.1.6 Multiple email addresses separated by comma can be included in the "Return_To" field in the metadata file.

2.3.1.7 Time Period ("Time_Period_From" and "Time_Period_To") in metadata should be based on adjudication date of the submission quarter.

2.3.1.8 Metadata file specifications: All denied claims submission files should have "Type_Of_Feed" value of "DENIED". All fields in metadata file are mandatory.

Metadata File Format:

	Description
MCO_ID="Value" (MCO: BMC, CAR, CHA, FLN, HNE, MBH, NHP)	The 3-letter identifier for the MCO
Date_Created=" YYYYMMDD"	Date the file was created
Denied_Claims="Value"	Name of denied claims file (#1)
Denied_Claims_Reason_Code="Value"	Name of Denied claims with reason codes file (#2)
Denied_Reason_Codes_Reference="Value"	Name of Reason code reference data file (#3)
Total_Records_Claims ="Value"	Total number of records in file #1
Total_Net_Payments_Claims="Value"	Total payment in file #1
Total_Records_Claims_Reason ="Value"	Total number of records in file #2
Total_Records_Reason_Reference ="Value"	Total number of records in file #3
Time_Period_From="Value" (YYYYMMDD)	Beginning date of Quarter based on Adjudication date
Time_Period_To="Value" (YYYYMMDD)	End date of Quarter based on Adjudication date
Return_To="email address"	List of MCO email addresses for notifications
Type_Of_Feed="DENIED"	Type of feed is always 'DENIED'

2.3.2 Denied Claims Reason Code File Format

All the Denial Reason Codes have to be submitted in agreement with Remittance Advice Remark Codes reported on 835 transactions.
All the claim lines in Claims file must have at least one match in Denied Reason Code file.
All the Claim Number & Claim Suffix combinations in Denied Reason Code file should have a match in Claims file.

#	Field Name	Length	Data Type/Format
1	Org. Code	3	N
2	Claim Number	15	C
3	Claim Suffix	4	C
4	Denial Reason Code	10	C
5	Entity PIDSL	10	C

2.3.3 Denied Reason Codes Reference File Format

All Denial Reason Codes in Denied Reason Code file must have a match in Denial Reason Code Reference File and vice versa

#	Field Name	Length	Data Type/Format
1	Org. Code	3	N
2	Denial Reason Code	10	C
3	Denial Reason Code Description	200	C

2.3.4 Denied Claims Data Set Elements

The value 'X' indicates a Claim Category the data element is applicable under. The columns are labeled as:

- H – Facility (*except Long Term Care*)
- P – Professional
- L – Long Term Care
- R – Prescription Drug
- D – Dental

For the information on Tables A, B, C, D, F, F, G, H, I-A, I-B1, I-B2, I- C, K, M please refer to "Paid Encounter Data Set Request" specifications.

Demographic Data

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization. This code identifies your Organization : 465 Fallon Community Health Plan 469 Neighborhood Health Plan 997 Boston Medical Center HealthNet Plan 998 Network Health 999 Massachusetts Behavioral Health Partnership 470 CeltiCare 471 Health New England 501 Commonwealth Care Alliance 502 UnitedHealthCare 503 NaviCare 504 Senior Whole Health 505 Tufts Health Plan 506 BMC HealthNet Plan 601 Commonwealth Care Alliance 602 Network Health 603 Fallon Total	X	X	X	X	X	3	N
2	Claim Category	A code that indicates a category of the claim. Valid values are: 1 = Facility (*except Long Term Care*) 2 = Professional (includes transportation claims) 3 = Dental 4 = Vision 5 = Prescription Drug 6 = Long Term Care *(Nursing Home, Chronic Care & Rehab)*	X	X	X	X	X	1	C
3	Entity PIDSL	ACO PIDSL on the ACO claims or MCO PIDSL on the MCO claims Example: 999999999A	X	X	X	X	X	10	C
4	Record Indicator	This information refers to the payment arrangement	X	X	X	X	X	1	C

		under which the rendering provider was paid. Value identifies whether the record was a fee-for-service claim, or a service provided under a capitation arrangement (encounter records). For encounter records, indicate whether there are Fee-For-Service (FFS) equivalents and payment amounts on the record. 0 Artificial record – Refers to a line item inserted to hold amounts / quantities available only at a summary (claim) level. 1 Claim Record – Refers to a claim paid on a Fee-For- Service (FFS) basis							

Demographic Data (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
	Record Indicator (Continued)	2 Encounter Record with FFS equivalent - Refers to services provided under a capitation arrangement and for which a FFS equivalent is given 3 Encounter Record w/out FFS equivalent - Refers to services provided under a capitation arrangement but for which no FFS equivalent is available 4 Per Diem Payment - Refers to a record for an inpatient stay paid on a per diem basis. 5 DRG Payment - Refers to a record for an inpatient stay paid on a DRG basis 6 Bundled Summary-Level Line; this value refers to the amounts/quantities available in the MCE's source system. Use this value when none of the above Record Indicator values applies. 7 Bundled detail line with 0-dollar amount – Refers to a bundled detail claim line where the dollar amounts are 0 or not available at the detail level. Use this value when none of the above values apply ***See discussion under Dollar Amounts in the Data Elements Clarification Section.***							
5	Claim Number	A unique number assigned by the administrator to this claim (e.g., ICN, TCN, DCN). It is very important to include a Claim Number on each record since this will be the key to summarizing from the service detail to the claim level. ***See discussion under Claim Number/Suffix in the Data Elements Clarification Section***	X	X	X	X	X	15	C
6	Claim Suffix	This field identifies the line or sequence number in a claim with multiple service lines. ***See discussion under Claim Number/Suffix in the Data Elements Clarification Section***	X	X	X	X	X	4	C
7	Pricing Indicator	Pricing Indicator; currently it is a subject of internal discussion. *A notification will be sent to the MCEs when decision is made.	X	X	X	X	X	20	C
8	Recipient DOB	The birth date of the patient expressed as YYYYMMDD. For example, August 31, 1954 would be coded "19540831".	X	X	X	X	X	8	D/YYYYMMDD
9	Recipient Gender	The gender of the patient: 1= Male 2=Female 3=Other						1	C
10	Recipient ZIP Code	The ZIP Code of the patient's residence as of the date of service.						5	N
11	Medicare Code	A code indicating if Medicare coverage applies and, if so, the type of Medicare coverage. 0= No Medicare 1 = Part A Only 2 = Part B Only 3 = Part A and B						1	N

Service Data

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
12	Other Insurance Code	A Yes/No flag that indicates whether third party liability exists. 1 = Yes; 2 = No	X	X	X	X	X	1	C
13	Submission Clarification Code	420-DK- Code indicating that the pharmacist is clarifying the submission. Values from 1 to 36 should be sent on pharmacy claims when available. The values and descriptions of the Submission Clarification Code are in Table N of the Paid Encounter Data Set Requirements specifications V 4.7				X		7	N
14	Claim Type	MBHP Specific field	X	X	X	X	X	18	C
15	Admission Date	For facility services, the date the recipient was admitted to the facility. The format is YYYYMMDD.	X		X			8	D/YYYYMMDD
16	Discharge Date	For facility services, the date the recipient was discharged from the facility. The format is YYYYMMDD. Cannot be prior to Admission Date	X		X			8	D/YYYYMMDD
17	From Service Date	The actual date the service was rendered; if services were rendered over a period of time, this is the date of the first service for this record. The format is YYYYMMDD.	X	X	X	X	X	8	D/YYYYMMDD
18	To Service Date	The last date on which a service was rendered for this record. The format is YYYYMMDD.	X	X	X		X	8	D/YYYYMMDD
19	Primary Diagnosis	The ICD diagnosis code chiefly responsible for the hospital confinement or service provided. The code should be left justified, coded to the fifth digit when applicable (blank filled when less than five digits are applicable). *DO NOT include decimal points in the code.* ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		X	7	C/ No decimal points (780.31 must be entered as 78031)
20	Secondary Diagnosis	The ICD diagnosis code explaining a secondary or complicating condition for the service. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/ No decimal points
21	Tertiary Diagnosis	The tertiary ICD diagnosis code. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/ No decimal points
22	Diagnosis 4	The fourth ICD diagnosis code. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/ No decimal points
23	Diagnosis 5	The fifth ICD diagnosis code. See above for format. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/ No decimal points
24	Type of Admission	Should be valid and present on all Hospital and Long Term Care claims with hospital admission. For the UB standard values see Table A.	X		X			1	C
25	Source of Admission	Should be valid and present on all Hospital and Long Term Care claims with hospital admission. For the UB standard values see Table B	X		X			1	C

Service Data (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
26	Procedure Code	A code explaining the procedure performed. This code may be any valid code included in the coding systems identified in the Procedure Type field below. *Any internal coding systems used must be translated to one of the coding systems identified in field #**30** below.* Should not contain ICD procedure codes. All ICD procedure codes should be submitted in the surgical procedure code fields (#101 – #113) ***including the ICD-treatment procedure codes*** ***See discussion in Data Element Clarifications section.***	X	X	X		X	6	C
27	Procedure Modifier 1	A current procedure code modifier (CPT or HCPCS) corresponding to the procedure coding system used, when applicable.	X	X	X		X	2	C
28	Procedure Modifier 2	Second procedure code modifier, required, if used.	X	X	X		X	2	C
29	Procedure Modifier 3	Third procedure code modifier, required, if used.	X	X	X		X	2	C
30	Procedure Code Indicator	A code identifying the type of procedure code used in field#26: 2= CPT or HCPCS Level 1 Code 3= HCPCS Level II Code 4= HCPCS Level III Code (State Medicare code). 5= American Dental Association (ADA) Procedure Code (Also referred to as CDT code.) 6= State defined Procedure Code 7= Plan specific Procedure Code ICD procedure codes should go in surgical procedure code fields (Field # 103 – 111) *State defined procedure codes should be used, when coded, for services such as EPSDT procedures.* ***See discussion in the Data Element Clarifications section.***	X	X	X		X	1	N
31	Revenue Code	For facility services, the UB Revenue Code associated with the service. *Only standard UB92 Revenue Codes values are allowed; plans may **not** use "in house" codes.* *Revenue code less than 4 digits long should be submitted with one leading zero. For Example:* *a. Revenue code 1 should be submitted as '01';* *b. Revenue Code 23 - as '023;* *c. Revenue code 100 - as '0100';* *d. Revenue Code 2100 – as '2100'*	X		X			4	C
32	Place of Service	This field hosts Place of Service (POS) that comes on the Professional claim). See Table C for CMS 1500 standard		X			X	2	C

Service Data (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
33	Type Of Bill	For encounter data supporting UB claims submission the Type of Bill is submitted as a 3-digit bill type in accordance with national billing guideline. The first two digits denote the place of services and the third digits denotes the frequency. See Table D for UB Type of Bill values indicating place. ***Note*:** for UB Type of Bill, use the 1st and 2nd positions only.) Frequency values can be found in Table K of the Paid Encounter specifications.	X		X			3	C
34	Patient Discharge Status	This is 2-digit Discharge Status Code (UB Patient Status) for hospital admissions. Values from 1 to 9 should always be entered with leading '0'. *Examples:* a. Patient Discharge Status '1' should be submitted as '01'; B. Patient Discharge Status '19' should be submitted as '19'.	X		X			2	C
35	FILLER							2	C
36	Quantity	This value represents the actual quantity and should be submitted with decimal point when applicable. For inpatient admissions, the number of days of confinement. Count the day of admission but not the day of discharge (for admission and discharge on the same day, Quantity is counted as 1). For all other procedures, the number of units performed for this procedure. For most procedures, this number should be "1". In some cases, a procedure may be repeated, in which case this number should reflect the number of times the procedure was performed. For anesthesia services, this should be the total number of minutes that make up the beginning and ending clock time of anesthesia service administered. Please make sure that the Quantity corresponds to the procedure code. For example, if the psychiatric code 90844 is used (Individual psychotherapy, 45-50 minutes), the Quantity should be "1" NOT "45" or "50". For Inpatient records, it should represent number of days of care. Values of 30, 60, or 100 are most common on drug records. *Note:* Length of this field has been increased to accommodate the actual quantity. Quantity=10 should be submitted as 10; Quantity=10.5 should be submitted as 10.5; Quantity=10.55 should be submitted as 10.55	X	X	X		X	9	SN

Service Data (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
37	NDC Number	For prescription drugs, the valid National Drug Code number assigned by the Food and Drug Administration (FDA). For Compound drugs claims submit NDC Number for the primary drug, If primary drug is unknown, submit NDC Number for most expensive drug. NDC codes having less than 11 digits should be submitted with leading 0's. For Example NDC "603373932" should be submitted as "00603373932".	X	X		X		11	N
38	Metric Quantity	For prescription drugs, the total number of units or volume (e.g., tablets, milligrams) dispensed. Should be submitted with decimal point when applicable. *Note:* Length of this field has been increased to accommodate the actual Metric Quantity. Metric Quantity=10 should be submitted as 10; Metric Quantity=10.5 should be submitted as 10.5; Metric Quantity=10.55 should be submitted as 10.55	X	X		X		9	N
39	Days Supply	The number of days of drug therapy covered by this prescription.				X		3	N
40	Refill Indicator	A number indicating whether this is an original prescription (0) or a refill number (e.g., 1, 2, 3, etc.) on Pharmacy claims.				X		2	N
41	Dispense As Written Indicator	An indicator specifying why the product dispensed was selected by the pharmacist and should be entered in a 2 digit format with leading zero: 00 = No DAW 01 = Physician DAW 02 = Patient DAW 03 = Pharmacist DAW 04 = Generic Not In Stock 05 = Brand Dispensed as Generic 06 = Override 07 = Brand Mandated by Law 08 = No Generic Available 09 = Other				X		2	N
42	Dental Quadrant	One of the four equal sections into which the dental arches can be divided; begins at the midline of the arch and extends distally to the last tooth. 1 = Upper Right 2 = Upper Left 3 = Lower Left 4 = Lower Right					X	1	N
43	Tooth Number	The number or letter assigned to a tooth for identifications purposes as specified by the American Dental Association. A - T (for primary teeth) 1 - 32 (for secondary teeth)					X	2	C
44	Tooth Surface	The tooth surface on which the service was performed: M = Mesial D = Distal O = Occlusal L = Lingual I = Incisal F = Facial B = Buccal A = All 7 surfaces					X	6	C

		This field can list up to six values. When multiple surfaces are involved, please list the value for each surface without punctuation between values. For example, work on the mesial, occlusal, and lingual surfaces should be listed as "MOL "(three spaces following the third value).							
45	Paid Date	For encounter records, the date on which the record was processed. For services performed on a fee-for-service basis, the date on which the claim was paid. The format is YYYYMMDD.	X	X	X	X	X	8	D/YYYYMMDD
46	Service Class	MBHP Specific field	X	X	X	X	X	23	C

Provider Data

#	Field Name	Definition/Description	H	P	L	R		Length	Data Type
47	PCP Provider ID	A unique identifier for the Primary Care Physician selected by the patient as of the date of service. ***See discussion in the Data Element Clarifications section.***	X	X	X		X	15	C
48	PCP Provider ID Type	A code identifying the type of ID provided in PCP Provider ID above. For example, *6 = Internal ID (Plan Specific)*	X	X	X		X	1	N
49	PCC Internal Provider ID	PCC Internal ID	X	X	X	X	X	15	C
50	Servicing Provider ID	A unique identifier for the provider performing the service. ***See discussion in the Data Element Clarifications section.***	X	X	X	X	X	15	C
51	Servicing Provider ID Type	A code identifying the type of ID provided in Servicing Provider ID above. For example, *6 = Internal ID (Plan Specific)* *9 = NAPB Number (for pharmacy claims only)*	X	X	X	X	X	1	N
52	Referring Provider ID	A unique identifier for the provider. ***See discussion in the Data Element Clarifications section.***	X	X	X	X	X	15	C
53	Referring Provider ID Type	A code identifying the type of ID provided in Referring Provider ID above. For example, 1 = NPI *6 = Internal ID (Plan Specific)* *8 = DEA Number (for pharmacy claims only)*	X	X	X	X	X	1	N
54	Servicing Provider Class	A code indicating the class for this provider: 1 = Primary Care Provider 2 = In plan provider, non PCP 3 = Out of plan provider *Note*: This code relates to the class of the provider and a PCP does not necessarily indicate the recipient has selected or assigned PCP. PCP class should be assigned only to those physicians whom the plan considers to be a participating PCP.	X	X	X	X	X	1	C
55	Servicing Provider Type	A code indicating the type of provider rendering the service represented by this encounter or claim. (Use Servicing Provider Type values, see Table G)	X	X	X	X	X	3	N
56	Servicing Provider Specialty	The specialty code of the servicing provider. (Use CMS 1500 standard, see Table H)	X	X	X		X	3	C
57	Servicing Provider ZIP Code	The servicing provider's ZIP code. The ZIP code where the service occurred is preferred.	X	X	X	X	X	5	N
58	Billing Provider ID	A unique identifier for the provider billing for the service.	X	X	X	X	X	15	C
59	Authorization Type	MBHP Specific field	X	X	X	X	X	25	C

Financial Data

Most of the fields below apply to services for which reimbursement is made on a fee-for-service basis. For capitated services, the record should include fee-for-service equivalent information when available. Line item amounts are required for these fields.

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
60	Billed Charge	The amount the provider billed for the service.	X	X	X	X	X	9	SN
61	Gross Payment Amount	The amount that the provider was paid in total by all sources for this service. *NOTE: This field should include any withhold amount, if applicable.*						9	SN
62	TPL Amount	Any amount of third party liability paid by another medical coverage carrier for this service. If the TPL amount is available only at the summary level, it must be recorded on a special line on the claim, which will have a record indicator value of 0. See Dollar Amounts.	X	X	X	X	X	9	SN
63	Medicare Amount	Any amount paid by Medicare for this service.	X	X	X	X	X	9	SN
64	Copay/ Coinsurance	Any co-payment amount the member paid for this service.	X	X	X	X	X	9	SN
65	Deductible	Any deductible amount the member paid for this service.	X	X	X	X	X	9	SN
66	Ingredient Cost	The cost of the ingredients included in the prescription.				X		9	SN
67	Dispensing Fee	The dispensing fee charged for filling the prescription.				X		9	SN
68	Net Payment	The amount the Medicaid MCE paid for this service. (Should equal Eligible Charges less COB, Medicare, Copay/Coinsurance, and Deductible.)	X	X	X	X	X	9	SN
69	Withhold Amount	Any amount withheld from fee-for-service payments to the provider to cover performance guarantees or as incentives.						9	SN
70	Record Type	A code indicating the type of record: O = Original V = Void or Back Out R = Replacement A = Amendment ***See discussion under 'Former Claim Number / Suffix' in the Data Elements Clarification Section***	X	X	X	X	X	1	C
71	Group Number	For non-MHSA MCEs 1 = MCO MassHealth 2 = MCO Commonwealth Care 3 = SCO 5 = CarePlus 6 = One Care (ICO) 7 = ACO-A 8 = ACO-B 9 = ACO-C						25	C

Medicaid Program-Specific Data

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
72	DRG	The DRG code used to pay for an inpatient confinement and should always be submitted in 3- digit format. One and two digit codes should be completed with leading zeros to comply. For example: a. DRG code '1' should be submitted as '001'; b. DRG code '25' should be submitted as '025'; c. DRG code '301' should be submitted as '301'. ***See discussion in the Data Element Clarifications section***.	X		X			3	C
73	EPSDT Indicator	A flag that indicates those services which are related to EPSDT: 1 = EPSDT Screen 2 = EPSDT Treatment 3 = EPSDT Referral						1	N
74	Family Planning Indicator	A flag that indicates whether or not this service involved family planning services, which may be matched by CMS at a higher rate: 1 = Family planning services provided 2 = Abortion services provided 3 = Sterilization services provided 4 = No family planning services provided (see Table I)						1	C
75	MSS/IS	*Please leave this field blank, it will be further defined at a later date.* A flag that indicates services related to MSS/IS: 1 = Maternal Support Services 2 = Infant Support Services						1	N
76	New Member ID	The ***"Active" Medicaid*** identification number assigned to the individual. This number is assigned by MassHealth and may change.	X	X	X	X	X	25	C

Other Fields

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
77	Former Claim Number	If this is not an Original claim [Record Type = 'O'], then the previous claim number that this claim is replacing/voiding. ***See discussion under Former Claim Number / Suffix in the Data Elements Clarification Section***	X	X	X	X	X	15	C
78	Former Claim Suffix	If this is not an Original claim [Record Type = 'O'], then the previous claim suffix that this claim is replacing/voiding. ***See discussion under Former Claim Number / Suffix in the Data Elements Clarification Section***	X	X	X	X	X	4	C
79	Record Creation Date	The date on which the record was created. ***See discussion under Record Creation Date in the Data Elements Clarification Section.***	X	X	X	X	X	8	D
80	Service Category	Service groupings from financial reports like 4B (see Table I)	X	X	X	X	X	3	C
81	Prescribing Prov. ID	Federal Tax ID, UPIN, or other State assigned provider ID for the prescribing provider on the Pharmacy claim.				X		15	C
82	Date Script Written	Date prescribing provider issued the prescription.				X		8	D/YYYYMMDD
83	Compound Indicator	Indicates that the prescription was a compounded drug. 1 = Yes 2 = No				X		1	C
84	Rebate Indicator	PBM received rebate for drug dispensed. 1 = Yes 2 = No				X		1	c
85	Admitting Diagnosis	Diagnosis upon admission. May be different from principal diagnosis. Should not be External Injury codes. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
86	Allowable Amount	Amount allowed under the Health Plan formulary.	X	X	X	X	X	9	N
87	Attending Prov. ID	Provider ID of the provider who attended at facility. Federal Tax ID, UPIN, or other State assigned provider ID.	X					15	C
88	Non-covered Days	Days not covered by Health Plan.	X		X			3	N
89	External Injury Diagnosis 1	If there is an External Injury Diagnosis code 1 (ICD E-Code) present on the claim, it should be submitted in this field. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C
90	Claim Received Date	Date claim received by Health Plan, if processed by a PBM.				X		8	D/YYYYMMDD
91	Frequency	The third digit of the UB92 Bill Classification field.	X		X			1	C

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
92	PCC Internal Provider ID_Type	A code identifying the type of ID provided in PCC Internal Provider ID in field #49 above: *Example:* *6 = Internal ID (Plan Specific)* 8 = DEA Number 9 = NABP Number 1 = NPI	X	X	X	X	X	1	N
93	Billing Provider ID _Type	A code identifying the type of ID provided in Billing Provider ID above. For example, *6 = Internal ID (Plan Specific)* *9 = NABP Number (for pharmacy claims only)*	X	X	X	X	X	1	N
94	Prescribing Prov. ID _Type	A code identifying the type of ID provided in Prescribing Provider ID above. For example, 1 = NPI *6 = Internal ID (Plan Specific)* *8 = DEA Number*				X		1	N
95	Attending Prov. ID _Type	A code identifying the type of ID provided in Attending Prov. ID above. For example, *6 = Internal ID (Plan Specific)*	X					1	N
96	Admission Time	For inpatient facility services, the time the recipient was admitted to the facility. If not an inpatient facility, the value should be missing. This field ***must*** be in HH24MI format. For example, 10:30AM would be 1030 and 10:30PM would be 2230.	X		X			4	N/HH24MI
97	Discharge Time	For inpatient facility services, the time the recipient was discharged from the facility. If not an inpatient facility, the value should be missing. This field ***must*** be in HH24MI format. For example, 10:30AM would be 1030 and 10:30PM would be 2230.	X		X			4	N/HH24MI
98	Diagnosis 6	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/No decimal points
99	Diagnosis 7	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/No decimal points
100	Diagnosis 8	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/No decimal points
101	Diagnosis 9	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/No decimal points
102	Diagnosis 10	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/No decimal points
103	Surgical Procedure code 1	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
104	Surgical Procedure code 2	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
105	Surgical Procedure code 3	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
106	Surgical Procedure code 4	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
107	Surgical Procedure code 5	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
108	Surgical Procedure code 6	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
109	Surgical Procedure code 7	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
110	Surgical Procedure code 8	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
111	Surgical Procedure code 9	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
112	Employment	Is the patient's condition related to Employment Y N	X	X	X	X	X	1	C
113	Auto Accident	Is the patient's condition related to an Auto Accident Y N	X	X	X	X	X	1	C
114	Other Accident	Is the patient's condition related to Other Accident Y N	X	X	X	X	X	1	C
115	Total Charges	This field represents the total charges, covered, and uncovered related to the current billing period.	X	X	X	X	X	9	N
116	Non Covered charges	This field represents the uncovered charges by the payer related to the revenue code. This is the amount, if any,	X	X	X	X	X	9	N

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		that is not covered by the primary payer for this service.							
117	Coinsurance	Any coinsurance amount the member paid for this service.	X	X	X	X	X	9	N
118	Void Reason Code	The reason the claim line was voided 1 TPL 2 accident recovery 3 provider audit recoveries 4 Other						1	C
119	DRG Description	Description of DRG Code	X		X			132	C

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
120	DRG Type	*Values:* 1=Medicare CMS-DRG 2=Medicare MS-DRG 3=Refined DRGs (R-DRG) 4=All Patient DRGs (AP-DRG) 5=Severity DRGs (S-DRG) 6=All Patient, Severity-Adjusted DRGs (APS-DRG) 7=All Patient Refined DRGs (APR-DRG) 8=International-Refined DRGs (IR-DRG) 9=Other ***Please use the accurate and specific DRG type and avoid using the value "Other". Please communicate to MassHealth any DRG types you are using that are missing from the above list***	X		X			1	C
121	DRG Version	DRG Version number associated with DRG type	X		X			3	C/ No decimal points (26.1 must be entered as 261)
122	DRG Severity of Illness Level	A code that describes the Severity of the claim with the assigned DRG: Valid values are: 1 = minor 2 = moderate 3 = major 4 = extreme ***Associated with DRG Type=APR-DRG (DRT Type =7) or any other DRG that has these fields***	X		X			1	C
123	DRG Risk of Mortality Level	A code that describes the Mortality of the patient with the assigned DRG code. Valid values are: 1 = minor 2 = moderate 3 = major 4 = extreme ***Associated with DRG Type=APR-DRG (DRT Type =7) or any other DRG that has these fields.***	X		X			1	C
124	Patient Pay Amount	Patient paid amount for nursing facility stays and hospitals	X		X			9	SN
125	Patient Reason for Visit Diagnosis 1	ICD diagnosis code describing the patient's (or patient representative's) stated reason for seeking care at the time of outpatient (ER) visit ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
126	Patient Reason for Visit Diagnosis 2	ICD diagnosis code describing the patient's (or patient representative's) stated reason for seeking care at the time of outpatient (ER) visit ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
127	Patient Reason for Visit Diagnosis 3	ICD diagnosis code describing the patient's (or patient representative's) stated reason for seeking care at the time of outpatient (ER) visit ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points

128	Present on Admission (POA) 1	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
129	Present on Admission (POA) 2	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
130	Present on Admission (POA) 3	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
131	Present on Admission (POA) 4	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
132	Present on Admission (POA) 5	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
133	Present on Admission (POA) 6	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
134	Present on Admission (POA) 7	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
135	Present on Admission (POA) 8	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
136	Present on Admission (POA) 9	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
137	Present on Admission (POA) 10	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
138	Diagnosis 11	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/No decimal points
139	Present on Admission (POA) 11	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
140	Diagnosis 12	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/No decimal points
141	Present on Admission (POA) 12	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
142	Diagnosis 13	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
143	Present on Admission (POA) 13	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
144	Diagnosis 14	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
145	Present on Admission (POA) 14	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
146	Diagnosis 15	The ICD diagnosis code.	X		X			7	C/No

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		See discussion in Data Element Clarifications section, including clarification on ICD-10							decimal points

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
147	Present on Admission (POA) 15	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
148	Diagnosis 16	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
149	Present on Admission (POA) 16	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
150	Diagnosis 17	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
151	Present on Admission (POA) 17	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
152	Diagnosis 18	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
153	Present on Admission (POA) 18	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
154	Diagnosis 19	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
155	Present on Admission (POA) 19	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
156	Diagnosis 20	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
157	Present on Admission (POA) 20	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
158	Diagnosis 21	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
159	Present on Admission (POA) 21	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
160	Diagnosis 22	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
161	Present on Admission (POA) 22	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C

162	Diagnosis 23	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
163	Present on Admission (POA) 23	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
164	Diagnosis 24	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
165	Present on Admission (POA) 24	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
166	Diagnosis 25	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
167	Present on Admission (POA) 25	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
168	Diagnosis 26	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
169	Present on Admission (POA) 26	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
170	Present on Admission (POA) EI 1	This indicator is associated with External Injury Diagnosis 1 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
171	External Injury Diagnosis 2	If there is an External Injury Diagnosis code 2 (ICD- E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
172	Present on Admission (POA) EI 2	This indicator is associated with External Injury Diagnosis 2 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
173	External Injury Diagnosis 3	If there is an External Injury Diagnosis code 3 (ICD- E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
174	Present on Admission (POA) EI 3	This indicator is associated with External Injury Diagnosis 3 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
175	External Injury Diagnosis 4	If there is an External Injury Diagnosis code 4 (ICD- E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
176	Present on	This indicator is associated with External Injury Diagnosis	X		X			1	C

	Admission (POA) EI 4	4 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)							

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
177	External Injury Diagnosis 5	If there is an External Injury Diagnosis code 5 (ICD- E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
178	Present on Admission (POA) EI 5	This indicator is associated with External Injury Diagnosis 5 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
179	External Injury Diagnosis 6	If there is an External Injury Diagnosis code 6 (ICD- E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
180	Present on Admission (POA) EI 6	This indicator is associated with External Injury Diagnosis 6 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
181	External Injury Diagnosis 7	If there is an External Injury Diagnosis code 7 (ICD- E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
182	Present on Admission (POA) EI 7	This indicator is associated with External Injury Diagnosis 7 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
183	External Injury Diagnosis 8	If there is an External Injury Diagnosis code 8 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
184	Present on Admission (POA) EI 8	This indicator is associated with External Injury Diagnosis 8 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
185	External Injury Diagnosis 9	If there is an External Injury Diagnosis code 9 (ICD E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
186	Present on Admission (POA) EI 9	This indicator is associated with External Injury Diagnosis 9 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
187	External Injury Diagnosis 10	If there is an External Injury Diagnosis code 10 (ICD- E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
188	Present on Admission (POA) EI 10	This indicator is associated with External Injury Diagnosis 10 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
189	External Injury Diagnosis 11	If there is an External Injury Diagnosis code 11 (ICD- E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
190	Present on Admission (POA) EI 11	This indicator is associated with External Injury Diagnosis 11 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
191	External Injury Diagnosis 12	If there is an External Injury Diagnosis code 12 (ICD- E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
192	Present on Admission (POA) EI 12	This indicator is associated with External Injury Diagnosis 12 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
193	ICD Version Qualifier	ICD9 or ICD10. The value "ICD9" must be populated on claim records with either ICD-9-CM diagnosis codes or ICD-9-CM procedure codes. The value "ICD10" must be populated on claim records with either ICD-10-CM diagnosis codes or ICD-10-CM procedure codes. One claim record must ***never*** have a combination of ICD9 and ICD10 codes. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		X	5	C
194	Procedure Modifier 4	4th procedure code modifier, required if used.	X	X	X		X	2	C
195	Service Category Type	This field describes the Type of Financial reports the service category is based on. The values are: '4B' for MCO Service Categories 'ACO' for ACO Categories 'SCO' for SCO Service Categories 'ICO' for Care One (ICO) Service Categories						3	C
196	Ambulance Patient Count	AMBULANCE PATIENT COUNT. REQUIRED WHEN MORE THAN ONE PATIENT IS TRANSPORTED IN THE SAME VEHICLE FOR AMBULANCE OR NON-EMERGENCY TRANSPORTATION SERVICES.						3	N
197	Obstetric Unit Anesthesia Count	The number of additional units reported by an anesthesia provider to reflect additional complexity of services.						5	N
198	Prescription Number	Rx Number.				X		15	C
199	Taxonomy Code	This is the Taxonomy code for Servicing Provider identified on the claim. Taxonomy codes are National specialty codes used by providers to indicate their specialty. These codes can be found on the Website of Centers for Medicare & Medicaid Service (CMS)	X	X	X		X	10	C
200	Rate Increase Indicator	Indicates if the provider is eligible to receive the enhanced primary care rate ***for this service***, as specified in the Affordable Care Act – Section 1202 final						1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		regulations. 1=Yes 2=No 3=Unknown 4=Not Applicable ***Note:*** **If a service is considered eligible based on the ACA regulations, then the value should be equal to "1" even if the MCE is already paying the provider at the higher rate.**							
201	Bundle Indicator	Indicates if the claim line is part of a bundle. Values: Y=Yes, the claim line is part of a bundle. All bundled lines including the line with the bundled payment should have a value of 'Y' N=No, the claim line is not part of a bundle.						1	C
202	Bundle Claim Number	This is the claim number of the claim line with the bundled payment. ***See discussion in Data Element Clarifications section.***						15	C
203	Bundle Claim Suffix	This the claim suffix of the claim line with the bundled payment. ***See discussion in Data Element Clarifications section.***						4	C
204	Value Code	Code used to relate values to identify data elements necessary to process a UB92 claim. Submit only when the value=54 for Newborn claims	X					2	AN
205	Value Amount	Weight of a newborn in grams. Must be present on all newborn claims when the value code "54"is submitted in Field#206	X					9	N
206	Surgical Procedure Code 10	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
207	Surgical Procedure Code 11	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
208	Surgical Procedure Code 12	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
209	Surgical Procedure Code 13	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
210	Surgical Procedure Code 14	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
211	Surgical Procedure Code 15	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
212	Surgical Procedure Code 16	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
213	Surgical Procedure Code 17	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
214	Surgical Procedure Code 18	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
215	Surgical Procedure Code 19	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
216	Surgical Procedure Code 20	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
217	Surgical Procedure Code 21	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
218	Surgical Procedure Code 22	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
219	Surgical Procedure Code 23	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
220	Surgical Procedure Code 24	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
221	Surgical Procedure Code 25	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section,***	X					7	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		including clarification on ICD-10							
222	Attending Prov. ID Address Location Code	Code to identify address location of Attending Provider ID	X					5	C
223	Billing Provider ID Address Location Code	Code to identify address location of Billing Provider ID	X	X	X	X	X	5	C
224	Prescribing Prov. ID Address Location Code	Code to identify address location of Prescribing Provider ID				X		5	C
225	PCP Provider ID Address Location Code	Code to identify address location of PCP Provider ID	X	X	X	X	X	5	C
226	Referring Provider ID Address Location Code	Code to identify address location of Referring Provider ID	X	X	X			5	C
227	Servicing Provider ID Address Location Code	Code to identify address location of Servicing Provider ID	X	X	X	X	X	5	C
228	PCC Provider ID Address Location Code	Code to identify address location of PCC Internal Provider ID In field # 49	X	X	X	X	X	5	C
229	Adjudication Date	The date when the record was adjudicated.	X	X	X	X	X	8	D/YYYYMMDD

3. Error Handling Section

The submission will be rejected if:

- The data elements do not meet format and layout requirements
- The metadata file is not to the specifications' requirements
- Org. Code is missing or invalid

Please refer to "2.2 File Submission Requirements" segment for data elements validation/ error/result information.

EHS DW will reject records based on the following error codes:

Error Code	Description
1	Incorrect Data Type
2	Invalid Format
3	Missing value
4	Code missing from reference data
5	Invalid Date
72	Claim Number/Suffix in Denied Claims Reason Code file not in Denied Claims file
73	Claim Number/Suffix in Denied Claims file not in Denied Claims Reason Code file
74	Correction to a claim that is not in MH DW

4. Error Reports and Notifications to the Plans

When denied claims files are loaded, three error reports are placed on MCOs SFTP servers:

- Error Denied Claims Summary Report
- Error Denied Claims Details Report
- Error Denial Reference Report

4.1 Error Denied Claims Summary Report Format

Example:

MCO_Denied_Claims_20170406.zip file processed on MM/DD/YYYY (04/11/2017)
err_MCO.2017.04.11.04.26.03.denied_claim_summary.txt

Field #	Field Name	Frequency	Error Code	Error Description
5	Claim Number	25	73	Claim Number/Suffix in Denied_Claims file not in Denied_Claims_Reason_Code file
58	BILLING_PROVIDER_ID	2	3	Missing Value
73	NEW_MEDICAID_ID	3	4	Code missing from reference data

4.2 Error Denied Claims Details Report Format

MCO_Denied_Claims_20171006.zip file processed on MM/DD/YYYY (10/09/2017)
err_MCO.2017.10.09.09.48.49.denied_claim_detail.txt
Error Denied Claims Detail Report format repeats the format of the claims file in submission with two additional columns on the right – "Error Code" and "Error Description".
Because the claims file contains 231 columns, an example of the report cannot be provider here.

4.3 Error Denial Reason Code Report Format

Example:

MCO_Denied_Claims_20170406.zip file processed on MM/DD/YYYY (04/11/2017)
err_MCO. 2017.04.11.04.26.03.rsnm2m.txt

Error Denied Reason Code Report format repeats the format of the Denied Claims Reason Code file format with two extra columns on the right – "Error Code" and "Error Description"

Org. Code	Entity PIDSL	CLAIM_NUMBER	CLAIM_FUFFIX	Denial Reason Code	Error Code	Error Description
888	963852147C	5555555555RX	25	DINCORRT	72	Claim Number/Suffix in Denied_Claims_Reason_Code file not in Denied_Claims file