COMMONWEALTH OF MASSACHUSETTS ~ STANDARD CONTRACT FORM

This form is jointly issued and published by the Executive Office for Administration and Finance (ANF), the Office of the Comptroller (CTR) and the Operational Services Division (OSD) as the default contract for all Commonwealth Departments when another form is not prescribed by regulation or policy. Any changes to the official printed language of this form shall be void. Additional non-conflicting terms may be added by Attachment. Contractors may not require any additional agreements, engagement letters, contract forms or other additional terms as part of this Contract without prior Department approval. Click on hyperlinks for definitions, instructions and legal requirements that are incorporated by reference into this Contract. An electronic copy of this form is available at www.mass.gov/osc under Guidance For Vendors - Forms or www.mass.gov/osd under OSD Forms.

CONTRACTOR LEGAL NAME: UnitedHealthcare Insurance Company (and d/b/a):	**COMMONWEALTH DEPARTMENT NAME**: Executive Office of Health and Human Services **MMARS Department Code**: EHS
Legal Address: (W-9, W-4,T&C): 450 Columbus BLVD Harford, CT 06103-1801	**Business Mailing Address**: One Ashburton Place, 5th Floor, Boston, MA 02108
Contract Manager: Bernadette Di Re	**Billing Address** (if different):
E-Mail: Bernadette.di.re@uhc.com	**Contract Manager**: Susan Ciccariello
Phone: 781-419-8566 Fax: 617-472-8798	**E-Mail**: susan.ciccariello@state.ma.us
Contractor Vendor Code: VC0000283588	**Phone**: 617-222-7548 Fax: 617-222-7585
Vendor Code Address ID (e.g. "AD001"): AD001. (Note: The Address Id Must be set up for EFT payments.)	**MMARS Doc ID(s):** **RFR/Procurement or Other ID Number**: 15LCEHSSCORFA

___ **NEW CONTRACT**	_X_ **CONTRACT AMENDMENT**
PROCUREMENT OR EXCEPTION TYPE: (Check one option only) __ Statewide Contract (OSD or an OSD-designated Department) __ Collective Purchase (Attach OSD approval, scope, budget) __ Department Procurement (includes State or Federal grants 815 CMR 2.00) (Attach RFR and Response or other procurement supporting documentation) __ Emergency Contract (Attach justification for emergency, scope, budget) __ Contract Employee (Attach Employment Status Form, scope, budget) __ Legislative/Legal or Other: (Attach authorizing language/justification, scope and budget)	Enter Current Contract End Date *Prior* to Amendment: 12/31/2020. Enter Amendment Amount: $ rate contract. (or "no change") **AMENDMENT TYPE**: (Check one option only. Attach details of Amendment changes.) _x_ Amendment to Scope or Budget (Attach updated scope and budget) __ Interim Contract (Attach justification for Interim Contract and updated scope/budget) __ Contract Employee (Attach any updates to scope or budget) __ Legislative/Legal or Other: (Attach authorizing language/justification and updated scope and budget)

The following **COMMONWEALTH TERMS AND CONDITIONS** (T&C) has been executed, filed with CTR and is incorporated by reference into this Contract.

_x_ Commonwealth Terms and Conditions __ Commonwealth Terms and Conditions For Human and Social Services

COMPENSATION: (Check ONE option): The Department certifies that payments for authorized performance accepted in accordance with the terms of this Contract will be supported in the state accounting system by sufficient appropriations or other non-appropriated funds, subject to intercept for Commonwealth owed debts under 815 CMR 9.00.

_x_ Rate Contract (No Maximum Obligation. Attach details of all rates, units, calculations, conditions or terms and any changes if rates or terms are being amended.)

__ Maximum Obligation Contract Enter Total Maximum Obligation for total duration of this Contract (or *new* Total if Contract is being amended). $ _____.

PROMPT PAYMENT DISCOUNTS (PPD): Commonwealth payments are issued through EFT 45 days from invoice receipt. Contractors requesting accelerated payments must identify a PPD as follows: Payment issued within 10 days __% PPD; Payment issued within 15 days __ % PPD; Payment issued within 20 days __ % PPD; Payment issued within 30 days __% PPD. If PPD percentages are left blank, identify reason: __agree to standard 45 day cycle __ statutory/legal or Ready Payments (G.L. c. 29, § 23A); __ only initial payment (subsequent payments scheduled to support standard EFT 45 day payment cycle. See Prompt Pay Discounts Policy.)

BRIEF DESCRIPTION OF CONTRACT PERFORMANCE or REASON FOR AMENDMENT: (Enter the Contract title, purpose, fiscal year(s) and a detailed description of the scope of performance or what is being amended for a Contract Amendment. Attach all supporting documentation and justifications.) Amendment 3: (1) updates capitation rates; (2) adds provisions governing the SCO passive enrollment initiative; (3) clarifies responsibility to report encounter data; (4) ensures that the contract complies with CMS's managed care regulations; and (5) updates Appendix E, Exhibit 1 HIPF rates.

ANTICIPATED START DATE: (Complete ONE option only) The Department and Contractor certify for this Contract, or Contract Amendment, that Contract obligations:

_x_ 1. may be incurred as of the Effective Date (latest signature date below) and no obligations have been incurred prior to the Effective Date.

__ 2. may be incurred as of _____, a date LATER than the Effective Date below and no obligations have been incurred prior to the Effective Date.

__3. were incurred as of _____, 20___ , a date PRIOR to the Effective Date below, and the parties agree that payments for any obligations incurred prior to the Effective Date are authorized to be made either as settlement payments or as authorized reimbursement payments, and that the details and circumstances of all obligations under this Contract are attached and incorporated into this Contract. Acceptance of payments forever releases the Commonwealth from further claims related to these obligations.

CONTRACT END DATE: Contract performance shall terminate as of December 31, 2020, with no new obligations being incurred after this date unless the Contract is properly amended, provided that the terms of this Contract and performance expectations and obligations shall survive its termination for the purpose of resolving any claim or dispute, for completing any negotiated terms and warranties, to allow any close out or transition performance, reporting, invoicing or final payments, or during any lapse between amendments.

CERTIFICATIONS: Notwithstanding verbal or other representations by the parties, the "Effective Date" of this Contract or Amendment shall be the latest date that this Contract or Amendment has been executed by an authorized signatory of the Contractor, the Department, or a later Contract or Amendment Start Date specified above, subject to any required approvals. The Contractor makes all certifications required under the attached Contractor Certifications (incorporated by reference if not attached hereto) under the pains and penalties of perjury, agrees to provide any required documentation upon request to support compliance, and agrees that all terms governing performance of this Contract and doing business in Massachusetts are attached or incorporated by reference herein according to the following hierarchy of document precedence, the applicable Commonwealth Terms and Conditions, this Standard Contract Form including the Instructions and Contractor Certifications, the Request for Response (RFR) or other solicitation, the Contractor's Response, and additional negotiated terms, provided that additional negotiated terms will take precedence over the relevant terms in the RFR and the Contractor's Response only if made using the process outlined in 801 CMR 21.07, incorporated herein, provided that any amended RFR or Response terms result in best value, lower costs, or a more cost effective Contract.

AUTHORIZING SIGNATURE FOR THE CONTRACTOR: X: Bernadette Di Re. Date: 6-27-16 (Signature and Date Must Be Handwritten At Time of Signature) Print Name: Bernadette Di Re. Print Title: CEO, UnitedHealthcare Community Plans of Massachusetts.	**AUTHORIZING SIGNATURE FOR THE COMMONWEALTH:** X: _____. Date: 6/27/17. (Signature and Date Must Be Handwritten At Time of Signature) Print Name: Daniel Tsai. Print Title: Assistant Secretary for MassHealth.

COMMONWEALTH OF MASSACHUSETTS ~ STANDARD CONTRACT FORM

INSTRUCTIONS AND CONTRACTOR CERTIFICATIONS

The following instructions and terms are incorporated by reference and apply to this Standard Contract Form. Text that appears underlined indicates a "hyperlink" to an Internet or bookmarked site and are unofficial versions of these documents and Departments and Contractors should consult with their legal counsel to ensure compliance with all legal requirements. Using the Web Toolbar will make navigation between the form and the hyperlinks easier. Please note that not all applicable laws have been cited.

CONTRACTOR LEGAL NAME (AND D/B/A): Enter the **Full Legal Name** of the Contractor's business as it appears on the Contractor's W-9 or W-4 Form (Contract Employees only) and the applicable Commonwealth Terms and Conditions If Contractor also has a "doing business as" (d/b/a) name, BOTH the legal name and the "d/b/a" name must appear in this section.

Contractor Legal Address: Enter the Legal Address of the Contractor as it appears on the Contractor's W-9 or W-4 Form (Contract Employees only) and the applicable Commonwealth Terms and Conditions, which must match the legal address on the 1099I table in MMARS (or the Legal Address in HR/CMS for Contract Employee).

Contractor Contract Manager: Enter the authorized Contract Manager who will be responsible for managing the Contract. The Contract Manager should be an Authorized Signatory or, at a minimum, a person designated by the Contractor to represent the Contractor, receive legal notices and negotiate ongoing Contract issues. The Contract Manager is considered "Key Personnel" and may not be changed without the prior written approval of the Department. If the Contract is posted on COMMBUYS, the name of the Contract Manager must be included in the Contract on COMMBUYS.

Contractor E-Mail Address/Phone/Fax: Enter the electronic mail (e-mail) address, phone and fax number of the Contractor Contract Manager. This information must be kept current by the Contractor to ensure that the Department can contact the Contractor and provide any required legal notices. Notice received by the Contract Manager (with confirmation of actual receipt) through the listed address, fax number(s) or electronic mail address will meet any written legal notice requirements.

Contractor Vendor Code: The Department must enter the MMARS Vendor Code assigned by the Commonwealth. If a Vendor Code has not yet been assigned, leave this space blank and the Department will complete this section when a Vendor Code has been assigned. The Department is responsible under the Vendor File and W-9s Policy for verifying with authorized signatories of the Contractor, as part of contract execution, that the legal name, address and Federal Tax Identification Number (TIN) in the Contract documents match the state accounting system.

Vendor Code Address ID: (e.g., "AD001") The Department must enter the MMARS Vendor Code Address Id identifying the payment remittance address for Contract payments, which MUST be set up for EFT payments PRIOR to the first payment under the Contract in accordance with the Bill Paying and Vendor File and W-9 policies.

COMMONWEALTH DEPARTMENT NAME: Enter the full Department name with the authority to obligate funds encumbered for the Contract.

Commonwealth MMARS Alpha Department Code: Enter the three (3) letter MMARS Code assigned to this Commonwealth Department in the state accounting system.

Department Business Mailing Address: Enter the address where all formal correspondence to the Department must be sent. Unless otherwise specified in the Contract, legal notice sent or received by the Department's Contract Manager (with confirmation of actual receipt) through the listed address, fax number(s) or electronic mail address for the Contract Manager will meet any requirements for legal notice.

Department Billing Address: Enter the Billing Address or email address if invoices must be sent to a different location. Billing or confirmation of delivery of performance issues should be resolved through the listed Contract Managers.

Department Contract Manager: Identify the authorized Contract Manager who will be responsible for managing the Contract, who should be an authorized signatory or an employee designated by the Department to represent the Department to receive legal notices and negotiate ongoing Contract issues.

Department E-Mail Address/Phone/Fax: Enter the electronic mail (e-mail) address, phone and fax number of the Department Contract Manager. Unless otherwise specified in the Contract, legal notice sent or received by the Contract Manager (with confirmation of actual receipt) through the listed address, fax number(s) or electronic mail address will meet any requirements for written notice under the Contract.

MMARS Document ID(s): Enter the MMARS 20 character encumbrance transaction number associated with this Contract which must remain the same for the life of the Contract. If multiple numbers exist for this Contract, identify all Doc Ids.

RFR/Procurement or Other ID Number or Name: Enter the Request for Response (RFR) or other Procurement Reference number, Contract ID Number or other reference/tracking number for this Contract or Amendment and will be entered into the Board Award Field in the MMARS encumbrance transaction for this Contract.

NEW CONTRACTS (left side of Form):

Complete this section ONLY if this Contract is brand new. (Complete the CONTRACT AMENDMENT section for any material changes to an existing or an expired Contract, and for exercising options to renew or annual contracts under a multi-year procurement or grant program.)

PROCUREMENT OR EXCEPTION TYPE: Check the appropriate type of procurement or exception for this Contract. Only one option can be selected. See State Finance Law and General Requirements, Acquisition Policy and Fixed Assets, the Commodities and Services Policy and the Procurement Information Center (Department Contract Guidance) for details.

Statewide Contract (OSD or an OSD-designated Department). Check this option for a Statewide Contract under OSD, or by an OSD-designated Department.

Collective Purchase approved by OSD. Check this option for Contracts approved by OSD for collective purchases through federal, state, local government or other entities.

Department Contract Procurement. Check this option for a Department procurement including state grants and federal sub-grants under 815 CMR 2.00 and State Grants and Federal Subgrants Policy, Departmental Master Agreements (MA). If multi-Department user Contract, identify multi-Department use is allowable in Brief Description.

Emergency Contract. Check this option when the Department has determined that an unforeseen crisis or incident has arisen which requires or mandates immediate purchases to avoid substantial harm to the functioning of government or the provision of necessary or mandated services or whenever the health, welfare or safety of clients or other persons or serious damage to property is threatened.

Contract Employee. Check this option when the Department requires the performance of an Individual Contractor, and when the planned Contract performance with an Individual has been classified using the Employment Status Form (prior to the Contractor's selection) as work of a Contract Employee and not that of an Independent Contractor.

Legislative/Legal or Other. Check this option when legislation, an existing legal obligation, prohibition or other circumstance exempts or prohibits a Contract from being competitively procured, or identify any other procurement exception not already listed. Legislative "earmarks" exempt the Contract solely from procurement requirements, and all other Contract and state finance laws and policies apply. Supporting documentation must be attached to explain and justify the exemption.

CONTRACT AMENDMENT (Right Side of Form)

Complete this section for any Contract being renewed, amended or to continue a lapsed Contract. All Contracts with available options to renew must be amended referencing the original procurement and Contract doc ids, since all continuing contracts must be maintained in the same Contract file (even if the underlying appropriation changes each fiscal year.) "See Amendments, Suspensions, and Termination Policy.)

Enter Current Contract End Date: Enter the termination date of the Current Contract being amended, even if this date has already passed. (Note: Current Start Date is not requested since this date does not change and is already recorded in MMARS.)

Enter Amendment Amount: Enter the amount of the Amendment increase or decrease to a Maximum Obligation Contract. Enter "no change" for Rate Contracts or if no change.

AMENDMENT TYPE: Identify the type of Amendment being done. Documentation supporting the updates to performance and budget must be attached. **Amendment to Scope or Budget.** Check this option when renewing a Contract or executing any Amendment ("material change" in Contract terms) even if the Contract has lapsed. The parties may negotiate a change in any element of Contract performance or cost identified in the RFR or the Contractor's response which results in lower costs, or a more cost-effective or better value performance than was presented in the original selected response, provided the negotiation results in a better value within the scope of the RFR than what was proposed by the Contractor in the original selected response. Any "material" change in the Contract terms must be memorialized in a formal Amendment even if a corresponding MMARS transaction is not needed to support the change. Additional negotiated terms will take precedence over the relevant terms in the RFR and the Contractor's Response only if made using the process outlined in 801 CMR 21.07, incorporated herein, provided that any amended RFR or Response terms result in best value, lower costs, or a more cost effective Contract.

Interim Contracts. Check this option for an Interim Contract to prevent a lapse of Contract performance whenever an existing Contract is being re-procured but the new procurement has not been completed, to bridge the gap during implementation between an expiring and a new procurement, or to contract with an interim Contractor when a current Contractor is unable to complete full performance under a Contract.

Contract Employee. Check this option when the Department requires a renewal or other amendment to the performance of a Contract Employee.

Legislative/Legal or Other. Check this option when legislation, an existing legal obligation, prohibition or other circumstance exempts or prohibits a Contract from being competitively procured, or identify any other procurement exception not already listed. Legislative "earmarks" exempt the Contract solely from procurement requirements, and all other Contract and state finance laws and policies apply. Attach supporting documentation to explain and justify the exemption and whether Contractor selection has been publicly posted.

COMMONWEALTH TERMS AND CONDITIONS

Identify which Commonwealth Terms and Conditions the Contractor has executed and is incorporated by reference into this Contract. This Form is signed only once and recorded on the Vendor Customer File (VCUST). See Vendor File and W-9s Policy.

COMPENSATION

Identify if the Contract is a **Rate Contract** (with no stated Maximum Obligation) or a **Maximum Obligation Contract** (with a stated Maximum Obligation) and identify the Maximum Obligation. If the Contract is being amended, enter the new Maximum Obligation based upon the increase or decreasing Amendment. The Total Maximum Obligation must reflect the total funding for the dates of service under the contract, including the Amendment amount if the Contract is being amended. The Maximum Obligation must match the MMARS encumbrance. Funding and allotments must be verified as available and encumbered prior to incurring obligations. If a Contract includes both a Maximum Obligation component and Rate Contract component, check off both, specific Maximum Obligation amounts or amended amounts and Attachments must clearly outline the Contract breakdown to match the encumbrance.

PAYMENTS AND PROMPT PAY DISCOUNTS

Payments are processed within a 45 day payment cycle through EFT in accordance with the Commonwealth Bill Paying Policy for investment and cash flow purposes. Departments may NOT negotiate accelerated payments and Payees are NOT entitled to accelerated payments UNLESS a prompt payment discount (PPD) is provided to support the Commonwealth's loss of investment earnings for this earlier payment, or unless a payments is legally mandated to be made in less than 45 days (e.g., construction contracts, Ready Payments under G.L. c. 29, s. 23A). See Prompt Pay Discounts Policy. PPD are identified as a percentage discount which will be automatically deducted when an accelerated payment is made. Reduced contracts rates may not be negotiated to replace a PPD. If PPD fields are left blank please identify that the Contractor agrees to the standard 45 day cycle; a statutory/legal exemption such as Ready Payments (G.L. c. 29, § 23A); or only an initial accelerated payment for reimbursements or start up costs for a grant, with subsequent payments scheduled to support standard EFT 45 day payment cycle. Financial hardship is not a sufficient justification to accelerate cash flow for *all* payments under a Contract. Initial grant or contract payments may be accelerated for the *first* invoice or initial grant installment, but subsequent periodic installments or invoice payments should be scheduled to support the Payee cash flow needs and the standard 45 day EFT payment cycle in accordance with the Bill Paying Policy. Any accelerated payment that does not provide for a PPD must have a legal justification in Contract file for audit purposes explaining why accelerated payments were allowable without a PPD.

BRIEF DESCRIPTION OF CONTRACT PERFORMANCE

Enter a brief description of the Contract performance, project name and/or other identifying information for the Contract to specifically identify the Contract performance, match the Contract with attachments, determine the appropriate expenditure code (as listed in the Expenditure Classification Handbook) or to identify or clarify important information related to the Contract such as the Fiscal Year(s) of performance (ex. "FY2012" or "FY2012-14"). Identify settlements or other exceptions and attach more detailed justification and supporting documents. Enter "Multi-Department Use" if other Departments can access procurement. For Amendments, identify the purpose and what items are being amended. Merely stating "see attached" or referencing attachments without a narrative description of performance is insufficient.

ANTICIPATED START DATE

The Department and Contractor must certify WHEN obligations under this Contract/Amendment may be incurred. Option 1 is the default option when performance may begin as of the Effective Date (latest signature date and any required approvals). If the parties want a new Contract or renewal to begin as of the upcoming fiscal year then list the fiscal year(s) (ex. "FY2012" or "FY2012-14") in the Brief Description section. Performance starts and encumbrances reflect the default Effective Date (if no FY is listed) or the later FY start date (if a FY is listed). Use Option 2 only when the Contract will be signed well in advance of the start date and identify a specific future start date. Do not use Option 2 for a fiscal year start unless it is certain that the Contract will be signed prior to fiscal year. Option 3 is used in lieu of the Settlement and Release Form when the Contract/Amendment is signed late, and obligations have already been incurred by the Contractor prior to the Effective Date for which the Department has either requested, accepted or deemed legally eligible for reimbursement, and the Contract includes supporting documents justifying the performance or proof of eligibility, and approximate costs. Any obligations incurred outside the scope of the Effective Date under any Option listed, even if the incorrect Option is selected, shall be automatically deemed a settlement included under the terms of the Contract and upon payment to the Contractor will release the Commonwealth from further obligations for the identified performance. All settlement payments require justification and must be under same encumbrance and object codes as the Contract payments. Performance dates are subject to G.L. c.4, § 9.

CONTRACT END DATE

The Department must enter the date that Contract performance will terminate. **If the Contract is being amended and the Contract End Date is not changing, this date must be re-entered again here.** A Contract must be signed for at least the initial duration but not longer than the period of procurement listed in the RFR, or other solicitation document (if applicable). No new performance is allowable beyond the end date without an amendment, but the Department may allow a Contractor to complete minimal close out performance obligations if substantial performance has been made prior to the termination date of the Contract and prior to the end of the fiscal year in which payments are appropriated, provided that any close out performance is subject to appropriation and funding limits under state finance law, and CTR may adjust encumbrances and payments in the state accounting system to enable final close out payments. Performance dates are subject to G.L. c.4, § 9.

CERTIFICATIONS AND EXECUTION

See Department Head Signature Authorization Policy and the Contractor Authorized Signatory Listing for policies on Contractor and Department signatures.

Authorizing Signature for Contractor/Date: The Authorized Contractor Signatory must (in their own handwriting and in ink) sign AND enter the date the Contract is signed. See section above under "Anticipated Contract Start Date". Acceptance of payment by the Contractor shall waive any right of the Contractor to claim the Contract/Amendment is not valid and the Contractor may not void the Contract. **Rubber stamps, typed or other images are not acceptable.** Proof of Contractor signature authorization on a **Contractor Authorized Signatory Listing** may be required by the Department if not already on file.

Contractor Name /Title: The Contractor Authorized Signatory's name and title must appear legibly as it appears on the **Contractor Authorized Signatory Listing**.

Authorizing Signature For Commonwealth/Date: The Authorized Department Signatory must (in their own handwriting and in ink) sign AND enter the date the Contract is signed. See section above under "Anticipated Start Date". **Rubber stamps, typed or other images are not accepted.** The Authorized Signatory must be an employee within the Department legally responsible for the Contract. See Department Head Signature Authorization. The Department must have the legislative funding appropriated for all the costs of this Contract or funding allocated under an approved Interdepartmental Service Agreement (ISA). A Department may not contract for performance to be delivered to or by another state department without specific legislative authorization (unless this Contract is a Statewide Contract). For Contracts requiring Secretariat signoff, evidence of Secretariat signoff must be included in the Contract file.

Department Name /Title: Enter the Authorized Signatory's name and title legibly.

CONTRACTOR CERTIFICATIONS AND LEGAL REFERENCES

Notwithstanding verbal or other representations by the parties, the "Effective Date" of this Contract or Amendment shall be the latest date that this Contract or Amendment has been executed by an authorized signatory of the Contractor, the Department, or a later Contract or Amendment Start Date specified, subject to any required approvals. The Contractor makes all certifications required under this Contract under the pains and penalties of perjury, and agrees to provide any required documentation upon request to support compliance, and agrees that all terms governing performance of this Contract and doing business in Massachusetts are attached or incorporated by reference herein:

Commonwealth and Contractor Ownership Rights. The Contractor certifies and agrees that the Commonwealth is entitled to ownership and possession of all "deliverables" purchased or developed with Contract funds. A Department may not relinquish Commonwealth rights to deliverables nor may Contractors sell products developed with Commonwealth resources without just compensation. The Contract should detail all Commonwealth deliverables and ownership rights and any Contractor proprietary rights.

Qualifications. The Contractor certifies it is qualified and shall at all times remain qualified to perform this Contract; that performance shall be timely and meet or exceed industry standards for the performance required, including obtaining requisite licenses, registrations, permits, resources for performance, and sufficient professional, liability; and other appropriate insurance to cover the performance. If the Contractor is a business, the Contractor certifies that it is listed under the Secretary of State's website as licensed to do business in Massachusetts, as required by law.

Business Ethics and Fraud, Waste and Abuse Prevention. The Contractor certifies that performance under this Contract, in addition to meeting the terms of the Contract, will be made using ethical business standards and good stewardship of taxpayer and other public funding and resources to prevent fraud, waste and abuse.

Collusion. The Contractor certifies that this Contract has been offered in good faith and without collusion, fraud or unfair trade practices with any other person, that any actions to avoid or frustrate fair and open competition are prohibited by law, and shall be grounds for rejection or disqualification of a Response or termination of this Contract.

Public Records and Access The Contractor shall provide full access to records related to performance and compliance to the Department and officials listed under Executive Order 195 and G.L. c. 11, s.12 seven (7) years beginning on the first day after the final payment under this Contract or such longer period necessary for the resolution of any litigation, claim, negotiation, audit or other inquiry involving this Contract. Access to view Contractor

records related to any breach or allegation of fraud, waste and/or abuse may not be denied and Contractor can not claim confidentiality or trade secret protections solely for viewing but not retaining documents. Routine Contract performance compliance reports or documents related to any alleged breach or allegation of non-compliance, fraud, waste, abuse or collusion may be provided electronically and shall be provided at Contractor's own expense. Reasonable costs for copies of non-routine Contract related records shall not exceed the rates for public records under 950 C.M.R. 32.00.

Debarment. The Contractor certifies that neither it nor any of its subcontractors are currently debarred or suspended by the federal or state government under any law or regulation including, Executive Order 147; G.L. c. 29, s. 29F G.L. c.30, § 39R, G.L. c.149, § 27C, G.L. c.149, § 44C, G.L. c.149, § 148B and G.L. c. 152, s. 25C.

Applicable Laws. The Contractor shall comply with all applicable state laws and regulations including but not limited to the applicable Massachusetts General Laws; the Official Code of Massachusetts Regulations; Code of Massachusetts Regulations (unofficial); 801 CMR 21.00 (Procurement of Commodity and Service Procurements, Including Human and Social Services); 815 CMR 2.00 (Grants and Subsidies); 808 CMR 1.00 (Compliance, Reporting and Auditing for Human And Social Services); AICPA Standards; confidentiality of Department records under G.L. c. 66A; and the Massachusetts Constitution Article XVIII if applicable.

Invoices. The Contractor must submit invoices in accordance with the terms of the Contract and the Commonwealth Bill Paying Policy. Contractors must be able to reconcile and properly attribute concurrent payments from multiple Departments. Final invoices in any fiscal year must be submitted no later than August 15th for performance made and received (goods delivered, services completed) prior to June 30th, in order to make payment for that performance prior to the close of the fiscal year to prevent reversion of appropriated funds. Failure to submit timely invoices by August 15th or other date listed in the Contract shall authorize the Department to issue an estimated payment based upon the Department's determination of performance delivered and accepted. The Contractor's acceptance of this estimated payment releases the Commonwealth from further claims for these invoices. If budgetary funds revert due to the Contractor's failure to submit timely final invoices, or for disputing an estimated payment, the Department may deduct a penalty up to 10% from any final payment in the next fiscal year for failure to submit timely invoices.

Payments Subject To Appropriation. Pursuant to G.L. c. 29 § 26, § 27 and § 29, Departments are required to expend funds only for the purposes set forth by the Legislature and within the funding limits established through appropriation, allotment and subsidiary, including mandated allotment reductions triggered by G.L. c. 29, § 9C. A Department cannot authorize or accept performance in excess of an existing appropriation and allotment, or sufficient non-appropriated available funds. Any oral or written representations, commitments, or assurances made by the Department or any other Commonwealth representative are not binding. The Commonwealth has no legal obligation to compensate a Contractor for performance that is not requested and is intentionally delivered by a Contractor outside the scope of a Contract. Contractors should verify funding prior to beginning performance.

Intercept. Contractors may be registered as Customers in the Vendor file if the Contractor owes a Commonwealth debt. Unresolved and undisputed debts, and overpayments of Contract payments that are not reimbursed timely shall be subject to intercept pursuant to G.L. c. 7A, s. 3 and 815 CMR 9.00. Contract overpayments will be subject to immediate intercept or payment offset. The Contractor may not penalize any state Department or assess late fees, cancel a Contract or other services if amounts are intercepted or offset due to recoupment of an overpayment, outstanding taxes, child support, other overdue debts or Contract overpayments.

Tax Law Compliance. The Contractor certifies under the pains and penalties of perjury tax compliance with Federal tax laws; state tax laws including but not limited to G.L. c. 62C, G.L. c. 62C, s. 49A; compliance with all state tax laws, reporting of employees and contractors, withholding and remitting of tax withholdings and child support and is in good standing with respect to all state taxes and returns due; reporting of employees and contractors under G.L. c. 62E, withholding and remitting child support including G.L. c. 119A, s. 12; TIR 05-11; New Independent Contractor Provisions and applicable TIRs.

Bankruptcy, Judgments, Potential Structural Changes, Pending Legal Matters and Conflicts. The Contractor certifies it has not been in bankruptcy and/or receivership within the last three calendar years, and the Contractor certifies that it will immediately notify the Department in writing **at least 45 days prior** to filing for bankruptcy and/or receivership, any potential structural change in its organization, or if there is **any risk** to the solvency of the Contractor that may impact the Contractor's ability to timely fulfill the terms of this Contract or Amendment. The Contractor certifies that at any time during the period of the Contract the Contractor is required to affirmatively disclose in writing to the Department Contract Manager the details of any judgment, criminal conviction, investigation or litigation pending against the Contractor or any of its officers, directors, employees, agents, or subcontractors, including any potential conflicts of interest of which the Contractor has knowledge, or learns of during the Contract term. Law firms or Attorneys providing legal services are required to identify any potential conflict with representation of any Department client in accordance with Massachusetts Board of Bar Overseers (BBO) rules.

Federal Anti-Lobbying and Other Federal Requirements. If receiving federal funds, the Contractor certifies compliance with federal anti-lobbying requirements including 31 USC 1352; other federal requirements; Executive Order 11246; Air Pollution Act; Federal Water Pollution Control Act and Federal Employment Laws.

Protection of Personal Data and Information. The Contractor certifies that all steps will be taken to ensure the security and confidentiality of all Commonwealth data for which the Contractor becomes a holder, either as part of performance or inadvertently during performance, with special attention to restricting access, use and disbursement of personal data and information under G.L. c. 93H and c. 66A and Executive Order 504. The Contractor is required to comply with G.L. c. 93I for the proper disposal of all paper and electronic media, backups or systems containing personal data and information, provided further that the Contractor is required to ensure that any personal data or information transmitted electronically or through a portable device be properly encrypted using (at a minimum) Information Technology Division (ITD) Protection of Sensitive Information, provided further that any Contractor having access to credit card or banking information of Commonwealth customers certifies that the Contractor is PCI compliant in accordance with the Payment Card Industry Council Standards and shall provide confirmation compliance during the Contract, provide further that the Contractor shall immediately notify the Department in the event of any security breach including the unauthorized access, disbursement, use or disposal of personal data or information, and in the event of a security breach, the Contractor shall cooperate fully with the Commonwealth and provide access to any information necessary for the Commonwealth to respond to the security breach and shall be fully responsible for any damages associated with the Contractor's breach including but not limited to G.L. c. 214, s. 3B.

Corporate and Business Filings and Reports. The Contractor certifies compliance with any certification, filing, reporting and service of process requirements of the Secretary of the Commonwealth, the Office of the Attorney General or other Departments as related to its conduct of business in the Commonwealth; and with its incorporating state (or foreign entity).

Employer Requirements. Contractors that are employers certify compliance with applicable state and federal employment laws or regulations, including but not limited to G.L. c. 5, s. 1 (Prevailing Wages for Printing and Distribution of Public Documents); G.L. c. 7, s. 22 (Prevailing Wages for Contracts for Meat Products and Clothing and Apparel); minimum wages and prevailing wage programs and payments; unemployment insurance and contributions; workers' compensation and insurance, child labor laws, AGO fair labor practices; G.L. c. 149 (Labor and Industries); G.L. c. 150A (Labor Relations); G.L. c. 151 and 455 CMR 2.00 (Minimum Fair Wages); G.L. c. 151A (Employment and Training); G. L. c. 151B (Unlawful Discrimination); G.L. c. 151E (Business Discrimination); G.L. c. 152 (Workers' Compensation); G.L. c.153 (Liability for Injuries); 29 USC c. 8 (Federal Fair Labor Standards); 29 USC c. 28 and the Federal Family and Medical Leave Act.

Federal And State Laws And Regulations Prohibiting Discrimination including but not limited to the Federal Equal Employment Oppurtunity (EEO) Laws the Americans with Disabilities Act.; 42 U.S.C Sec. 12,101, et seq., the Rehabilitation Act, 29 USC c. 16 s. 794; 29 USC c. 16. s. 701; 29 USC c. 14, 623; the 42 USC c. 45; (Federal Fair Housing Act); G. L. c. 151B (Unlawful Discrimination); G.L. c. 151E (Business Discrimination); the Public Accommodations Law G.L. c. 272, s. 92A; G.L. c. 272, s. 98 and 98A, Massachusetts Constitution Article CXIV and G.L. c. 93, s. 103; 47 USC c. 5, sc. II, Part II, s. 255 (Telecommunication Act; Chapter 149, Section 105D, G.L. c. 151C, G.L. c. 272, Section 92A, Section 98 and Section 98A, and G.L. c. 111, Section 199A, and Massachusetts Disability-Based Non-Discrimination Standards For Executive Branch Entities, and related Standards and Guidance, authorized under Massachusetts Executive Order or any disability-based protection arising from state or federal law or precedent. See also MCAD and MCAD links and Resources.

Small Business Purchasing Program (SBPP). A Contractor may be eligible to participate in the SBPP, created pursuant to Executive Order 523, if qualified through the SBPP COMMBUYS subscription process at: www.commbuys.com and with acceptance of the terms of the SBPP participation agreement.

Limitation of Liability for Information Technology Contracts (and other Contracts as Authorized). The Information Technology Mandatory Specifications and the IT Acquisition Accessibility Contract Language are incorporated by reference into Information Technology Contracts. The following language will apply to Information Technology contracts in the U01, U02, U03, U04, U05, U06, U07, U08, U09, U10, U75, U98 object codes in the Expenditure Classification Handbook or other Contracts as approved by CTR or OSD. Pursuant to Section 11. Indemnification of the Commonwealth Terms and Conditions, the term "other damages" shall include, but shall not be limited to, the reasonable costs the Commonwealth incurs to repair, return, replace or seek cover (purchase of comparable substitute commodities and services) under a Contract. "Other damages" shall not include damages to the Commonwealth as a result of third party claims, provided, however, that the foregoing in no way limits the Commonwealth's right of recovery for personal injury or property damages or patent and copyright infringement under Section 11 nor the Commonwealth's ability to join the contractor as a third party defendant. Further, the term "other damages" shall not include, and in no event shall the contractor be liable for, damages for the Commonwealth's use of contractor provided products or services, loss of Commonwealth records, or data (or other intangible property), loss of use of equipment, lost revenue, lost savings or lost profits of the Commonwealth. In no event shall "other

damages" exceed the greater of $100,000, or two times the value of the product or service (as defined in the Contract scope of work) that is the subject of the claim. Section 11 sets forth the contractor's entire liability under a Contract. Nothing in this section shall limit the Commonwealth's ability to negotiate higher limitations of liability in a particular Contract, provided that any such limitation must specifically reference Section 11 of the Commonwealth Terms and Conditions. In the event the limitation of liability conflicts with accounting standards which mandate that there can be no cap of damages, the limitation shall be considered waived for that audit engagement. These terms may be applied to other Contracts only with prior written confirmation from the Operational Services Division or the Office of the Comptroller. The terms in this Clarification may not be modified.

Northern Ireland Certification. Pursuant to G.L. c. 7 s. 22C for state agencies, state authorities, the House of Representatives or the state Senate, by signing this Contract the Contractor certifies that it does not employ ten or more employees in an office or other facility in Northern Ireland and if the Contractor employs ten or more employees in an office or other facility located in Northern Ireland the Contractor certifies that it does not discriminate in employment, compensation, or the terms, conditions and privileges of employment on account of religious or political belief; and it promotes religious tolerance within the work place, and the eradication of any manifestations of religious and other illegal discrimination; and the Contractor is not engaged in the manufacture, distribution or sale of firearms, munitions, including rubber or plastic bullets, tear gas, armored vehicles or military aircraft for use or deployment in any activity in Northern Ireland.

Pandemic, Disaster or Emergency Performance. In the event of a serious emergency, pandemic or disaster outside the control of the Department, the Department may negotiate emergency performance from the Contractor to address the immediate needs of the Commonwealth even if not contemplated under the original Contract or procurement. Payments are subject to appropriation and other payment terms.

Consultant Contractor Certifications (For Consultant Contracts "HH" and "NN" and "U05" object codes subject to G.L. Chapter 29, s. 29A). Contractors must make required disclosures as part of the RFR Response or using the Consultant Contractor Mandatory Submission Form.

Attorneys. Attorneys or firms providing legal services or representing Commonwealth Departments may be subject to G.L. c. 30, s. 65, and if providing litigation services must be approved by the Office of the Attorney General to appear on behalf of a Department, and shall have a continuing obligation to notify the Commonwealth of any conflicts of interest arising under the Contract.

Subcontractor Performance. The Contractor certifies full responsibility for Contract performance, including subcontractors, and that comparable Contract terms will be included in subcontracts, and that the Department will not be required to directly or indirectly manage subcontractors or have any payment obligations to subcontractors. .

EXECUTIVE ORDERS

For covered Executive state Departments, the Contractor certifies compliance with applicable Executive Orders (see also Massachusetts Executive Orders), including but not limited to the specific orders listed below. A breach during period of a Contract may be considered a material breach and subject Contractor to appropriate monetary or Contract sanctions.

Executive Order 481. Prohibiting the Use of Undocumented Workers on State Contracts. For all state agencies in the Executive Branch, including all executive offices, boards, commissions, agencies, Departments, divisions, councils, bureaus, and offices, now existing and hereafter established, by signing this Contract the Contractor certifies under the pains and penalties of perjury that they shall not knowingly use undocumented workers in connection with the performance of this Contract; that, pursuant to federal requirements, shall verify the immigration status of workers assigned to a Contract without engaging in unlawful discrimination; and shall not knowingly or recklessly alter, falsify, or accept altered or falsified documents from any such worker

Executive Order 130. Anti-Boycott. The Contractor warrants, represents and agrees that during the time this Contract is in effect, neither it nor any affiliated company, as hereafter defined, participates in or cooperates with an international boycott (See IRC § 999(b)(3)-(4), and IRS Audit Guidelines Boycotts) or engages in conduct declared to be unlawful by G.L. c. 151E, s. 2. A breach in the warranty, representation, and agreement contained in this paragraph, without limiting such other rights as it may have, the Commonwealth shall be entitled to rescind this Contract. As used herein, an affiliated company shall be any business entity of which at least 51% of the ownership interests are directly or indirectly owned by the Contractor or by a person or persons or business entity or entities directly or indirectly owning at least 51% of the ownership interests of the Contractor, or which directly or indirectly owns at least 51% of the ownership interests of the Contractor.

Executive Order 346. Hiring of State Employees By State Contractors Contractor certifies compliance with both the conflict of interest law G.L. c. 268A specifically s. 5 (f) and this order; and includes limitations regarding the hiring of state employees by private companies contracting with the Commonwealth. A privatization contract shall be deemed to include a specific prohibition against the hiring at any time during the term of Contract, and for any position in the Contractor's company, any state management employee who is, was, or will be involved in the preparation of the RFP, the negotiations leading to the awarding of the Contract, the decision to award the Contract, and/or the supervision or oversight of performance under the Contract.

Executive Order 444. Disclosure of Family Relationships With Other State Employees. Each person applying for employment (including Contract work) within the Executive Branch under the Governor must disclose in writing the names of all immediate family related to immediate family by marriage who serve as employees or elected officials of the Commonwealth. All disclosures made by applicants hired by the Executive Branch under the Governor shall be made available for public inspection to the extent permissible by law by the official with whom such disclosure has been filed.

Executive Order 504. Regarding the Security and Confidentiality of Personal Information. For all Contracts involving the Contractor's access to personal information, as defined in G.L. c. 93H, and personal data, as defined in G.L. c. 66A, owned or controlled by Executive Department agencies, or access to agency systems containing such information or data (herein collectively "personal information"), Contractor certifies under the pains and penalties of perjury that the Contractor (1) has read Commonwealth of Massachusetts Executive Order 504 and agrees to protect any and all personal information; and (2) has reviewed all of the Commonwealth **Information Technology Division's Security Policies.** Notwithstanding any contractual provision to the contrary, in connection with the Contractor's performance under this Contract, for all state agencies in the Executive Department, including all executive offices, boards, commissions, agencies, departments, divisions, councils, bureaus, and offices, now existing and hereafter established, the Contractor shall: (1) obtain a copy, review, and comply with the contracting agency's Information Security Program (ISP) and any pertinent security guidelines, standards, and policies; (2) comply with all of the Commonwealth of Massachusetts Information Technology Division's "Security Policies") (3) communicate and enforce the contracting agency's ISP and such Security Policies against all employees (whether such employees are direct or contracted) and subcontractors; (4) implement and maintain any other reasonable appropriate security procedures and practices necessary to protect personal information to which the Contractor is given access by the contracting agency from the unauthorized access, destruction, use, modification, disclosure or loss; (5) be responsible for the full or partial breach of any of these terms by its employees (whether such employees are direct or contracted) or subcontractors during or after the term of this Contract, and any breach of these terms may be regarded as a material breach of this Contract; (6) in the event of any unauthorized access, destruction, use, modification, disclosure or loss of the personal information (collectively referred to as the "unauthorized use"): (a) immediately notify the contracting agency if the Contractor becomes aware of the unauthorized use; (b) provide full cooperation and access to information necessary for the contracting agency to determine the scope of the unauthorized use; and (c) provide full cooperation and access to information necessary for the contracting agency and the Contractor to fulfill any notification requirements. Breach of these terms may be regarded as a material breach of this Contract, such that the Commonwealth may exercise any and all contractual rights and remedies, including without limitation indemnification under Section 11 of the Commonwealth's Terms and Conditions, withholding of payments, Contract suspension, or termination. In addition, the Contractor may be subject to applicable statutory or regulatory penalties, including and without limitation, those imposed pursuant to G.L. c. 93H and under G.L. c. 214, § 3B for violations under M.G.L c. 66A.

Executive Orders 523, 524 and 526. Executive Order 526 (Order Regarding Non-Discrimination, Diversity, Equal Opportunity and Affirmative Action which supersedes Executive Order 478). Executive Order 524 (Establishing the Massachusetts Supplier Diversity Program which supersedes Executive Order 390). Executive Order 523 (Establishing the Massachusetts Small Business Purchasing Program.) All programs, activities, and services provided, performed, licensed, chartered, funded, regulated, or contracted for by the state shall be conducted without unlawful discrimination based on race, color, age, gender, ethnicity, sexual orientation, gender identity or expression, religion, creed, ancestry, national origin, disability, veteran's status (including Vietnam-era veterans), or background. The Contractor and any subcontractors may not engage in discriminatory employment practices; and the Contractor certifies compliance with applicable federal and state laws, rules, and regulations governing fair labor and employment practices; and the Contractor commits to purchase supplies and services from certified minority or women-owned businesses, small businesses, or businesses owned by socially or economically disadvantaged persons or persons with disabilities. These provisions shall be enforced through the contracting agency, OSD, and/or the Massachusetts Commission Against Discrimination. Any breach shall be regarded as a material breach of the contract that may subject the contractor to appropriate sanctions.

AMENDMENT #3
TO THE
CONTRACT FOR SENIOR CARE ORGANIZATIONS
BY AND BETWEEN
THE EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
AND
UNITEDHEALTHCARE INSURANCE COMPANY

WHEREAS, the Executive Office of Health and Human Services Office of Medicaid (referred to throughout the Contract as either "EOHHS" or "MassHealth") and UnitedHealthcare Insurance Company ("Contractor") entered into a Senior Care Organizations (SCO) Contract on June 16, 2015, with an effective start date of January 1, 2016, to provide certain medical services; and

WHEREAS, EOHHS and the Contractor amended the SCO Contract in a document entitled Amendment #1 to the Contract for Senior Care Organizations By and Between the Executive Office of Health and Human Services and UnitedHealthcare Insurance Company on June 16, 2016 (the "First Amendment"); and

WHEREAS, EOHHS and the Contractor further amended the SCO Contract in a document entitled Amendment #2 to the Contract for Senior Care Organizations By and Between the Executive Office of Health and Human Services and UnitedHealthcare Insurance Company on January 18, 2017 (the "Second Amendment"); and

WHEREAS, unless further amended hereinafter, the First and Second Amendments remain in full force and effect; and

WHEREAS, EOHHS and the Contractor desire to further amend their agreement in accordance with the terms and conditions set forth herein; and

WHEREAS, the parties agree that the terms stated herein are subject to the approval of the federal Centers for Medicare and Medicaid Services (CMS);

NOW, THEREFORE, in consideration of their mutual undertakings, EOHHS and the Contractor agree to further amend the SCO Contract as follows:

1. **SECTION 1. DEFINITIONS OF TERMS** shall be amended as follows:

   a. The definition of "**Chronically Homeless**" shall be deleted in its entirety and replaced with the following:

      "**Chronically Homeless** shall have the meaning ascribed to that term by 24 CFR 91.5."

   b. The definition of "**Complaint**" shall be deleted in its entirety and replaced with the following:

      "**Complaint** - An Enrollee's formal or informal, oral or written, expression of grievance or dissatisfaction with any aspect of the Contractor's provision of care or customer service."

c. "**Eligible Individual**" shall be added as a defined term following the paragraph that defines the term "**Dual Eligible Senior**":

"**Eligible Individual** – A MassHealth Member enrolled in MassHealth Standard and satisfying the criteria set forth in 130 CMR 508.008(A)."

d. "**Encounter Data**" shall be added as a defined term following the paragraph that defines the term "**Emergency Condition**":

"**Encounter Data** – A dataset provided by the Contractor that records every service provided to an Enrollee. This dataset shall be developed in the format specified by EOHHS and shall be updated electronically according to protocols and timetables established by EOHHS in accordance with **Appendix I**."

e. "**Incident Report**" shall be added as a defined term following the paragraph that defines the term "**Healthcare Effectiveness Data and Information Set (HEDIS)**":

"**Incident Report** – A written report concerning an allegation of abuse, neglect, or exploitation of an Enrollee that the Contractor must submit to EOHHS pursuant to **Section 2.10.D.9** of this Contract."

f. The definition of "**Initial Assessment**" shall be deleted in its entirety and replaced with the following:

"**Initial Assessment** – A comprehensive assessment of an Enrollee that includes: (1) an evaluation of clinical status, Functional Status, nutritional status, and physical well-being; (2) the medical history of the Enrollee, including relevant family members and illnesses; (3) screenings for mental-health status and tobacco, alcohol and drug use; and (4) an assessment of the Enrollee's need for long services and supports, including the availability of informal support. EOHHS may prescribe the Initial Assessment tool."

g. "**Opt-In Enrollment**" and "**Opt Out**" shall be added as defined terms following the paragraph that defines the term "**Ongoing Assessment**":

"**Opt-In Enrollment** – Enrollment in a SCO plan initiated by an Eligible Individual."

"**Opt Out** – A process by which an Eligible Individual or his/her Authorized Representative chooses not to be enrolled with the Contractor via Passive Enrollment. An Eligible Individual may Opt Out at any time before the effective date of his or her Passive Enrollment."

h. "**Passive Enrollee**" and "**Passive Enrollment**" shall be added as defined terms following the paragraph that defines the term "**Outreach**":

"**Passive Enrollee** – An individual selected for enrollment with the Contractor through the Passive Enrollment process."

"**Passive Enrollment** – An Enrollment process through which an Eligible Individual is enrolled by EOHHS (or its vendor) with a Contractor following a minimum 60-day advance notification

period during which the Eligible Individual may elect to make a different enrollment decision (including Opting-Out or enrolling with a different Senior Care Organization)."

2. **SECTION 2. CONTRACTOR RESPONSIBILITIES** shall be amended as follows:

   a. **Section 2.1.C** is hereby deleted in its entirety and replaced with the following:

   "C. Mental Health Parity Law

   In accordance with 130 CMR 450.117(J), the Contractor shall review its administrative and other practices, including the administrative and other practices of any contracted Behavioral Health organization, for the prior calendar year for compliance with the relevant provisions of the federal Mental Health Parity Law; regulations, including subpart K of 42 CFR 438; and guidance; and submit a certification of compliance to EOHHS in accordance with 130 CMR 450.117(J)(1) and any additional instructions provided by EOHHS."

   b. **Section 2.3** is hereby deleted in its entirety and replaced with the following:

   "2.3 Enrollment Activities

   Enrollment in the Senior Care Options Program is voluntary. For a MassHealth Member to be eligible to enroll in the Senior Care Options Program, the Member must be MassHealth Standard eligible and meet all other eligibility requirements as set forth in 130 CMR 508.008(A).

   Medicare eligibility is not a prerequisite for enrollment in the Senior Care Options Program. MassHealth Members with or without Medicare may enroll in the Senior Care Options Program, provided they meet all eligibility requirements as set forth in 130 CMR 508.008(A).

   Note: An individual enrolled in Medicare but not eligible for MassHealth Standard (i.e. not a Dual Eligible Senior) is not eligible to enroll in the Senior Care Options Program.

   In accordance with **Section 2.1**, prior to commencing the initial enrollment of MassHealth Members, the Contractor must demonstrate to EOHHS that it has been designated by CMS as a Medicare Advantage Special Needs Plan for persons dually eligible for Medicare and Medicaid and has Medicare Part D authority.

   A. Opt-In Enrollment -- The Contractor may submit Opt-In Enrollments to EOHHS on behalf of MassHealth Members eligible for, and seeking to enroll in, the Senior Care Options Program. Prior to submitting such an enrollment to EOHHS, the Contractor shall verify through EOHHS's electronic on-line Eligibility Verification System (EVS) that the MassHealth Member is MassHealth Standard eligible. The Contractor must utilize enrollment forms that are approved by EOHHS and CMS, and must maintain on file any such forms that have been signed by Enrollees.

B. Passive Enrollment

1. EOHHS may conduct Passive Enrollment during the term of the Contract. Individuals who Opt Out will not be included in future Passive Enrollments.
2. The schedule for Passive Enrollment will be determined by EOHHS. EOHHS reserves the right to make changes to the Passive Enrollment schedule at its discretion and at any time.
3. EOHHS will provide notice to each Passive Enrollee at least 60 days prior to the effective date of his or her enrollment with the Contractor.
4. EOHHS will accept Opt Out requests from Passive Enrollees prior to the effective date of enrollment.
5. EOHHS may stop Passive Enrollment in the Contractor's plan at its discretion, and for any reason, including if the Contractor does not comply with this Contract.
6. EOHHS will monitor Passive Enrollment assignments to all SCO plans, and may make adjustments to the volume and spacing of Passive Enrollment periods at its discretion. In exercising this discretion, EOHHS may consider any factor(s) that it deems relevant, including the capacity of the Contractor, and the capacity of the other SCO plans, to accept potential Passive Enrollees.

C. All Enrollments. This **Section 2.3.C** applies to all Enrollments, whether Opt-In Enrollments pursuant to **Section 2.3.A** or Passive Enrollments pursuant to **Section 2.3.B**.

1. Subject to the eligibility requirements set forth in 130 CMR 508.008(A), the Contractor must accept each Enrollee in the order in which he or she seeks to join the Contractor's plan or is assigned to the Contractor's plan, without restrictions, regardless of his or her income status, physical or mental condition, age, gender, sexual orientation, religion, creed, color, physical or mental disability, national origin, ancestry, pre-existing condition(s), or expected health status, in accordance with federal and State requirements.
2. EOHHS will assign Rate Cells (RCs) upon enrollment. For certain RCs, the Contractor must submit a request, including documentation supporting the requested RC. For additional information on RCs, see **Section 4**.
3. Enrollments received and approved by the last business day of the month will be effective on the first calendar day of the following month.
4. The Contractor will be responsible for providing Covered Services to Enrollees from the effective date of enrollment.
5. The Contractor must have a mechanism for receiving timely information about all enrollments in the Contractor's program, including the effective date of enrollment, from CMS and EOHHS systems.

D. Primary Care Providers

1. Selection of a Primary Care Provider

Upon enrollment, the Contractor must assist the Enrollee to choose a PCP and assist the Enrollee in selecting a new PCP whenever necessary. If the Enrollee has not selected a PCP by the effective date of enrollment, the Contractor must assign the Enrollee a PCP.

2. Termination of a PCP

When a PCP is terminated from the Contractor's program, the Contractor must make a good faith effort to give written notification of termination of the PCP, within 15 days after receipt or issuance of the termination notice, to each Enrollee who received his or her Primary Care from, or was seen on a regular basis by, the terminated PCP.

E. Initial Assessment

The Contractor must complete an Initial Assessment of the Enrollee within 30 calendar days of the effective date of the Enrollee's enrollment with the Contractor. The Initial Assessment must include:

1. An evaluation of the Enrollee's clinical status, Functional Status, nutritional status, and physical well-being;
2. The Enrollee's medical history, including relevant family members and illnesses;
3. A screening of the Enrollee's mental-health status, and tobacco, alcohol and drug use; and
4. An assessment of the Enrollee's need for long term services and supports, including the availability of informal support.

F. Enrollee Orientation

The Contractor must:

1. Provide an orientation to Enrollees within 30 calendar days of the effective date of enrollment;
2. Make available to family members, significant informal caregivers, and designated representatives, as appropriate, any enrollment and orientation materials upon request;
3. For Enrollees for whom written materials are not appropriate, provide non-written orientation in a format such as telephone calls, home visits, video screenings, or group presentations;
4. Notify its Enrollees:

    a. That written information is available in Prevalent Languages;

    b. That oral interpretation services are available for any language;

    c. How Enrollees can access oral interpretation services; and

d. How Enrollees can access non-written materials described in **Subsection 2.3.F.3** above.

5. Ensure that all orientation materials are provided in a manner and format that may be easily understood, including oral interpretation services in all non-English languages when requested. Orientation materials must include the following:

   a. A list of Covered Services;

   b. A Provider Network directory;

   c. A description of the roles of the PCP and PCT and the process by which Enrollees select and change PCPs;

   d. The Contractor's Evidence of Coverage (see **Appendix B**) including, but not limited to, descriptions of:

      1) Enrollee rights;

      2) An explanation of the Centralized Enrollee Record (CER) and the process by which clinical information, including diagnostic and medication information, will be available to key caregivers (see **Subsection 2.4.A.8-10**);

      3) How to obtain a copy of the Enrollee's CER;

      4) How to obtain access to specialty, behavioral health, and long term care services;

      5) How to obtain services for Emergency Conditions and Urgent Care in and out of the Provider Network and in and out of the Service Area;

      6) Information about advance directives (at a minimum, that required by subpart I of 42 CFR 489), designating a health care proxy, and other mechanisms for ensuring that future medical decisions are made according to the desires of the Enrollee;

      7) How to obtain assistance from ESRs;

      8) How to file Complaints and Appeals with the Contractor;

      9) How the Enrollee can identify who the Enrollee wants to receive written notices of denials, terminations, and reductions;

      10) How to obtain assistance with the Medicare and Medicaid Appeals processes through the ESR and external ombudsman; and

      11) How to disenroll voluntarily.

G. Disenrollment

1. An Enrollee may initiate disenrollment from the Contractor's program for any reason and at any time.
2. An Enrollee may initiate disenrollment from the Contractor's program by submitting a request to disenroll either to the State or to the Contractor.
3. The Contractor:
   a. Must have a mechanism for receiving timely information about all disenrollments from the Contractor's program, including the effective date of disenrollment, from CMS and EOHHS systems. Disenrollments received and approved by the last business day of the month will be effective on the first calendar day of the following month;
   b. Must be responsible for ceasing the provision of Covered Services to an Enrollee upon the effective date of disenrollment;
   c. May request that an Enrollee be involuntarily disenrolled for the following reasons *only*:
      1) Loss of MassHealth eligibility;
      2) Remaining out of the Service Area for more than six consecutive months; or
      3) If approved in advance by EOHHS, when the Contractor's ability to furnish services to the Enrollee or to other Enrollees is seriously impaired; and
   d. *May not* request that an Enrollee be involuntarily disenrolled for any of the following reasons:
      1) An adverse change in the enrollee's health status;
      2) The Enrollee's utilization of medical services;
      3) The Enrollee's diminished mental capacity; or
      4) The Enrollee's uncooperative or disruptive behavior (except when the Enrollee's continued enrollment seriously impairs the Contractor's ability to furnish services to the Enrollee or other Enrollees); and
   e. Must transfer Enrollee record information to the new Provider upon written request signed by the disenrolled Enrollee; and
   f. Must make disenrollment determinations within the timeframe set forth in 42 CFR 438.56(e)(1). In the event that the Contractor fails to make a disenrollment determination within such timeframe, the disenrollment is considered approved.

H. Closing Enrollment

The Contractor shall not discontinue or suspend enrollment for Enrollees for any amount of time without 30 calendar days advance notice and the approval of EOHHS."

c. **Section 2.4.A.3** is hereby amended by deleting the phrase "ICD-9" and replacing it with "ICD-10."

d. **Section 2.4.A.5.b.3** is hereby amended by deleting the phrase "service plan" and replacing it with "IPC."

e. **Section 2.4.A.6.c** is hereby amended by deleting the term "network" and replacing it with "the Provider Network."

f. **Section 2.4.E.8** is hereby amended by adding the phrase "or other forms of dementia" following the phrase "Alzheimer's disease."

g. **Section 2.4** is hereby amended by adding new subsection (F) as follows:

"F. Continuity of Care Period for Passively Enrolled individuals

1. For all Covered Services, the Contractor must develop policies and procedures to ensure continuity of care for all Passively Enrolled Enrollees for at least 90 calendar days after the effective date of each such Enrollee's enrollment with the Contractor. Unless an Enrollee agrees to the implementation of the IPC prior to the expiration of this 90-day period, during this 90-day period, the Contractor must, at a minimum:

    a. Allow Enrollees to remain with their current providers and make payment to such providers at current MassHealth fee-for-service provider rates, even if such providers are not part of the Contractor's Provider Network;

    b. Honor all prescriptions for covered drugs that were issued prior to the completion of the IPC;

    c. Honor all prior authorizations that MassHealth issued prior to the completion of the IPC; and

    d. Prevent gaps in the provision of Covered Services by ensuring that Enrollees are promptly linked with Network Providers following the completion of the IPC.

2. If, as a result of the development of the IPC or the Initial Assessment, the Contractor proposes modifications to the Enrollee's prior authorized services, the Contractor must notify the Enrollee, in writing, of his or her opportunity to appeal the proposed modifications. The Enrollee shall be entitled to all Appeal rights, including aid pending Appeal, if applicable, as set forth in **Section 2.9** of this Contract.

3. If, prior to Enrollment, an Enrollee is receiving a service that the Contractor will not cover after the end of the 90-day continuity of care period described in **Section 2.4.F.1**, the Contractor must inform the Enrollee of this fact, in writing, prior to the end of the 90-day continuity of care period, using the procedure set forth at 42 CFR

438.404 and 42 CFR 422.568. Upon receipt of such notice, the Enrollee shall be entitled to all Appeal rights, including aid pending Appeal, if applicable, as set forth in **Section 2.9** of this Contract."

h. **Section 2.5.B.3.d.2** is hereby amended by deleting the phrase "interdisciplinary team" and replacing it with "PCT."

i. **Section 2.5.B.4.d.4** is hereby amended by deleting the phrase "40 hours per week" and replacing it with "50 hours per week."

j. **Section 2.5.B.4.d.5** is hereby amended by deleting the phrase "40 hours per week" and replacing it with "50 hours per week."

k. **Section 2.5.B.4.d.10** is hereby amended by deleting the phrase "40 hours per week" and replacing it with "50 hours per week."

l. **Section 2.5.B.4.d.11** is hereby amended by deleting the phrase "40 hours per week" and replacing it with "50 hours per week."

m. **Section 2.5.D.1.b** is hereby deleted in its entirety and replaced with the following:

"b. Provide a copy to all new Enrollees and thereafter upon request of any Enrollee."

n. **Section 2.8** is hereby amended by adding the phrase "or customer service provided by the Contractor" at the end of the first sentence of that section.

o. **Section 2.10.D.9** is hereby amended by deleting the first sentence thereof and replacing it with:

"The Contractor is a mandated reporter of elder abuse under State law. The Contractor must submit to EOHHS Incident Reports that document all alleged incidents of abuse, neglect and exploitation of an Enrollee and all actions taken by the Contractor in response to those alleged incidents. In addition, the Contractor must have and comply with written protocols to prevent and treat abuse, neglect, and exploitation of Enrollees."

p. **Section 2.11.B.1** is hereby amended by deleting the phrase "and CMS" from the first and second sentences of that section.

q. **Section 2.12.C** is hereby amended by deleting all uses of the figure "80 percent" and replacing them with "85 percent."

r. **Section 2.13.B.3** is hereby amended by deleting the phrase "agreed upon time frames" and replacing it with "time frames prescribed by EOHHS."

s. **Section 2.13.B.4** is hereby amended by deleting the phrase "or agreed to" and replacing it with "and prescribed."

t. **Section 2.14.A.1** is hereby deleted in its entirety and replaced with the following:

"1. The Contractor must report clinical indicator data for all Enrollees in accordance with the specific HEDIS measures developed for Medicare Advantage Special Needs Plans (SNPs) by the National Commission on Quality Assurance (NCQA). The Contractor must comply with, and report to EOHHS, the HEDIS SNP Measures as required and approved by NCQA and CMS and report to EOHHS on the same time schedule required by CMS."

u. **Section 2.14.B** is hereby deleted in its entirety and replaced with the following:

"B. Encounter Reporting

The Contractor shall meet any diagnosis and/or encounter reporting requirements that are mandated by federal or state law, or by EOHHS. This includes the diagnosis and/or encounter reporting requirements that apply to Medicare Advantage plans and Medicaid managed care organizations, as well as the EOHHS Encounter data specifications set forth in Appendix I, as may be amended from time to time. The Contractor shall maintain processes to ensure the validity, accuracy and completeness of the Encounter Data in accordance with the standards specified in this section.

1. The Contractor shall collect and maintain 100% Encounter Data for all Covered Services provided to Enrollees, including from any subcapitated sources. Such data must be able to be linked to MassHealth eligibility data.

2. The Contractor shall participate in site visits and other reviews and assessments by EOHHS, or its designee, for the purpose of evaluating the Contractor's collection and maintenance of Encounter Data.

3. Upon request by EOHHS, or its designee, the Contractor shall provide medical records of Enrollees and a report from administrative databases of the Encounters of such Enrollees in order to conduct validation assessments. Such validation assessments may be conducted annually.

4. The Contractor shall produce Encounter Data according to the specifications, format, and mode of transfer reasonably established by EOHHS, or its designee, in consultation with the Contractor. Such Encounter Data shall include, but is not limited to, the data elements described in Appendix I, the delivering physician, and elements and level of detail determined necessary by EOHHS. As directed by EOHHS, such Encounter Data shall also include the National Provider Identifier (NPI) of the ordering and referring physicians and professionals and any National Drug Code (NDC).

5. The Contractor shall provide Encounter Data to EOHHS on a monthly basis or within time frames specified by EOHHS in consultation with the Contractor, including at a frequency determined necessary by EOHHS to comply with any and all applicable statutes, rules, regulations and guidance.

6. The Contractor shall submit Encounter Data that is at a minimum 99% complete and 95% accurate. To meet the completeness standard, all critical fields in the data must contain, at a minimum, valid values. To meet the accuracy standard, the Contractor

must have systems in place to monitor and audit claims. The Contractor must also correct and resubmit voided and denied encounters as necessary. The data shall be considered complete and accurate if the error rate in the initial submission is no more than 3% and the number of encounters that need to be manually overridden is no more than 1%.

7. If EOHHS, or the Contractor, determines at any time that the Contractor's Encounter Data is not 99% complete and 95% accurate, the Contractor shall:

   a. Notify EOHHS, prior to Encounter Data submission, that the data is not complete or accurate, and provide an action plan and timeline for resolution;

   b. Submit for EOHHS approval, within a time frame established by EOHHS which shall in no event exceed 30 days from the day the Contractor identifies or is notified that it is not in compliance with the Encounter Data requirements, a corrective action plan to implement improvements or enhancements to bring the accuracy and/or completeness to an acceptable level;

   c. Implement the EOHHS-approved corrective action plan within a time frame approved by EOHHS which shall in no event exceed 30 days from the date that the Contractor submits the corrective action plan to EOHHS for approval; and

   d. Participate in a validation study to be performed by EOHHS, or its designee, following the end of a twelve-month period after the implementation of the corrective action plan to assess whether the Encounter Data is 99% complete and 95% accurate. The Contractor may be financially liable for such validation study.

8. The Contractor shall report as a voided claim in the monthly Encounter Data submission any claims that the Contractor pays, and then later determines should not have paid.

9. The Contractor shall submit Encounter data to EOHHS by the last calendar day of the month following the month of the claim payment. Such submission shall be consistent with all Encounter data specifications set forth in Appendix I.

10. The Contractor shall submit any correction/manual override file within 10 business days from the date EOHHS places the error report on the Contractor's server. Such submission shall be consistent with all Encounter data specifications set forth in Appendix I."

v. **Section 2.14.R** is hereby amended by deleting the phrase "March 31 of each year" and replacing it with "a semi-annual basis."

w. **Section 2.14.S** is hereby amended by deleting the phrase "March 31 of each year" and replacing it with "a semi-annual basis."

x. **Section 2.14** is hereby amended by adding new subsections T, U, and V as follows:

"T. Passive Enrollment Report

The Contractor must submit to EOHHS a monthly report on the outcomes of the Contractor's onboarding activities with regard to members who joined SCO through Passive Enrollment. This report shall be in a form prescribed by EOHHS and shall contain all the data elements required by EOHHS.

U. Community Support Program (CSP) Report

The Contractor must submit to EOHHS a quarterly report on the outcomes of the Contractor's activities with regard to the Community Support Program (CSP). This report shall be in a form prescribed by EOHHS and shall contain all the data elements required by EOHHS.

V. Provider Network Data

The Contractor must submit to EOHHS, on a semi-annual basis, complete provider network data in the format prescribed by EOHHS."

3. **SECTION 3. EOHHS RESPONSIBILITIES IN COORDINATION WITH CMS** shall be amended as follows:

a. **Section 3.1.A** is hereby amended by adding a new subsection 7 as follows:

"7. At its discretion, conduct annual validity studies to determine the completeness and accuracy of Encounter Data including comparing utilization data from medical records of Enrollees (chosen randomly by EOHHS) with the Encounter Data provided by the Contractor. If EOHHS determines that the Contractor's Encounter Data are less than 99% complete or less than 95% accurate, EOHHS will provide the Contractor with written documentation of its determination and the Contractor shall be required to implement a corrective action plan to bring the accuracy to the acceptable level. EOHHS may conduct a validity study following the end of a twelve month period after the implementation of the corrective action plan to assess whether the Contractor has attained 99% completeness. EOHHS, at its discretion, may impose intermediate sanctions or terminate the Contract if the Contractor fails to achieve a 95% accuracy level following completion of the corrective action plan as determined by the validity study or as otherwise determined by EOHHS."

4. **SECTION 4. PAYMENT AND FINANCIAL PROVISIONS** shall be amended as follows:

a. **Section 4.1.C** is hereby amended by adding a new subsection 4 as follows:

"4. For Calendar Year 2015, such adjustment shall be a retroactive, one-time adjustment made as a single payment on or after April 22, 2017."

5. **SECTION 5. ADDITIONAL TERMS AND CONDITIONS** shall be amended as follows:

   a. **Section 5.5.G.3** is hereby deleted in its entirety.

   b. **Section 5.5.H.3** is hereby deleted in its entirety and replaced with the following:

      "3. In accordance with 42 USC § 1396u-2, 42 CFR 438.3(d), 42 CFR 438.210(a)(3)(ii), MGL c. 151B, § 4(10), and all other applicable state or federal laws and regulations, the Contractor shall not discriminate against, and will not use any policy or practice that has the effect of discriminating against, a MassHealth Member eligible to enroll in the Senior Care Options Program on the basis of health status, need for health care services, diagnosis, illness, race, color, sex, sexual orientation, gender identity, disability, or national origin."

   c. **Section 5.8.A.1** is hereby amended by deleting the term "**Appendices A through H**" and replacing it with "**Appendices A through I.**"

   d. **Section 5.8.B.2** is hereby amended by deleting the term "**Appendices A through H**" and replacing it with "**Appendices A through I.**"

   e. **Section 5.11** is hereby deleted in its entirety and replaced with the following **Section 5.11** and **Section 5.12:**

      "Section 5.11 Service Area Expansions

      In calendar years 2019 and 2020, the Contractor may submit a written request to EOHHS to expand the Contractor's Service Area to include all or part of Nantucket, Dukes, and/or Berkshire Counties. The Contractor shall provide to EOHHS any information requested by EOHHS in the course of its review of the Contractor's requested Service Area expansion. EOHHS may, in its sole discretion, grant in full, grant in part, or reject the Contractor's requested Service Area expansion. In the event that EOHHS grants the Contractor's requested Service Area expansion, whether in full or in part, the Parties shall amend **Appendix H** accordingly.

      Section 5.12 Written Notices

      Notices to the parties as to any matter hereunder will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand to:

      To EOHHS:
      Elizabeth Goodman, Director
      MassHealth Office of Long Term Services and Supports
      One Ashburton Place, 5th floor
      Boston, MA 02108

      With copies to:
      General Counsel
      Executive Office of Health and Human Services
      One Ashburton Place, 11th floor
      Boston, MA 02108

To the Contractor:
Bernadette Di Re
President
950 Winter Street – Suite 3800
MA030-1000
Waltham, MA 02451"

6. **The APPENDICES** shall be amended by:

   a. Deleting **Appendix E** in its entirety and replacing it with the new **Appendix E** attached hereto.

   b. Adding a new **Appendix I** attached hereto.

Appendix E

Rates For CY 2017

	Community Settings of Care			Institutional Settings of Care		
	Other	AD/CMI	NHC*	Tier 1**	Tier 2	Tier 3
Dually Eligible Greater Boston	RC 20 $141.55	RC 22 $359.67	RC 24 $2,614.68	RC 26 $4,422.18	RC 27 $6,240.02	RC 28 $7,990.09
Dually Eligible Outside Greater Boston	RC 21 $129.30	RC 23 $343.05	RC 25 $2,916.88	RC 26 $4,422.18	RC 27 $6,240.02	RC 28 $7,990.09
MassHealth Only, Greater Boston	RC 30 $508.69	RC 32 $1,378.08	RC 34 $3,976.65	RC 36 $4,422.18	RC 37 $6,240.02	RC 38 $7,990.09
MassHealth Only, Outside Greater Boston	RC 31 $465.85	RC 33 $1,426.14	RC 35 $3,842.00	RC 36 $4,422.18	RC 37 $6,240.02	RC 38 $7,990.09

* This rating category also includes individuals who are in the first three months of a nursing facility, skilled nursing facility (SNF) and/or institutionalized hospice setting

** This rating category also includes individuals who are in their first three months in a community setting following a discharge from a nursing facility after a stay lasting more than three months

Appendix E, Exhibit 1:

Adjustment to the Capitation Rates to Account for the Health Insurer Provider Fee (HIPF) under Section 9010 of the ACA

For the HIPF for calendar year 2015, EOHHS shall:

1. Perform the following retrospective add-on adjustment to the Contract Year 2015 capitation rates (as reflected in the version of Appendix E annexed to the original Senior Care Organizations Contract, prior to any amendments thereto). Such adjustment shall be applied to the period of January 1, 2015 through December 31, 2015.

Community Other	Dual	Boston	$0.23
Community Other	Dual	Non-Boston	$0.08
Community Other	Non-Dual	Boston	$1.20
Community Other	Non-Dual	Non-Boston	$1.07
Community AD &/or CMI	Dual	Boston	$0.92
Community AD &/or CMI	Dual	Non-Boston	$0.69
Community AD &/or CMI	Non-Dual	Boston	$3.45
Community AD &/or CMI	Non-Dual	Non-Boston	$3.55
Community NHC	Dual	Boston	$8.85
Community NHC	Dual	Non-Boston	$9.66
Community NHC	Non-Dual	Boston	$12.43
Community NHC	Non-Dual	Non-Boston	$11.42
Institutional - Tier 1	Combined	Statewide	$13.88
Institutional - Tier 2	Combined	Statewide	$20.03
Institutional - Tier 3	Combined	Statewide	$24.78

COMMONWEALTH OF MASSACHUSETTS

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

MassHealth Data Warehouse

Encounter Data Set Request

Version 4.4

September 9, 2016

Revision History

Date	Description	Author
09/09/2016	**I. *In Data Elements Clarifications* (*section 2.0):*** 1. Introduced new Inpatient Claim logic for the claims with DOS on or after October 1, 2016. **II. In Table I-B "Service Category (Using the SCO reporting groups)"** Replaced "100" series values with '300' series values. New Service Categories are in Table !-B1; Old Service Categories are in Table I-B2.	**Alla Kamenetsky**
01/11/2016	***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.	**Alla Kamenetsky**
09/29/2015	**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. 3. Removed proposed "Health Policy	

Date	Description	Author
	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)" 1 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)	**Rima Kayyali** **Alla Kamenetsky**

Date	Description	Author
	"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. *in 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*** 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	

Date	Description	Author
	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**	**Alla Kamenetsky**

Date	Description	Author
	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**	
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) –**	**Rima Kayyali**

Date	Description	Author
	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 Comm Care Populations (Section 1.1), and that it should be submitted subsequent to submission of Manual Override (Section 6.0)	
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

Date	Description	Author
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

1.0 Introduction

MassHealth was required to build and maintain a database of health care services provided to Massachusetts Medicaid recipients enrolled in **managed care programs**. MassHealth 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 (MCO, MBHP, SCO, One Care (ICO) – all referred to as MCE in this document) provide MassHealth with records accurately reflecting all encounters provided to Medicaid recipients enrolled in its managed care program. Only with complete and accurate encounter data MassHealth is able to assess the effectiveness of the managed care program.

This Encounter Data Set Request contains information on the data elements, format, and media requirements for submitting data to MassHealth for this project. Because data submission schedules are subject to frequent revision, they are not included in this document. A separate schedule has been provided to each MCE outlining the expected dates for data submission as well as defining the data ranges of data to be included in each submission.

MassHealth expects the MCEs to provide new, replaced or voided claims in each feed. 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 will repeat interactively until the number of rejected claims falls 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 Prasad Balab 617-847-3360 (Email:***prasad.balab@state.ma.us)***

1.1 Data Requirements

- The data referred to in this document are encounter data, or records of health care services performed for Massachusetts Medicaid managed care beneficiaries. An encounter is defined as a unique service or procedure performed for the 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 MassHealth.

- Each row in a feed file shall have a unique Claim Number + Suffix combination. When the claim is not a “Void or Back out”, MCEs shall submit **paid claim lines** only. Please contact MassHealth if MCE has any issues with submitting paid claim lines only.

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

- On receipt of a feed file MassHealth will scan the file for errors and return a file in the same format as the input with two extra columns added at the end to indicate errors. Corrections to the data shall be made and resubmitted within a week after MassHealth returns the error file. This cycle shall repeat until the number of errors in the input file falls below a MassHealth defined threshold for each MCE.

- Submit monthly financial reports to be validated against the Encounter Data in MassHealth data Warehouse. The monthly reports should follow the same logic as the quarterly financial reports (e.g., 4B reports for MCOs, financial reports for SCOs and Care One ICOs). Cost reported must be associated with dates of service during the reported month for claims paid through the end of the following month. For example, financial report for the month of March will be submitted in May for claims with dates of service from March 1 through March 31and paid through April 30. **For MCEs providing services to MassHealth and Commonwealth Care members, both populations should be included in the financial report.**

  This is a stand-alone summary report and should be submitted as a pipe-delimited text file. Please see "Monthly Financial Report" under section 6.0 - Media Requirements for specific instructions on report layout and submission.

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

MassHealth identified certain data elements that warranted further evaluation and clarification. These elements include: DRG, Diagnosis Codes, Procedure Codes, and Provider IDs. The information in the "Data Element Clarifications" section details what is currently expected for these data elements.

Data Elements

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

Encounter Record Layout

This section details the record layout MCEs must use when creating the Encounter Data file. The same record layout is to be used for each Claim Category (facility, professional, dental, etc.). MassHealth requests that you provide a pipe-delimited text file, which means that each service line should be its own separate record. Follow instructions and clarifications specified in this document carefully before creating Encounter Data file. Contact MassHealth if you need further clarification.

Media Requirements and Data Formats

This section contains information on the types of data formats that MassHealth can accept. 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

This section contains the tables referenced in the specific fields of the Data Elements section (Tables A through H).

Data Quality Checks

This section 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 that same ID 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.
At least 80% of the records should have NPI numbers included.

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 shall submit the individual NPI (Type1) for Servicing/Rendering, Referring, Prescribing and Primary Care Providers. MCEs shall submit individual (Type 1) or group (Type 2) NPI for billing providers and IPA/PMG. MassHealth will reject claims that point to a servicing/rendering, billing and referring provider with missing NPI in the Provider File with the exception of "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. If a plan does collect DRGs, that plan should provide it on its data submissions.
2. If a plan does not collect DRGs, that plan should ensure that their primary, secondary, and tertiary diagnosis information is 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 MCEs reporting DRGs to also report DRG related fields such as 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. MassHealth's current validating process requires that diagnosis codes contain the required number of digits outlined in the ICD code books.

Include in each Encounter Data submission the following diagnosis fields: Primary Diagnosis (field #19), Secondary Diagnosis (field #20), Tertiary Diagnosis (field #21), and all other Diagnosis listed in Data Elements. At least one diagnosis code is required for all provider types as specified in section 8.0.

Procedure Code
Many plans accept and use non-standard codes such as State specific and MCE specific codes. MassHealth's current validity process looks for <u>standard codes only</u>: 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 services or not during that period.
Note: Capitation payment is <u>not</u> "Bundled" payment usually paid for Episodes of care or other bundled services.

Dollar Amounts
MassHealth wants to ensure that the dollar amounts on the individual lines on the claim actually represent the actual or computed amount associated with each detail line. Therefore, whenever dollar amounts are not available at the detail level and the summary-level line is not available, the MCE shall 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 source

system and not artificially created, then it shall 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 (are **not** artificially created and are **not** summary-level lines) shall have any Record Indicator value **other than** 0 or 6 as deemed appropriate by the MCE based on the definition of the Record Indicator values in the Record Indicator Table below.

For claims covered by capitation payments, MCE must report the equivalence of a capitation payment (either FFS equivalent amounts or amounts reported by the provider/vendor) on the 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

Record Indicator Table (cont'd):

Record Indicator	Dollar Amount Split
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 shall 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 is requiring the MCEs including MBHP to add the former claim number and suffix to the claim lines of record type ‘R’, ‘V’. MassHealth’s 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 this date shall be the date of the last adjustment to that claim. For encounter records [Record Indicator 2 or 3] this shall be the same as the Paid Date.

Inpatient Claim

MassHealth will apply 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. The new logic will only apply to 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".

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'.

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

3.0 Encounter Data Set Elements

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 fields which contain codified values (e.g. Patient Status), we have used values which are national standards (e.g. UB92 coding standards) whenever possible.

The value 'X' indicates that the data element is applicable under each Claim Category. 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

If the managed care program includes withhold risk-sharing arrangement with the providers such that a portion of the approved payment amount is withheld from the provider payment and placed in a risk-sharing pool for later distribution, then the withhold amount should be recorded as a separate field and also be included in the eligible charge and net payment fields.

Demographic Data

#	Field Name	Definition/Description	H	P	L	R	D
1	Claim Payer	**This code identifies your Managed Care Organization (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 xxxx MassHealth PCC Plan **This code identifies your Senior Care Organization (SCO):** 501 Commonwealth Care Alliance 502 UnitedHealthCare 503 NaviCare 504 Senior Whole Health 505 Tufts Health Plan 506 BMC HealthNet Plan **This code identifies your One Care Organization (ICO)**: 601 Commonwealth Care Alliance 602 Network Health 603 Fallon Total Care	X	X	X	X	X
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
3	Plan Identifier	Current New MMIS code indicating the MCE or specific health plan within an MCE which is submitting the data. (Current Medicaid Provider ID of the MCE). Do not submit legacy IDs	X	X	X	X	X
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	X	X	X	X	X

Demographic Data (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
	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 – 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 ***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
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
7	FILLER		X	X	X	X	X
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
9	Recipient Gender	The gender of the patient: 1 = Male 2 = Female	X	X	X	X	X
10	Recipient ZIP Code	The ZIP Code of the patient's residence as of the date of service.	X	X	X	X	X
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	X	X	X	X	X

Service Data

#	Field Name	Definition/Description	H	P	L	R	D
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
13	FILLER		X	X	X	X	X
14	Claim Type	MBHP Specific field	X	X	X	X	X
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		
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
18	To Service Date	The last date on which a service was rendered for this record. The format is YYYYMMDD.	X	X	X		X
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
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		
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		
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		
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		
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		
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		

Service Data (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
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
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
28	Procedure Modifier 2	Second procedure code modifier, required, if used.	X	X	X		X
29	Procedure Modifier 3	Third procedure code modifier, required, if used.	X	X	X		X
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
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		
32	Place of Service	This field hosts both, the Place of Service (POS) that comes on the Professional claim and the Type of Bill (TOB) that comes on the Institutional claims. It is essential to submit correct information that corresponds to Place of Service Type (field #33). See Table C for CMS 1500 standard or Table D for the UB Type of Bill values indicating place. ***Note*: for** UB Type of Bill, use the 1st and 2nd positions	X	X	X		X

		only.)					

Service Data (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
33	Place of Service Type	The value in this field indicates whether the Place of Service field (#32) contains Place of Service (POS) or Type of Bill (TOB). Can be submitted as '1' or '2'. The type of code provided: 1 = Place of Service on CMS 1500/Professional claims 2 = Type of Bill on UB04/Institutional claims. The codes need to be consistent. For example, Place Of Service Type= 1 (for Professional claim) will ***not*** be allowed on a claim with Claim Category =1 for Facility or Institutional claim.	X	X	X		X
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		
35	Type of Service	A code indicating the type of service to which this encounter or claim belongs. (Use CMS 1500 standard, see Table F)		X			
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

Service Data (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
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	
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	
39	Days Supply	The number of days of drug therapy covered by this prescription.				X	
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	
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	
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
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
44	Tooth Surface	The tooth surface on which the service was performed: M = Mesial D = Distal O = Occlusal L = Lingual I = Incisal					X

		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).					
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
46	Service Class	MBHP Specific field	X	X	X	X	X

Provider Data

#	Field Name	Definition/Description	H	P	L	R	D
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
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
49	IPA/PMG ID	The plan specific reference that identifies the Primary Medical Group (PMG) or Independent Physician Association (IPA) with which the primary care provider is associated. If the PCP is a solo practitioner, please provide the internal plan ID.	X	X	X		X
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
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
52	Referring Provider ID	A unique identifier for the provider. ***See discussion in the Data Element Clarifications section.***	X	X	X	X	X
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
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
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
56	Servicing Provider Specialty	The specialty code of the servicing provider. (Use CMS 1500 standard, see Table H)	X	X	X		X
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
58	Billing Provider ID	A unique identifier for the provider billing for the service.	X	X	X	X	X
59	Authorization Type	MBHP Specific field	X	X	X	X	X

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
60	Billed Charge	The amount the provider billed for the service.	X	X	X	X	X
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
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
63	Medicare Amount	Any amount paid by Medicare for this service.	X	X	X	X	X
64	Copay/ Coinsurance	Any co-payment amount the member paid for this service.	X	X	X	X	X
65	Deductible	Any deductible amount the member paid for this service.	X	X	X	X	X
66	Ingredient Cost	The cost of the ingredients included in the prescription.				X	
67	Dispensing Fee	The dispensing fee charged for filling the prescription.				X	
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
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
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
71	Group Number	For non-MHSA MCEs 1 = MCO MassHealth 2 = MCO Commonwealth Care 3 = SCO 5 = CarePlus 6 = One Care (ICO)	X	X	X	X	X

Medicaid Program-Specific Data

#	Field Name	Definition/Description	H	P	L	R	D
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		
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
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	
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			
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

Other Fields

#	Field Name	Definition/Description	H	P	L	R	D
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
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
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
80	Service Category	Service groupings from financial reports like 4B (see Table I)	X	X	X	X	X
81	Prescribing Prov. ID	Federal Tax ID or UPIN or other State assigned provider ID for the prescribing provider on the Pharmacy claim.				X	
82	Date Script Written	Date prescribing provider issued the prescription.				X	
83	Compound Indicator	Indicates that the prescription was a compounded drug. 1 = Yes 2 = No				X	
84	Rebate Indicator	PBM received rebate for drug dispensed. 1 = Yes 2 = No				X	
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		
86	Allowable Amount	Amount allowed under the Health Plan formulary.	X	X	X	X	X
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				
88	Non-covered Days	Days not covered by Health Plan.	X		X		
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		
90	Claim Received Date	Date claim received by Health Plan, if processed by a PBM.				X	
91	Frequency	The third digit of the UB92 Bill Classification field.	X		X		

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
92	IPA/PMG ID_Type	A code identifying the type of ID provided in IPA/PMG ID Provider ID above: 6 = Internal ID (Plan Specific)	X	X	X		X
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
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	
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				
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		
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		
98	Diagnosis 6	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		
99	Diagnosis 7	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		
100	Diagnosis 8	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		
101	Diagnosis 9	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		
102	Diagnosis 10	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		
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				

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
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				
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				
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				
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				
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				
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				
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				
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				
112	Employment	Is the patient's condition related to Employment Y N	X	X	X	X	X
113	Auto Accident	Is the patient's condition related to an Auto Accident Y N	X	X	X	X	X
114	Other Accident	Is the patient's condition related to Other Accident Y N	X	X	X	X	X
115	Total Charges	This field represents the total charges, covered and uncovered related to the current billing period.	X	X	X	X	X
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	X	X	X	X	X

#	Field Name	Definition/Description	H	P	L	R	D
		payer for this service.					
117	Coinsurance	Any coinsurance amount the member paid for this service.	X	X	X	X	X
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
119	DRG Description	Description of DRG Code	X		X		

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
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		
121	DRG Version	DRG Version number associated with DRG type	X		X		
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		
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		
124	Patient Pay Amount	Patient paid amount for nursing facility stays and hospitals	X		X		
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		
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		
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		
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		

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
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		
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		
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		
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		
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		
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		
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		
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		
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		
138	Diagnosis 11	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		
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		
140	Diagnosis 12	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		
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		
142	Diagnosis 13	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
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		
144	Diagnosis 14	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
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		
146	Diagnosis 15	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
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		
148	Diagnosis 16	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
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		
150	Diagnosis 17	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
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		
152	Diagnosis 18	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
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		
154	Diagnosis 19	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
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		
156	Diagnosis 20	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
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		
158	Diagnosis 21	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
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		
160	Diagnosis 22	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
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		
162	Diagnosis 23	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
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		
164	Diagnosis 24	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
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		
166	Diagnosis 25	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
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		
168	Diagnosis 26	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
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		
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		
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		
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		
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		
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		
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		
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	X		X		

		Table M for values)					

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
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		
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		
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		
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		
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		
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		
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		
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		
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		
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		
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		

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
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		
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		
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		
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		
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		
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
194	Procedure Modifier 4	4th procedure code modifier, required, if used.	X	X	X		X
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 'SCO' for SCO Service Categories 'ICO' for Care One (ICO) Service Categories	X	X	X	X	X
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.		X			
197	Obstetric Unit Anesthesia Count	The number of additional units reported by an anesthesia provider to reflect additional complexity of services.		X			
198	Prescription Number	Rx Number.				X	
199	Taxonomy Code	This is the Taxonomy code for Servicing Provider	X	X	X		X

#	Field Name	Definition/Description	H	P	L	R	D
		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)					
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		
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
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
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

3.1 Provider Data Set

Data Elements
This section contains field names and definitions for the provider record. If ***necessary***, due to changes in provider contract status, you may provide multiple records per provider if provider effective and term dates are populated accurately. To be able to link providers across MCEs, it is essential to accurately report as many data elements as possible especially 2 through 11, 26, 30 and 33. Please read Appendix 'A' in section 9.0 for guidelines on Provider file.

File Processing
All fields should be submitted when available including:

1. Tax Id Number when available (filed#30);
2. APCD ORG ID when available in APCD data (filed#34);

Reject file if:

a. NPI is missing on more than 20% of the records. At least 80% of the records should have NPI.

b. Provider Type is missing on more than 20% of the records. 80% of the records should have Provider Type entered.

The following fields are 100% required on all records:

1. Claim Payer (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 Type (Field #16);
15. Provider Effective Date (Field #18);
16. Provider Term Date (Field #19);
17. Provider DEA Number when applicable (Field #24);
18. National Provider Identification Number (NPI) when covered under HIPAA (Field#26);

#	Field Name	Definition/Description
1	Claim Payer	Unique ID assigned to each submitting organization. (Claim Payer)
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.
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)
4	License Number	State license number.
5	Medicaid Number	State Medicaid number (MassHealth/MMIS Provider ID). .
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
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
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
9	Provider Office Address City	City where services were rendered.
10	Provider Office Address State	State where services were rendered.
11	Provider Office Address ZIP	Zip where services were rendered. ZIP+4
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
13	Provider Mailing Address City	City where correspondence is received.
14	Provider Mailing Address State	State where correspondence is received.
15	Provider Mailing Address ZIP	Zip where correspondence is received. ZIP+4
16	Provider Type	Please use the values from Table G. **Note** that value "-4" for "Incomplete/No Information" option has been removed.

Provider Data Set (cont'd)

#	Field Name	Definition/Description
17	Filler	
18	Provider Effective Date	Date provider becomes eligible to perform services.
19	Provider Term Date	Date provider is no longer eligible to perform services.
20	Provider Non-par Indicator	Non-participating provider indicator. 1 non-participating provider 2 participating provider
21	Provider Network ID	The network the provider is affiliated to by the Health Plan (internal plan ID).
22	IPA/PMG ID	The plan specific reference that identifies the Primary Medical Group (PMG) or Independent Physician Association (IPA) with which the primary care provider is associated. If the PCP is a solo practitioner, please provide the internal plan ID.
23	Panel Open Indicator	Is the provider accepting new patients? 1 Accepting new patients 2 Not accepting new patients
24	Provider DEA Number	Provider DEA Number
25	Provider Type Description	Description of the provider type
26	National Provider Identifier (NPI)	National Provider Identifier issued by the National Plan and Provider Enumeration System (NPPES). It is required on all claims.
27	Medicare ID Number	
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.
29	NABP Number	
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 that 9-character long are invalid.
31	IPA/PMG ID_Type	A code identifying the type of ID provided in IPA/PMG ID Provider ID above: *Equals 6 If IPA/PMG ID is an Internal ID (Plan Specific)*
32	Gender Code	'M' for Male and 'F' for Female

Provider Data Set (cont'd)

#	Field Name	Definition/Description
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".**
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.

3.2 MCE Internal Provider Type Data Set Elements

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
1	Claim Payer	Unique ID assigned to each submitting organization. (Claim Payer)
2	Provider ID	Provider ID.
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
4	Internal Provider Type Code	Provider Type code as defined internally by the MCE
5	Internal Provider Type Description	Description of Provider Type code as defined internally by the MCE

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
1	Claim Payer	Unique ID assigned to each submitting organization. (Claim Payer)
2	Provider ID	Provider ID. Federal Tax ID, UPIN or Health Plan ID.
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.
4	Provider Specialty Date	Date provider becomes eligible to perform specialty services.

	Field Name	Definition/Description
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
6	Provider Specialty Description	Description of the Provider Specialty

3.4 Additional Reference Data Set Elements

These files currently apply only to MBHP.

Authorization Type Data Set Elements

#	Field Name	Description
1	Claim Payer	Unique ID assigned to each submitting organization. (Claim Payer)
2	ATHTYP	Two digit code identifying the type of service.
3	ATHTYP DESCRIPTION	Description for the ATHYTYP codes.

Claim Type Data Set Elements

#	Field Name	Description
1	Claim Payer	Unique ID assigned to each submitting organization. (Claim Payer)
2	CLATYP	Code identifying a service.
3	CLATYP DESCRIPTION	Description for the CLATYP codes.

Group Number Data Set Elements

#	Field Name	Description
1	Claim Payer	Unique ID assigned to each submitting organization. (Claim Payer)
2	Member Rating Category	Description for the Member Rating Category.
3	DMA/DMH Indicator	Description for the DMA/DMH Indicator.
4	Eligibility Group Name	Description for the Eligibility Group Name.
5	Eligibility Group Number	Six digit number identifying the Eligibility Group.
6	MMIS Plan Type	Two digit code identifying the MMIS Eligibility Plan Type.

Service Class Data Set Elements

#	Field Name	Description
1	Claim Payer	Unique ID assigned to each submitting organization. (Claim Payer)
2	Service Class	Code identifying a service class.

3	Description	Description of service class codes

Services Data Set Elements

#	Field Name	Description
1	Submitter/Plan ID (Claim Payer)	Unique ID assigned to each submitting organization. (Claim Payer)
2	SVCLVLE	Description of Service Level I.
3	SVCLVLMHSA	Description of Service Level II.
4	SVCGRP	Description of Service Level III.
5	SVCDESC	Description of Service Level IV.
6	UNITTYP	Description of Unit Type.
7	UNITCONVE	Unit Conversion Value. This must be a positive number greater than zero.
8	ATHTYP	Authorization Type Code.
9	SVCCOD_REFSERVICES	Service Code.
10	CLATYP_REFSERVICES	Claim Type Code.
11	MOD1_REFSERVICES	Modifier Code.
12	ID_SERVICES	ID Services Value.
13	CBHI_FLAG	An indicator to distinguish CBHI Services
14	SERVICE_24_HOUR	Specifies if it was 24-Hour or Non-24-Hour Service (or other descriptions such as P4P)
15	IMTERMEDIATE_SVCLVLE	Specifies what kind of Intermediate Service Level was provided
16	SVCLVLI	Specifies service level provided
17	MHSAEM	Service provided: whether it was EM, or MH, or NA, or SA
18	SVCDIRECTORY	Service Directory

4.0 Encounter Record Layout

#	Field Name	H	P	L	R	D	Length	Type/Format
1	Claim Payer	X	X	X	X	X	4	N
2	Claim Category	X	X	X	X	X	1	C
3	Plan Identifier	X	X	X	X	X	9	C
4	Record Indicator	X	X	X	X	X	1	C
5	Claim Number	X	X	X	X	X	15	C
6	Claim Suffix	X	X	X	X	X	4	C
7	FILLER	X	X	X	X	X	9	C
8	Recipient DOB	X	X	X	X	X	8	D/YYYYMMDD
9	Recipient Gender	X	X	X	X	X	1	C
10	Recipient ZIP Code	X	X	X	X	X	5	N
11	Medicare Code	X	X	X	X	X	1	N
12	Other Insurance Code	X	X	X	X	X	1	C
13	FILLER	X	X	X	X	X	7	N
14	Claim Type	X	X	X	X	X	18	C
15	Admission Date	X		X			8	D/YYYYMMDD
16	Discharge Date	X		X			8	D/YYYYMMDD
17	From Service Date	X	X	X	X	X	8	D/YYYYMMDD
18	To Service Date	X	X	X		X	8	D/YYYYMMDD
19	Primary Diagnosis	X	X	X		X	7	C/ No decimal points (780.31 must be entered as 78031)
20	Secondary Diagnosis	X	X	X			7	C/ No decimal points
21	Tertiary Diagnosis	X	X	X			7	C/ No decimal points
22	Diagnosis 4	X	X	X			7	C/ No decimal points
23	Diagnosis 5	X	X	X			7	C/ No decimal points
24	Type of Admission	X		X			1	C
25	Source of Admission	X		X			1	C
26	Procedure Code	X	X	X		X	6	C
27	Procedure Modifier 1	X	X	X		X	2	C
28	Procedure Modifier 2	X	X	X		X	2	C
29	Procedure Modifier 3	X	X	X		X	2	C
30	Procedure Code Indicator	X	X	X		X	1	N
31	Revenue Code	X		X			4	C
32	Place of Service	X	X	X		X	2	C
33	Place of Service Type	X	X	X		X	2	C
34	Patient Discharge Status	X		X			2	C
35	Type of Service		X				2	C
36	Quantity	X	X	X		X	9	SN
37	NDC Number				X		11	N
38	Metric Quantity				X		9	N
39	Days Supply				X		3	N

Service Data (cont'd)

#	Field Name	H	P	L	R	D	length	type/Format
40	Refill Indicator				X		2	N
41	Dispense As Written Indicator				X		2	N
42	Dental Quadrant					X	1	N
43	Tooth Number					X	2	C
44	Tooth Surface					X	6	C
45	Paid Date	X	X	X	X	X	8	D/YYYYMMDD
46	Service Class	X	X	X	X	X	23	C
Provider Data								
47	PCP Provider ID	X	X	X		X	15	C
48	PCP Provider ID Type	X	X	X		X	1	N
49	IPA/PMG ID	X	X	X		X	15	C
50	Servicing Provider ID	X	X	X	X	X	15	C
51	Servicing Provider ID Type	X	X	X	X	X	1	N
52	Referring Provider ID	X	X	X	X	X	15	C
53	Referring Provider ID Type	X	X	X	X	X	1	N
54	Servicing Provider Class	X	X	X	X	X	1	C
55	Servicing Provider Type	X	X	X	X	X	3	N
56	Servicing Provider Specialty	X	X	X		X	3	C
57	Servicing Provider ZIP Code	X	X	X	X	X	5	N
58	Billing Provider ID	X	X	X	X	X	15	C
59	Authorization Type	X	X	X	X	X	25	C
Financial Data								
60	Billed Charge	X	X	X	X	X	9	SN
61	Gross Payment Amount	X	X	X	X	X	9	SN
62	TPL Amount	X	X	X	X	X	9	SN
63	Medicare Amount	X	X	X	X	X	9	SN
64	Copay/Coinsurance	X	X	X	X	X	9	SN
65	Deductible	X	X	X	X	X	9	SN
66	Ingredient Cost				X		9	SN
67	Dispensing Fee				X		9	SN
68	Net Payment	X	X	X	X	X	9	SN
69	Withhold Amount	X	X	X		X	9	SN
70	Record Type	X	X	X	X	X	1	C
71	Group Number	X	X	X	X	X	25	C
MassHealth Specific Data								
72	DRG	X		X			3	C
73	EPSDT Indicator		X			X	1	N
74	Family Planning Indicator	X	X		X		1	C
75	MSS/IS		X				1	N
76	New Member ID	X	X	X	X	X	25	C
Other Fields								
77	Former Claim Number	X	X	X	X	X	15	C
78	Former Claim Suffix	X	X	X	X	X	4	C
79	Record Creation Date	X	X	X	X	X	8	D
80	Service Category	X	X	X	X	X	3	C
81	Prescribing Prov. ID				X		15	C
82	Date Script Written				X		8	D/YYYYMMDD

#	Field Name	H	P	L	R	D	length	Type
83	Compound Indicator				X		1	C
84	Rebate Indicator				X		1	C
85	Admitting Diagnosis	X		X			7	C/No decimal points
86	Allowable Amount	X	X	X	X	X	9	N
87	Attending Prov. ID	X					15	C
88	Non-covered Days	X		X			3	N
89	External Injury Diagnosis 1	X		X			7	C
90	Claim Received Date				X		8	D/YYYYMMDD
91	Frequency	X		X			1	C
92	IPA/PMG ID_Type	X	X	X		X	1	N
93	Billing Provider ID _Type	X	X	X	X	X	1	N
94	Prescribing Prov. ID _Type				X		1	N
95	Attending Prov. ID _Type	X					1	N
96	Admission Time	X		X			4	N/HH24MI
97	Discharge Time	X		X			4	N/HH24MI
98	Diagnosis 6	X	X	X			7	C/No decimal points
99	Diagnosis 7	X	X	X			7	C/No decimal points
100	Diagnosis 8	X	X	X			7	C/No decimal points
101	Diagnosis 9	X	X	X			7	C/No decimal points
102	Diagnosis 10	X	X	X			7	C/No decimal points
103	Surgical Procedure code 1	X					7	C
104	Surgical Procedure code 2	X					7	C
105	Surgical Procedure code 3	X					7	C
106	Surgical Procedure code 4	X					7	C
107	Surgical Procedure code 5	X					7	C
108	Surgical Procedure code 6	X					7	C
109	Surgical Procedure code 7	X					7	C
110	Surgical Procedure code 8	X					7	C
111	Surgical Procedure code 9	X					7	C
112	Employment	X	X	X	X	X	1	C
113	Auto Accident	X	X	X	X	X	1	C
114	Other Accident	X	X	X	X	X	1	C
115	Total Charges	X	X	X	X	X	9	N
116	Non Covered charges	X	X	X	X	X	9	N
117	Coinsurance	X	X	X	X	X	9	N
118	Void Reason Code	X	X	X	X	X	1	C
119	DRG Description	X		X			132	C
120	DRG Type	X		X			1	C
121	DRG Version	X		X			3	C/ No decimal points (26.1 must be entered as 261)
122	DRG Severity of Illness Level	X		X			1	C
123	DRG Risk of Mortality Level	X		X			1	C
124	Patient Pay Amount	X		X			9	SN
125	Patient Reason for Visit Diagnosis 1	X		X			7	C/No decimal points

#	Field Name	H	P	L	R	D	length	Type
126	Patient Reason for Visit Diagnosis 2	X		X			7	C/No decimal points
127	Patient Reason for Visit Diagnosis 3	X		X			7	C/No decimal points
128	Present on Admission (POA) 1	X		X			1	C
129	Present on Admission (POA) 2	X		X			1	C
130	Present on Admission (POA) 3	X		X			1	C
131	Present on Admission (POA) 4	X		X			1	C
132	Present on Admission (POA) 5	X		X			1	C
133	Present on Admission (POA) 6	X		X			1	C
134	Present on Admission (POA) 7	X		X			1	C
135	Present on Admission (POA) 8	X		X			1	C
136	Present on Admission (POA) 9	X		X			1	C
137	Present on Admission (POA) 10	X		X			1	C
138	Diagnosis 11	X	X	X			7	C/No decimal points
139	Present on Admission (POA) 11	X		X			1	C
140	Diagnosis 12	X	X	X			7	C/No decimal points
141	Present on Admission (POA) 12	X		X			1	C
142	Diagnosis 13	X		X			7	C/No decimal points
143	Present on Admission (POA) 13	X		X			1	C
144	Diagnosis 14	X		X			7	C/No decimal points
145	Present on Admission (POA) 14	X		X			1	C
146	Diagnosis 15	X		X			7	C/No decimal points
147	Present on Admission (POA) 15	X		X			1	C
148	Diagnosis 16	X		X			7	C/No decimal points
149	Present on Admission (POA) 16	X		X			1	C
150	Diagnosis 17	X		X			7	C/No decimal points
151	Present on Admission (POA) 17	X		X			1	C
152	Diagnosis 18	X		X			7	C/No decimal points
153	Present on Admission (POA) 18	X		X			1	C
154	Diagnosis 19	X		X			7	C/No decimal points
155	Present on Admission (POA) 19	X		X			1	C

156	Diagnosis 20	X		X			7	C/No decimal points
157	Present on Admission (POA) 20	X		X			1	C
158	Diagnosis 21	X		X			7	C/No decimal points
159	Present on Admission (POA) 21	X		X			1	C
160	Diagnosis 22	X		X			7	C/No decimal points
161	Present on Admission (POA) 22	X		X			1	C
162	Diagnosis 23	X		X			7	C/No decimal points
163	Present on Admission (POA) 23	X		X			1	C
164	Diagnosis 24	X		X			7	C
165	Present on Admission (POA) 24	X		X			1	C
166	Diagnosis 25	X		X			7	C/No decimal points
167	Present on Admission (POA) 25	X		X			1	C
168	Diagnosis 26	X		X			7	C/No decimal points

#	Field Name	H	P	L	R	D	length	Type
169	Present on Admission (POA) 26	X		X			1	C
170	Present on Admission (POA) EI 1	X		X			1	C
171	External Injury Diagnosis 2	X		X			7	C/No decimal points
172	Present on Admission (POA) EI 2	X		X			1	C
173	External Injury Diagnosis 3	X		X			7	C/No decimal points
174	Present on Admission (POA) EI 3	X		X			1	C
175	External Injury Diagnosis 4	X		X			7	C/No decimal points
176	Present on Admission (POA) EI 4	X		X			1	C
177	External Injury Diagnosis 5	X		X			7	C/No decimal points
178	Present on Admission (POA) EI 5	X		X			1	C
179	External Injury Diagnosis 6	X		X			7	C/No decimal points
180	Present on Admission (POA) EI 6	X		X			1	C
181	External Injury Diagnosis 7	X		X			7	C/No decimal points
182	Present on Admission (POA) EI 7	X		X			1	C
183	External Injury Diagnosis 8	X		X			7	C/No decimal points
184	Present on Admission (POA) EI 8	X		X			1	C
185	External Injury Diagnosis 9	X		X			7	C/No decimal points
186	Present on Admission (POA) EI 9	X		X			1	C
187	External Injury Diagnosis 10	X		X			7	C/No decimal points
188	Present on Admission (POA) EI 10	X		X			1	C
189	External Injury Diagnosis 11	X		X			7	C/No decimal points
190	Present on Admission (POA) EI 11	X		X			1	C
191	External Injury Diagnosis 12	X		X			7	C/No decimal points
192	Present on Admission (POA) EI 12	X		X			1	C
193	ICD Version Qualifier	X	X	X		X	5	C
194	Procedure Modifier 4	X	X	X		X	2	C
195	Service Category Type	X	X	X	X	X	3	C
196	Ambulance Patient Count		X				3	N
197	Obstetric Unit Anesthesia Count		X				5	N
198	Prescription Number				X		15	C

199	Taxonomy Code	X	X	X		X	10	C
200	Rate Increase Indicator	X	X	X			1	C
201	Bundle Indicator	X	X	X	X	X	1	C
202	Bundle Claim Number	X	X	X	X	X	15	C
203	Bundle Claim Suffix	X	X	X	X	X	4	C

4.1 Provider Record Layout

#	Field Name	length	type
1	Submitter/Plan ID (Claim Payer)	9	C
2	Provider ID	15	C
3	ID Type	1	C
4	State License Number	9	C
5	Medicaid Number	10	C
6	Provider Last Name	200	C
7	Provider First Name	100	C
8	Provider Office Address Street	45	C
9	Provider Office Address City	20	C
10	Provider Office Address State	2	C
11	Provider Office Address ZIP	9	C
12	Provider Mailing Address Street	45	C
13	Provider Mailing Address City	20	C
14	Provider Mailing Address State	2	C
15	Provider Mailing Address ZIP	9	C
16	Provider Type	3	N
17	Filler	3	C
18	Provider Effective Date	8	D
19	Provider Term Date	8	D
20	Provider Non-par Indicator	1	C
21	Provider Network ID	15	C
22	IPA/PMG ID	15	C
23	Panel Open Indicator	1	C
24	Provider DEA Number	11	C
25	Provider Type Description	50	C
26	National Provider Identifier (NPI)	10	C
27	Medicare ID Number	15	C
28	Social Security Number	9	C
29	NAPB Number	9	C
30	Tax ID	9	C
31	IPA/PMG ID Type	1	C
32	Gender Code	1	C
33	Primary Care Eligibility Indicator	1	C
34	APCD ORG ID	6	C

4.2 MCE Internal Provider Type Layout

#	Field Name	length	type
1	Submitter/Plan ID (Claim Payer)	9	C
2	Provider ID	15	C
3	Provider ID Type	1	C
4	Internal Provider Type Code	6	C
5	Internal Provider Type Description	120	C

4.3 Provider Specialty Layout

#	Field Name	length	type
1	Submitter/Plan ID (Claim Payer)	9	C
2	Provider ID	15	C
3	Provider Specialty	3	C
4	Provider Specialty Date	8	D
5	Provider ID Type	1	C
6	Provider Specialty Description	50	C

4.4 Amendment Process and Layout

1. There are no constraints on timing of the submission of amendment feeds. We will be able to handle amendments sent as part of a regular submission in a quarterly/monthly cycle or as one-off submissions outside the schedule. The format of this file is the same as the Encounter Data file. All columns should represent the "after-snap-shot" – i.e. data should be post-changes. This feed should be submitted with the standard metadata file.

2. Record type 'A' is used to identify an amendment record. While the record type of an amendment record will be 'A', it will inherit the record type of the record it is amending when it is inserted into our database.

3. Amendment processing has been created to allow MCEs to make retroactive changes to existing claims. By existing claims, we mean those that have been accepted by MassHealth after they either passed the weeding logic or were manually overridden.

4. Dollar amount changes on the claim happening on the source system – like adjustments, voids – should still be handled via existing process set up to handle those kinds of transactions.

5. Amendment claims must be submitted in a format that reflects the current processing logic. A claim submitted prior to the introduction of Commonwealth Care, when amended must have valid data in the Group Number field. In addition, all provider data must point to the current provider reference data.

6. We expect that this will primarily be used to reflect retroactive dimension changes – such as Member ID, Servicing Category etc. If MCEs have issues with constructing original claim, they can send MassHealth a list of claim number/suffixes and we can send a copy of the latest version of the data for that claim as exists in our data-warehouse -- back to the MCE.

7. The primary key for the amendment file will be the combination of claim number/suffix and former claim number/suffix. This combination must exist in our encounter database. If the claim number + claim suffix of the 'A' record is not found in our database, the record will be rejected with error code 11--Active Original Claim No-Claim Suffix Not Found.

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

9. The amendment process will have the same iterative error process as the regular submission.

4.5 Additional Reference Data Layout

These files currently apply only to MBHP

Authorization Type Data Set Layout

#	Field Name	length	type
1	Claim Payer	4	C
2	ATHTYP	6	C
3	DESCRIPTION	100	C

Claim Type Data Set Layout

#	Field Name	length	type
1	Claim Payer	4	C
2	CLATYP	6	C
3	DESCRIPTION	100	C

Group Number Data Set Layout

#	Field Name	length	type
1	Claim Payer	4	C
2	Member Rating Category	50	C
3	DMA/DMH Indicator	50	C
4	Eligibility Group Name	100	C
5	Eligibility Group Number	10	N
6	MMIS Plan Type	2	C

Service Class Data Set Layout

#	Field Name	length	type
1	Claim Payer	4	C
2	Service Class	10	C
3	Description	100	C

Additional Reference Data Layout (cont'd):

Services Data Set Layout

#	Field Name	length	type
1	Claim Payer	4	C
2	SVCLVLE	60	C
3	SVCLVLMHSA	90	C
4	SVCGRP	100	C
5	SVCDESC	120	C
6	UNITTYP	4	C
7	UNITCONVE	12	N
8	ATHTYP	1	C
9	SVCCOD_REFSERVICES	6	C
10	CLATYP_REFSERVICES	2	C
11	MOD1_REFSERVICES	2	C
12	ID_SERVICES	10	N
13	CBHI_FLAG	10	C
14	SERVICE_24_HOUR	11	C
15	IMTERMEDIATE_SVCLVLE	50	C
16	SVCLVLI	60	C
17	MHSAEM	2	C
18	SVCDIRECTORY	82	C

* **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).

For 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.

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

Please do not include the actual decimal point in the data.

H – Facility (Inpatient and Outpatient Hospital); P – Professional and Other Providers (including vision); L – Long Term Care, residential treatment Facility; R – Prescription drug; D - Dental

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

Error Codes (cont'd):

Error Code	Description
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)
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.

The MCEs and MBHP shall 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 for each MCE. Refer to the "Encounter Data" section in the

MassHealth Managed Care Organization 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:

PPP_Claims_YYYYMMDD.zip

Where "YYYYMMDD" is the date of file creation (4 digit year, 2 digit month, 2 digit day) and PPP identifies the MCE 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 Health Care
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

For example, the Boston Medical Center HealthNet Plan submission created on 7/1/2001 would have the name BMC_Claims_20010701.zip
The Manual Override File

The manual override file should be named PPP_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) Files in the metadata file must match actual files in the archive in case and extension.
b) Send a zero byte None.txt for missing files - provider or specialty and set corresponding field value to "None.txt"
c) Make sure that archive file sent down each time has a unique name - this is because -- if the job that we will run to pick up the files -- does not run on a day for some reason, there is a risk of losing the original file.
d) Discrepancy between actual feed and Metadata file fields: Total_Net_Payments and or Total_Records would result in entire feed being rejected.
e) The key in the key-value pair (example Total_Net_Payments) must match in spelling to what is on the spec.
f) From a processing perspective there is no difference between the original submission, an error file, or an Amendment file. All these types of submissions should use ENC as the type of feed.

Monthly Financial Report

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	Claim Payer	Unique ID assigned to each submitting organization. (Claim Payer).	4	Text
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. Please follow procedures in SecFTPClient_guide.doc for setting up the client. Details of the server are below:

Sever: virtualgateway01.ehs.state.ma.us
ID currently set up for MCOs: fln, nhp, bmc, cha, mbhp, gu02, gu04.
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: /home/<mce>: example /home/nhp.
Each home directory 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 with 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 file with the same name more than once to the server.

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 F	Type of Service (CMS 1500)
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)

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)
last updated November 1, 2009

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	Unassigned	N/A
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.
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)

Value	Place of Service Name	Place of Service Description
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)
18-19	Unassigned	N/A
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	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
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.
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 mentally retarded individuals.
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.

Value	Place of Service Name	Place of Service Description
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.
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/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded 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

Value	Place of Service Name	Place of Service Description
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)
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.

* Revised, effective April 1, 2004.
** Revised, effective October 1, 2005

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

TABLE D (cont'd)

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

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 F
Type of Service (CMS 1500)

Value	Description
1	Medical Care
2	Surgery
3	Consultation
4	Diagnostic Radiology
5	Diagnostic Lab
6	Therapeutic Radiology
7	Anesthesia
8	Surgical Assistant
9	Other Medical Items or Services
0	Blood Charges
A	Used DME
B	High risk screening mammography
C	Low risk screening mammography
D	Ambulance (effective 4/95)
E	Enteral/Parenteral nutrients/supplies
F	ASC Facility
G	Immunosuppressive drugs
H	Hospice Services
I	DME Purchase
J	Diabetic shoes
K	Hearing items & services
L	ESRD supplies
M	Monthly capitation payment for dialysis
N	Kidney Donor
P	Lump sum purchase of DME, prosthetics, orthotics
Q	Vision items or services
R	DME Rental
S	Surgical dressings or other medical supplies
T	Psychological Therapy
U	Occupational Therapy
V	Pneumococcal/Flu/Hepatitis B Vaccine
W	Physical Therapy
Y	Second Surgical Opinion
Z	Third Surgical Opinion

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

TABLE G
Servicing Provider Type (cont'd)

Value	Description
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
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

TABLE G
Servicing Provider Type (cont'd)

Value	Description
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
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

TABLE G
Servicing Provider Type (cont'd)

Value	Description
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

TABLE H
Servicing Provider Specialty (cont'd)

Value	Description
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
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

TABLE H
Servicing Provider Specialty (cont'd)

Value	Description
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
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 those claims with Dates of Service before 07/01/2010,**

TABLE I – B1

Service Category (Using the SCO reporting groups)

Note: Claims with Date of Service <u>on or after October 1, 2016</u> should be submitted with the service categories in Table I-B1.

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
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: Claims with Date of Service <u>before October 1, 2016</u> should be submitted with the old service categories in Table I-B2.

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	Pong-Term Care (LTC) Facility
213	Homer 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)

Value	Definition
Y	Yes, present at the time of IP admission
N	No, not present at the time of IP admission
U	No information in the record. Documentation is insufficient to determine if condition is POA
W	Clinically undetermined. Provider is unable to clinically determine whether condition was POA or not
Blank	Exempt from POA reporting. Leave blank if condition is on the “not applicable” list ;

8.0 Quantity and Quality Edits, Reasonability and Validity Checks

Raw Data

- Correct layout format
- Fields are correct in size and type of data (alpha vs. numeric)
- Missing fields
- Accurate data type (no unusual characters)
- 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 both quantity and quality
- Distribution reports
- Percentage reports
- Valid value reports
- Reasonability reports

#	Field Name	MassHealth Standard
1	Claim Payer	100% present
2	Claim Category	100% present and valid, as found in Data Elements table.
3	Plan Identifier	100% present
4	Record Indicator	100% present
5	Claim Number	100% present
6	Claim Suffix	100% present
7	Header / Detail Claim Line Indicator	100% present
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	Filler	
14	Claim Type	100% present and valid for MBHP only

#	Field Name	MassHealth Standard
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.
19	Primary Diagnosis	100% present and valid ICD codes on Professional, Hospital and Long Term Care I claims.. Required on all Professional and Institutional claims 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 hospital (institutional), Long Term Care, and professional claims.*
33	Place of Service Type	100% present and valid on all Institutional and Professional claims, Based on Place of Service field
34	Patient Discharge Status	100% present and valid value on all Inpatient claims, Long term Care claims, and all hospital (institutional) claims with admission.
35	Type of Service	100% present and valid value (*Type of Service, Table F) on Professional claims*
36	Quantity	100% present on all claim categories.
37	NDC Number	98% present and valid values, only on Pharmacy claims, reasonability of values (numeric and 11 digits)
38	Metric Quantity	100% present and valid values, only on Pharmacy claims, reasonability of values (total number of units or volume)
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.
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	IPA/PMG 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.

#	Field Name	MassHealth Standard
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

#	Field Name	MassHealth Standard
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
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.

#	Field Name	MassHealth Standard
92	IPA/PMG ID_Type	100% present and valid, when IPA/PMG 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
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

#	Field Name	MassHealth Standard
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 Long Term Care claims
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.

#	Field Name	MassHealth Standard
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
198	Prescription Number	100% present on Pharmacy claims
199	Taxonomy Code	Provide if available

#	Field Name	MassHealth Standard
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

9.0 Appendices

9.1 Appendix A - *Provider Data Set Guidelines*

1. Provider Data submitted is expected to be a snap shot at the time the provider file is created for encounter data submission.
2. **One record** per Provider ID and Provider ID Type is expected to be sent in the provider file included in the encounter submission. However, ***if*** MCEs find it ***necessary*** to include multiple records per provider ID and ID Type and ***only*** because of ***contractual*** changes in between submissions, then the provider effective and term dates have to be populated correctly to reflect the actual dates of these changes. In this case, the effective and term dates per Provider ID and Provider ID Type must not overlap.
3. Providers with multiple servicing sites or addresses ***must*** have different IDs for each site location.
4. Effective and Term dates should ***not*** be blank. Providers who are enrolled with the MCE at the time of a data submission are expected to have "End of time" Term date in that submission. The preferred value for the "End of Time" field is '99991231'.

Provider Error Process:

There is no manual override for the provider file and the error process is as follows:

1. Provider records with null ID and/or null ID Type will not be loaded into our system and will be rejected and returned in the provider error response file.

2. No duplicate Provider records should be submitted in the encounter provider data file. However, if duplicate records per provider ID, Provider ID Type 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 response 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. If MCEs send records with "null" or missing effective/term dates, a non-fatal error will be generated. These records will load into our system in order to ensure that claims do not get rejected. However, these records will also be returned in the provider error response file. MCE's will be expected to correct and resubmit these records in the Correction file for "Production" data submissions.

5. If provider records have all attributes missing except for provider ID and ID Type then these records will load into our system in order to ensure that claims do not get rejected. However, a non-fatal error will be generated and the error records will be returned in the provider error response file. MCE's will be expected to correct and resubmit these records in the Correction file for "Production" data submission.

6. Provider records rejected for the above reasons would be returned to the MCEs in the Provider Error Response file with the following error description:

a. “Provider ID is Missing”
b. “Provider ID Type is Missing”
c. “Duplicate Records”
d. “Provider Effective or Term Dates are missing”
e. “All Other Provider Attributes are Missing”

If the provider data file does not have any errors, a zero-byte provider error response file will be generated.

7. A provider “correction file” for provider records rejected for one of the above reasons, should be submitted with the zipped “Correction file” for the ***same*** submission. It should ***only include*** provider records from the provider error response file generated for that same submission.

   Any claims that are sent in a manual override and are forced into our system, and refer to a rejected provider record that did not get corrected, would be referring to a provider that does not exist in our system in the case when the provider IDs are missing, a provider that has missing attributes, or is the “single” provider record that got into our system in the case of duplicate records.

8. A provider file with 20% or more missing NPIs will get rejected and must be resubmitted in order to process the encounter data submission. At least 80% of the records should have NPI.

Appendix B - *Major Revisions*

Data Requirements:

1. Defined Paid Claim (Page 6)
2. Clarified that MCEs must submit paid claim lines (Page 7)
3. Added a request for monthly financial reports (Page 7)

How to Use this Document

4. Clarified that MCEs must use Encounter Record Layout section for data file layout and that all instructions in this document should be carefully followed (Page 7)

Data Elements Clarifications:

5. Added a clarification that MassHealth member IDs submitted in the Encounter data must be active as of the date of submission (Page 9)
6. Added a clarification on the requirement to report Provider NPI (Page 9)
7. Added a clarification on Dollar Amounts (Record Indicator) (Pages 10 -12)
8. Added a clarification on how MassHealth defines Inpatient Claims in the Encounter Data (Page 12)
9. Added a clarification on Administrative Fees (Page 13)
10. Added a clarification for two new fields – Bundle Claim Number and Bundle Claim Suffix (Page 13 - 14)

Encounter Data Set Elements:

11. Added fields (Pages 28 – 34)
12. Added "Rate Increase Indicator" to identify ***services*** that are eligible for ACA – 1202 rate increase.(Page 33)
13. Added a clarification to field "Primary Care Eligibility Indicator" in **Provider Data Set** (Page 37)
14. Added a new table under section 3.2 for MCE Internal Provider Type Data Set Elements) to get the Provider Types that are internally used by MCEs (Page 38)

Encounter Record Layout:

15. Clarified format (Pages 42 – 49)
16. Added a layout for new table to get the Provider Types that are internally used by the MCEs (MCE Internal Provider Type Layout - Page 48)

Media Requirements:

17. Modified data submission requirement from fixed-length data files to pipe-delimited files (Page 56)
18. Added the SCOs to data submission specifications (Pages 56 - 57)
19. Added One Care (ICOs) to 6.0 Media Requirements (Page 59) – 10/30/2014,
20. Added Instruction on Monthly Financial Report (Page 58)
21. Changed Instructions on Monthly Financial Report (Pages 62 - 63) - 10/30/2014

Standard Data Values:

22. Updated values in Table C (Pages 70-73)
23. Updated values in Table G (Pages 78-81)
24. Added Table I-B Service Category - SCO (Page 86)
25. Added Table I-C Service Category – One Care-ICO (Page 92) – 10/30/2014
26. Added Table M Present on Admission (Page 89)

9.2 Appendix C – *Member Enrollment File Specifications*

1. Overview:

MassHealth is requesting that MCEs begin submitting member enrollment data on a monthly basis as part of the Encounter data submission. MassHealth is requesting member level enrollment data to facilitate the implementation of multiple projects like the Primary Care Payment Reform Initiative and Integrated Health Care.

In particular, the updated Member Enrollment File is meant to capture member enrollment with a PCP and member demographics. In addition, MassHealth would like to start documenting information on Care Coordination and/or Care Management providers as a means to better understand this aspect of care delivery.

2. Technical Specifications:

MCE will submit a full refresh of the following three files on a monthly basis for the first six months. During this six month period MassHealth will evaluate the data and work with the MCE to determine the best approach for migrating to an incremental data approach rather than a full refresh.

Member File

1. Each MCE will submit an initial history file of all MassHealth and CommCare members who were enrolled with the MCE on or after 1/1/2010 including members who ended their enrollment after 1/1/2010.
2. The Member File will have the **member** MassHealth ID and demographic information.
3. The Member File will be 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 will only have the most current member demographic information.
5. MCE will submit a full refresh of the Member File on a monthly basis.
6. Member records submitted by MCEs will stay in our system unless the MCE sends us a "delete" file with 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.*** 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. MCE will submit an initial history file of all MassHealth and CommCare (CarePlus starting 1/1/2014) members who were 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. Members who are enrolled with an MCE and are in the Member File, but do not have PCP or CM Provider enrollment will ***not*** be included in this file.
3. All members included in the Member Enrollment File should also be included in the Member File.
4. The file will 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.
5. Begin and End Enrollment dates must reflect changes in member ***enrollment*** with a PCP, CM Provider and changes in Practice affiliation.
6. Any member enrollment record that existed in prior files and is not submitted in current files would be "soft" deleted from MassHealth system.

A. Member Enrollment File Providers and Practices

1. Care Coordinators, Care Managers, Care Coordination and Management Programs are all referred to as **CM Providers**.
2. PCPs and CM Providers are all considered **"Providers**" and their IDs will 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 will 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. <u>Submission Process</u>:

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.

6. Moving forward, the **Encounter** Zip File is required to be named **MCE_Claims_YYYYMMDD.zip** (e.g. BMC_Claims_20130930.zip). This the only change required in the current Encounter data submission process. Please use this naming convention for the encounter data file even when the member file is not sent. The Manual Override file should be named **MCE_Claims_YYYYMMDD**_MO**.zip**.
7. After the data transfer is complete, include a zero byte file called **mce_done.txt** for the Encounter Zip file and **mem_mce_done.txt** for 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"

Test Member Zip File

1. Test Member ZIP File must be dropped in FTP server in “test_mco” folder.
2. If the Provider IDs in the Member Enrollment File have not been sent to MassHealth in prior submissions, a Test Provider File needs to be dropped in the “test_mco” folder along with the Member Zip File.
3. Test Provider File must be named MCE_TestProvider_YYYYMMDD.txt (e.g. BMC_ TestProvider_20130930.txt) and must be submitted outside the Test Member Zip File.
4. All IDs for PCPs and Practices in the Test Member Enrollment File should exist in Encounter Provider File from prior submissions or in Test Provider File.
5. All IDs for **CM Providers** in the Test Member Enrollment File should exist in the Test Care Management Provider File.
   If Care Management Provider File cannot be submitted set corresponding field value in Member Metadata File to “none.txt”.
6. All member IDs in Member Enrollment File should exist in Member File

Production Member Zip File

1. Production Member ZIP File must be dropped in FTP server in “ehs_dw” folder.
2. There is no change in the Encounter data submission process.
   Encounter data zip file must be named MCE_Claims_YYYYMMDD.zip (e.g. BMC_Claims_20130930.zip)
3. Both Member ZIP File and Encounter Data ZIP File should be submitted at the same time.
4. All IDs for PCPs and Practices in the Production Member Enrollment File should exist in the **Encounter Provider File**.
5. All IDs for **CM Providers** in the Production Member Enrollment File should exist in the Production Care Management Provider File.
   If Care Management Provider File cannot be submitted, set corresponding field value in member metadata file to “none.txt”
6. All member IDs in Member Enrollment File should exist in Member File

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. Claim Payer (MCE) is missing
    4. Claim Payer (MCE) is not meeting Masshealth Standards
3. The Member File will ***not*** be used as part of the claims validation process. Rejected records in the Member File will ***not*** result in rejecting records from Encounter Claims Data.

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. In the following scenarios, all records for that Member ID will be rejected:
    1. Member ID is missing
    2. Member ID is invalid
    3. Provider ID is missing
    4. Provider ID is not found in MCE Provider Files
    5. Provider ID Type is missing
    6. Provider ID Type is not found in MCE Provider Files
    7. Practice ID Type is missing when Practice ID is not missing
    8. Practice ID Type not found in MCE Provider Files when Practice ID is not missing
    9. Provider Enroll Type is missing
    10. Provider Enroll Type is not valid as per specification
    11. Care Level is missing
    12. Care Level is not valid as per specification
    13. Begin Enrollment Date is missing or invalid
    14. End Enrollment Date is missing or invalid
    15. Claim Payer (MCE) is missing
    16. Claim Payer (MCE) is not meeting Masshealth Standards
4. The Member Enrollment File will not be used as part of the claims validation process. Rejected records in the Member Enrollment File will not result in rejecting records from Encounter Claims Data

Care Management Provider File

1. All records in the Care Management Provider File will be rejected in the following scenarios:
    a. Claim Payer (MCE) is missing
    b. Claim Payer (MCE) 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. ***File Layout:***

Member File Layout

#	Field	Description	Length	Type	Required	Comments
1	Claim Payer	This code identifies your Managed Care Entity (MCE): 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 xxxx MassHealth PCC Plan This code identifies your Senior Care Organization (SCO): 501 Commonwealth Care Alliance 502 UnitedHealthCare 503 NaviCare 504 Senior Whole Health 505 Tufts Health Plan 506 BMC HealthNet Plan This code identifies your One Care Organization (ICO): 601 Commonwealth Care Alliance 602 Network He 603 Fallon Total Care	9	C	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" or "Female". 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	Claim Payer	This code identifies your Managed Care Entity (MCE): 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 xxxx MassHealth PCC Plan This code identifies your Senior Care Organization (SCO): 501 Commonwealth Care Alliance 502 UnitedHealthCare 503 NaviCare 504 Senior Whole Health 505 Tufts Health Plan 506 BMC HealthNet Plan This code identifies your One Care Organization (ICO): 601 Commonwealth Care Alliance 602 Network He 603 Fallon Total Care	9	C	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	

#	Field	Description	Length	Type	Required	Comments
6	Begin Enrollment Date	This is the beginning enrollment date with a PCP or CM Providers	8	Date YYYYMMDD	Required	
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
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

Care Management Provider File Layout

#	Field	Description	Length	Type	Required	Comments
1	Claim Payer	This code identifies your Managed Care Entity (MCE): 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 xxxx MassHealth PCC Plan This code identifies your Senior Care Organization (SCO): 501 Commonwealth Care Alliance 502 UnitedHealthCare 503 NaviCare 504 Senior Whole Health 505 Tufts Health Plan 506 BMC HealthNet Plan This code identifies your One Care Organization (ICO): 601 Commonwealth Care Alliance 602 Network He 603 Fallon Total Care	9	C	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 and 'F' for Female	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	

#	Field	Description	Length	Type	Required	Comments
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).