APPENDIX F:

Encounter Data Set Request

Commonwealth of Massachusetts
MassHealth

Last revised: August 11, 2010

ENCOUNTER DATA SET

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Section

1.0 Introduction

MassHealth is required to build and maintain a database of health care services provided to Massachusetts Medicaid recipients enrolled in managed care programs. MassHealth will be 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 Organization (MCO) 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 will MassHealth be 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 MCO outlining the expected dates for data submission as well as defining the data ranges of data to be included in each submission.

MassHealth will expect the MCOs and MBHP to provide new, replaced or voided claims in each feed. MassHealth will reject and return repeated claims to the MCOs and MBHP with the appropriate error codes. MCOs and MBHP will be expected to remove the offending claims from their next submission which will take place within a week. The submission-rejection-resubmission cycle will repeat iteratively 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 Kelly Zeeh 617-210-5510 (Email: Kelly.Zeeh@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. In the initialization feed, all claims should reflect the final status of the claim on the date it is pulled. All claims in the initialization feed should be marked as an Original claim.

- 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.

- Submit only new or changed claims per feed. A feed shall consist of new [original] claims, 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 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 plan.

- If after MassHealth returns an error file to the plans, it is discovered that error records have changed due to voids or payment adjustments, a cancel record may be submitted. This will close all open errors associated with the claim number claim suffix combinations.

1.2 How to Use this Document

This *Encounter Data Set Request* is intended as a reference document. Its purpose is to identify the types of data that MassHealth needs to build an 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.

Record Layout
This section details the record layout. The same record layout is to be used for each Claim Category (facility, professional, dental, etc.). We request that you provide only fixed length records, which means that each service line should be its own separate record. Any data collected at the summary or claim level shall necessitate the creation of an additional row with record indicator 0. All summary level dollar amounts and quantities for such a claim shall be reported on this detail line.

Media Requirements and Data Formats
This section contains information on the types of data formats that MassHealth can accept along with external label requirements for data submitted on CD, cartridges, tape reels, or diskettes. You may choose to submit your data via e-mail, in which case the accompanying e-mail message should include all the information contained on the label. 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.

Provider IDs

MassHealth is asking plans to provide an identifier that is unique to the plan. The acceptable ID types are 6, 8, and 9. ID types 8 and 9 are to be used with pharmacy claims only. An ID type of 1 is acceptable for Referring Provider ID and Prescribing Provider ID. As many of the provider attributes, NPI, Tax ID etc., should be filled out in the provider file as possible.

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.

Diagnosis Codes

Only header codes with five digits shall be used. For example, the fifth digit indicates if a convulsion was associated with a fever (780.31) or some other type of convulsion (780.39).

Requirements for validity and completeness are detailed in the ICD-9-CM 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-9-CM code books.

Include in each Encounter Data submission the following diagnosis fields: Primary Diagnosis (field #19), Secondary Diagnosis (field #20), Tertiary Diagnosis (field #21), Other Diagnosis 4 (field #22), and Other Diagnosis 5 (field #23) and E Code (field #89) .

Procedure Code

Many plans accept and use non-standard codes such as State specific and MCO specific codes. MassHealth's current validity process looks for standard codes only: CPT, ICD-9, HCPCS, and ADA. The non-standard codes are considered invalid by MassHealth.

HIPPA 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).

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, the MCO shall add an extra detail line with a record indicator of 0 and report all summary-level amounts/quantities on that line.

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.
3: Encounter Record w/out FFS equivalent	Dollar amount, if any, as reported by the provider to the MCO.
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.

Claim Number & Suffix
Every Original / Void or Replacement claim submitted to MassHealth shall have a new claim number + suffix combination. All claims submitted to MassHealth in one feed shall have a unique claim number + suffix right across the historical database.

Former Claim Number & Suffix
In order to void or replace old transactions, MassHealth is requiring the MCOs and 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.

Record Creation Date
This is the date on which the claim was created in the MCO's or MBHP'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.

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.

Programs with withhold amount

If the managed care program includes a 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 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	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 3 = Dental 4 = Vision 5 = Prescription Drug 6 = Long Term Care *(Nursing Home, Chronic Care & Rehab)* 7 = Other	X	X	X	X	X
3	Plan Identifier	A code indicating the MCO or specific health plan within an MCO which is submitting the data. (Medicaid Provider ID)	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 claim level. 1 Claim Record – Refers to a claim paid on a Fee-For-Service (FFS) basis 2 Encounter Record with FFS equivalent - Refers to services provided under a capitation arrangement and for which a FFS equivalent is given	X	X	X	X	X

Demographic Data (continued)

#	Field Name	Definition/Description	H	P	L	R	D
	Record Indicator (Continued)	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 ***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., 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	BLANK		X	X	X	X	X
8	Recipient DOB	The birth date of the patient expressed as CCYYMMDD. 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
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

Demographic Data (continued)

#	Field Name	Definition/Description	H	P	L	R	D
13	Blank		X	X	X	X	X
14	Claim Type	MBHP Specific field	X	X	X	X	X

Service Data

#	Field Name	Definition/Description	H	P	L	R	D
15	Admission Date	For inpatient facility services, the date the recipient was admitted to the facility. The format is CCYYMMDD. If not an inpatient facility the value should be missing	X		X		
16	Discharge Date	For inpatient facility services, the date the recipient was discharged from the facility. The format is CCYYMMDD. Cannot be prior to Admission Date. If not an inpatient facility the value should be missing	X		X		
17	From Service Date	The actual date that the service was rendered. If services are rendered over a period of time, this is the date of the first service for this record. The format is CCYYMMDD.	X	X	X	X	X
18	To Service Date	The last date on which a service was rendered for this record. The format is CCYYMMDD.	X	X	X		X
19	Primary Diagnosis	The ICD-9-CM 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.***	X	X	X		
20	Secondary Diagnosis	The ICD-9-CM diagnosis code explaining a secondary or complicating condition for the service. See above for format.	X	X	X		
21	Tertiary Diagnosis	The tertiary ICD-9-CM diagnosis code. See above for format.	X	X	X		
22	Other Diagnosis 4	The fourth ICD-9-CM diagnosis code. See above for format.	X	X	X		
23	Diagnosis 5	The fifth ICD-9-CM diagnosis code. See above for format. See above for format.	X	X	X		
24	Type of Admission	If this is an inpatient facility claim, the type of the admission. (Use UB standard, see Table A)	X				
25	Source of Admission	If this is an inpatient facility claim, the source of the admission. (Use UB standard, see Table B)	X				

Service Data (continued)

#	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. The code should be left justified and blank filled (for ICD-9-CM procedure codes) with no decimal included in the code. *Any internal coding systems used must be translated to one of the coding systems identified in field **#30** below.* ***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 above: 1 = ICD-9-CM Procedure Code 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 *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 are allowed; plans may not use "in house" codes. For 3 digit Revenue codes, please add the leading zero.*	X		X		
32	Place of Service	A code indicating the location in which the service occurred. (See Table C for CMS 1500 standard or Table D for the UB Type of Bill values indicating place. Note that for UB Type of Bill, use the 1st and 2nd positions only.)	X	X	X		X
33	Place of Service Type	A code identifying the type of code provided: 1 = CMS 1500 2 = UB Type of Bill	X	X	X		X
34	Discharge Status	For inpatient admissions, the UB Patient Status. (See Table E)	X		X		

Service Data (continued)

#	Field Name	Definition/Description	H	P	L	R	D
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	X	X	X	X
36	Quantity	For inpatient admissions, the number of days of confinement. Count the day of admission but not the day of discharge. 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 number of units of anesthesia 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".	X	X	X		X
37	NDC Number	For prescription drugs, the valid National Drug Code number assigned by the Food and Drug Administration (FDA).				X	
38	Metric Quantity	For prescription drugs, the total number of units or volume (e.g., tablets, milligrams) dispensed.				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 the original prescription (0) or the refill number (e.g., 1, 2, 3, etc.)				X	
41	Dispense As Written Indicator	An indicator specifying why the product dispensed was selected by the pharmacist: 0 = No DAW 1 = Physician DAW 2 = Patient DAW 3 = Pharmacist DAW 4 = Generic Not In Stock 5 = Brand Dispensed as Generic 6 = Override 7 = Brand Mandated by Law 8 = No Generic Available 9 = 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

Service Data (continued)

#	Field Name	Definition/Description	H	P	L	R	D
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 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 " (two spaces following the third value).					X
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 CCYYMMDD.	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

Provider Data (Continued)

#	Field Name	Definition/Description	H	P	L	R	D
48	PCP Provider ID Type	A code identifying the type of ID provided in PCP Provider ID above: 6 = Internal ID (Plan Specific)	X	X	X		X
49	IPA/PMG ID	The plan specific reference that identifies the primary medical group or independent physician association with which the primary care provider is associated. If the PCP is a solo practitioner, please provide the internal plan ID. *6 = Internal ID (Plan Specific)*	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: 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: 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
64	Copay	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 MCO 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 C = Cancel A = Amendment ***See discussion under 'Former Claim Number / Suffix' in the Data Elements Clarification Section***	X	X	X	X	X
71	Group Number	MBHP Specific field For non-MHSA MCOS 1 = MassHealth 2 = Commonwealth Care	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. ***See discussion in the Data Element Clarifications section***.	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 current 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 4B reports (see Table I)	X	X	X	X	X
81	Prescribing Prov. ID	Provider prescribing the script. Federal Tax ID or UPIN or other State assigned provider ID.				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 E-code.	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	E-Code	If there is an E-Code present on the claim, it should be submitted in this field. See above for format.	X	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	X		X
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	X
93	Billing Provider ID _Type	A code identifying the type of ID provided in Billing Provider ID above: 6 = Internal ID (Plan Specific) *9 = NAPB 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: 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: *6 = Internal ID (Plan Specific)*	X		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 should be in HH24 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 should be in HH24 format. For example, 10:30AM would be 1030 and 10:30PM would be 2230.	X		X		
98	Diagnosis 6	The ICD-9-CM diagnosis code. See above for format. See above for format.	X	X	X		
99	Diagnosis 7	The ICD-9-CM diagnosis code. See above for format. See above for format.	X	X	X		
100	Diagnosis 8	The ICD-9-CM diagnosis code. See above for format. See above for format.	X	X	X		
101	Diagnosis 9	The ICD-9-CM diagnosis code. See above for format. See above for format.	X	X	X		
102	Diagnosis 10	The ICD-9-CM diagnosis code. See above for format. See above for format.	X	X	X		
103	Surgical Procedure code 1	For surgical revenue codes, the ICD-9-CM surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank.	X		X		X
104	Surgical Procedure code 2	For surgical revenue codes, the ICD-9-CM surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank.	X		X		X
105	Surgical Procedure code 3	For surgical revenue codes, the ICD-9-CM surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank.	X		X		X
106	Surgical Procedure code 4	For surgical revenue codes, the ICD-9-CM surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank.	X		X		X
107	Surgical Procedure code 5	For surgical revenue codes, the ICD-9-CM surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank.	X		X		X
108	Surgical Procedure code 6	For surgical revenue codes, the ICD-9-CM surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank.	X		X		X
109	Surgical Procedure	For surgical revenue codes, the ICD-9-CM surgical procedure code. If a surgical revenue code is not	X		X		X

	code 7	applicable, the value should be left blank.					
110	Surgical Procedure code 8	For surgical revenue codes, the ICD-9-CM surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank.	X		X		X
111	Surgical Procedure code 9	For surgical revenue codes, the ICD-9-CM surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank.	X		X		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 a 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.	X	X	X	X	X
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

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 status, please provide multiple records per provider.

#	Field Name	Definition/Description
1	Claim Payer	Unique ID assigned to each submitting organization. (Claim Payer)
2	Provider ID	Provider ID.
3	ID Type	A code identifying the type of ID provided in the Provider ID above: 1 = NPI 6 = Internal Plan ID 8 = DEA Number (For Pharmacy claims ONLY) 9 = NAPB Number (For Pharmacy claims ONLY)
4	License Number	State license number.
5	Medicaid Number	State Medicaid number.
6	Provider Last Name	Last name of provider.
7	Provider First Name	First name of provider.
8	Provider Office Address Street	Street address where services were rendered.
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.
12	Provider Mailing Address Street	Street address where correspondence is received.
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.
16	Provider Type	Please use the values from table G
17	Filler	

Provider Data Set Continued

#	Field Name	Definition/Description
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 or independent physician association with which the primary care provider is associated. If the PCP is a solo practitioner, please provide the internal plan ID. *6 = Internal ID (Plan Specific)*
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)	
27	Medicare ID Number	
28	Social Security Number	
29	NAPB Number	
30	Tax ID Number	

3.2 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 .

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 type specialties not contained in table H, assign them a new three digit number. List the description of the new values in the Provider Type Specialty Description field.
4	Provider Specialty Date	Date provider becomes eligible to perform specialty services.
5	Provider ID Type	A code identifying the type of ID provided in Provider ID above: A code identifying the type of ID provided in the Provider ID above: 6 = Internal ID (Plan Specific)) 8 = DEA Number 9 = NAPB Number
6	Provider Specialty Description	Description of the Provider Specialty

3.3 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	Decryption of service class codes

Services Data Set Elements

#	Field Name	Description
1	Submitter/Plan ID	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.

4.0 Encounter Record Layout

(564 bytes)

#	Field Name	H	P	L	R	D	start	length	type
Demographic Data									
1	Claim Payer	X	X	X	X	X	1	4	N
2	Claim Category	X	X	X	X	X	5	1	C
3	Plan Identifier	X	X	X	X	X	6	9	C
4	Record Indicator	X	X	X	X	X	15	1	C
5	Claim Number	X	X	X	X	X	16	15	C
6	Claim Suffix	X	X	X	X	X	31	3	C
7	FILLER	X	X	X	X	X	34	9	C
8	Recipient DOB	X	X	X	X	X	43	8	D
9	Recipient Gender	X	X	X	X	X	51	1	C
10	Recipient ZIP Code	X	X	X	X	X	52	5	N
11	Medicare Code	X	X	X	X	X	57	1	N
12	Other Insurance Code	X	X	X	X	X	58	1	C
13	FILLER	X	X	X	X	X	59	7	N
14	Claim Type	X	X	X	X	X	66	18	C
Service Data									
15	Admission Date	X		X			84	8	D
16	Discharge Date	X		X			92	8	D
17	From Service Date	X	X	X	X	X	100	8	D
18	To Service Date	X	X	X		X	108	8	D
19	Primary Diagnosis	X	X	X			116	5	C
20	Secondary Diagnosis	X	X	X			121	5	C
21	Tertiary Diagnosis	X	X	X			126	5	C
22	Other Diagnosis 4	X	X	X			131	5	C
23	E-Code or Other Diagnosis 5	X	X	X			136	5	C
24	Type of Admission	X					141	1	C
25	Source of Admission	X					142	1	C
26	Procedure Code	X	X	X		X	143	6	C
27	Procedure Modifier 1	X	X	X		X	149	2	C
28	Procedure Modifier 2	X	X	X		X	151	2	C
29	Procedure Modifier 3	X	X	X		X	153	2	C
30	Procedure Code Indicator	X	X	X		X	155	1	N
31	Revenue Code	X		X			156	4	C
32	Place of Service	X	X	X		X	160	2	C
33	Place of Service Type	X	X	X		X	162	2	C
34	Patient Discharge Status	X		X			164	2	C
35	Type of Service	X	X	X	X	X	166	2	C
36	Quantity	X	X	X		X	168	5	SN
37	NDC Number				X		173	11	N
38	Metric Quantity				X		184	5	N
39	Days Supply				X		189	3	N
40	Refill Indicator				X		192	2	N
41	Dispense As Written Indicator				X		194	2	N
42	Dental Quadrant					X	196	1	N

Service Data con't

#	Field Name	H	P	L	R	D	start	length	type
43	Tooth Number					X	197	2	C
44	Tooth Surface					X	199	6	C
45	Paid Date	X	X	X	X	X	205	8	D
46	Service Class	X	X	X	X	X	213	23	C

Provider Data

47	PCP Provider ID	X	X	X		X	236	10	C
48	PCP Provider ID Type	X	X	X		X	246	1	N
49	IPA/PMG ID	X	X	X		X	247	10	C
50	Servicing Provider ID	X	X	X	X	X	257	10	C
51	Servicing Provider ID Type	X	X	X	X	X	267	1	N
52	Referring Provider ID	X	X	X	X	X	268	10	C
53	Referring Provider ID Type	X	X	X	X	X	278	1	N
54	Servicing Provider Class	X	X	X	X		279	1	C
55	Servicing Provider Type	X	X	X		X	280	3	N
56	Servicing Provider Specialty	X	X	X		X	283	3	C
57	Servicing Provider ZIP Code	X	X	X	X	X	286	5	N
58	Billing Provider ID	X	X	X	X	X	291	10	C
59	Authorization Type	X	X	X	X	X	301	25	C

Financial Data

60	Billed Charge	X	X	X	X	X	326	9	SN
61	Gross Payment Amount	X	X	X	X	X	335	9	SN
62	TPL Amount	X	X	X	X	X	344	9	SN
63	Medicare Amount	X	X	X		X	353	9	SN
64	Copay/ Coinsurance	X	X	X	X	X	362	9	SN
65	Deductible	X	X	X	X	X	371	9	SN
66	Ingredient Cost				X		380	9	SN
67	Dispensing Fee				X		389	9	SN
68	Net Payment	X	X	X	X	X	398	9	SN
69	Withhold Amount	X	X	X		X	407	9	SN
70	Record Type	X	X	X	X	X	416	1	C
71	Group Number	X	X	X	X	X	417	25	C

MassHealth Specific Data

72	DRG	X					442	3	C
73	EPSDT Indicator		X			X	445	1	N
74	Family Planning Indicator	X	X		X		446	1	C
75	MSS/IS		X				447	1	N
76	New Member ID	X	X	X	X	X	448	25	C

Other Fields

77	Former Claim Number	X	X	X	X	X	473	15	C
78	Former Claim Suffix	X	X	X	X	X	488	3	C
79	Claim Creation Date	X	X	X	X	X	491	8	D
80	Service Category	X	X	X	X	X	499	3	C
81	Prescribing Prov. ID				X		502	10	C
82	Date Script Written				X		512	8	D
83	Compound Indicator				X		520	1	C
84	Rebate Indicator				X		521	1	C
85	Admitting Diagnosis	X		X			522	5	C

86	Allowable Amount	X	X	X	X	X	527	8	N

OtherFields Cont.

87	Attending Prov. ID	X					535	10	C
88	Non-covered Days	X		X			545	3	N
89	E-Code	X	X	X			548	5	C
90	Claim Received Date	X	X	X	X		553	8	D
91	Frequency	X	X	X		X	561	1	C
92	IPA/PMG ID_Type	X	X	X		X	562	1	N
93	Billing Provider ID _Type	X	X	X	X	X	563	1	N
94	Prescribing Prov. ID _Type				X		564	1	N
95	Attending Prov. ID _Type	X					565	1	N
96	Admission Time	X					566	4	N
97	Discharge Time	X					570	4	N
98	Diagnosis 6	X	X	X		X	574	5	C
99	Diagnosis 7	X	X	X		X	579	5	C
100	Diagnosis 8	X	X	X		X	584	5	C
101	Diagnosis 9	X	X	X		X	589	5	C
102	Diagnosis 10	X	X	X		X	594	5	C
103	Surgical Procedure code 1	X					599	5	C
104	Surgical Procedure code 2	X					604	5	C
105	Surgical Procedure code 3	X					609	5	C
106	Surgical Procedure code 4	X					614	5	C
107	Surgical Procedure code 5	X					619	5	C
108	Surgical Procedure code 6	X					624	5	C
109	Surgical Procedure code 7	X					629	5	C
110	Surgical Procedure code 8	X					634	5	C
111	Surgical Procedure code 9	X					639	5	C
112	Employment	X	X	X	X	X	644	1	C
113	Auto Accident	X	X	X	X	X	645	1	C
114	Other Accident	X	X	X	X	X	646	1	C
115	Total Charges	X	X	X	X	X	647	9	N
116	Non Covered charges	X	X	X	X	X	656	9	N
117	Coinsurance	X	X	X	X	X	665	9	N
118	Void Reason Code	X	X	X	X	X	674	1	C

4.1 Provider Record Layout

#	Field Name	start	length	type
1	Submitter/Plan ID	1	9	C
2	Provider ID	10	10	C
3	ID Type	20	1	C
4	State License Number	21	9	C
5	Medicaid Number	30	9	C
6	Provider Last Name	39	30	C
7	Provider First Name	69	30	C
8	Provider Office Address Street	99	45	C
9	Provider Office Address City	144	20	C
10	Provider Office Address State	164	2	C
11	Provider Office Address ZIP	166	5	C
12	Provider Mailing Address Street	171	45	C
13	Provider Mailing Address City	216	20	C
14	Provider Mailing Address State	236	2	C
15	Provider Mailing Address ZIP	238	5	C
16	Provider Type	243	3	N
17	Filler	246	3	C
18	Provider Effective Date	249	8	D
19	Provider Term Date	257	8	D
20	Provider Non-par Indicator	265	1	C
21	Provider Network ID	266	9	C
22	IPA/PMG ID	275	9	C
23	Panel Open Indicator	284	1	C
24	Provider DEA Number	285	11	C
25	Provider Type Description	296	50	C
26	National Provider Identifier (NPI)	346	10	C
27	Medicare ID Number	356	9	C
28	Social Security Number	365	9	C
29	NAPB Number	374	9	C
30	Tax ID	383	9	C

4.2 Provider Specialty Layout

#	Field Name	start	length	type
1	Submitter/Plan ID	1	9	C
2	Provider ID	10	10	C
3	Provider Specialty	20	3	C
4	Provider Specialty Date	23	8	D
5	Provider ID Type	31	1	C
6	Provider Specialty Description	32	50	C

4.3 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 MCOs 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 RHN, Servicing Category etc. If MCOs 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 MCO.

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.

4.4 Additional Reference Data Layout

These files currently apply only to MBHP.

Authorization Type Data Set Layout

#	Field Name	start	length	type
1	Claim Payer	1	4	C
2	ATHTYP	5	6	C
3	DESCRIPTION	11	100	C

Claim Type Data Set Layout

#	Field Name	start	length	type
1	Claim Payer	1	4	C
2	CLATYP	5	6	C
3	DESCRIPTION	11	100	C

Group Number Data Set Layout

#	Field Name	start	length	type
1	Claim Payer	1	4	C
2	Member Rating Category	5	50	C
3	DMA/DMH Indicator	55	50	C
4	Eligibility Group Name	105	100	C
5	Eligibility Group Number	205	10	N
6	MMIS Plan Type	215	2	C

Service Class Data Set Layout

#	Field Name	start	length	type
1	Claim Payer	1	4	C
2	Service Class	5	10	C
3	Description	15	100	C

Additional Reference Data Layout (cont.)

Services Data Set Layout

#	Field Name	start	length	type
1	Claim Payer	1	4	C
2	SVCLVLE	5	60	C
3	SVCLVLMHSA	65	90	C
4	SVCGRP	155	100	C
5	SVCDESC	255	120	C
6	UNITTYP	375	4	C
7	UNITCONVE	379	12	N
8	ATHTYP	391	1	C
9	SVCCOD_REFSERVICES	392	6	C
10	CLATYP_REFSERVICES	398	2	C
11	MOD1_REFSERVICES	400	2	C
12	ID_SERVICES	402	3	N

* 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 CCYYMMDD format, where CCYY 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 MCOs and MBHP and return files containing erroneous records back to the MCOs and MBHP for correction and resubmission. 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 MCOs 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 flds should not contain data for Orig Claim
23	Only Original claims allowed in the Init feed
24	Duplicate Claim No-Claim Suffix -- from prior submission
25	No open error found for this Cancel Record
26	Original Claim No-Claim Suffix, Former Claim No-Claim Suffix -- in same feed
27	Metadata - No metadata file found or file is empty.
28	Metadata - MCO_Id incorrect for the plan.
29	Metadata - MCO_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.

The MCOs 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 MCO.

6.0 MEDIA REQUIREMENTS

Format:

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

Please compress the data file using PKZIP/WINZIP or compatible program. All records in the data file should be the same length, and 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 Zipfile name should conform to the following naming convention:

PPPYYYYMMDD.zip

Where "YYYYMMDD" is the date of file creation (4 digit year, 2 digit month, 2 digit day) and PPP identifies the MCO according to the following:

BMC - Boston Health Net
CHA - Cambridge Network Health
PCC - MassHealth PCC Plan
FLN - Fallon Community Health Plan
MBH - Massachusetts Behavioral Health Partnership
NHP - Neighborhood Health Plan
HNE - Health New England
CAR - CeltiCare

For example, the Boston Medical Center submission created on 7/1/2001 would have the name BMC20010701.zip

The Manual Override File

The manual override file should be named PPPYYYYMMDD_MO. The _MO files should be sent only after the second round of errors have been returned to the plan. The manual override file should have a file type of EMO in the metadata file.

The Cancel File or Cancel Records
The cancel file should conform to the standard encounter layout. All records should have a record indicator with a value of "C". The record indicator of "C" will be used to handle records that void or adjust during the error fix process. A "C" record would cancel any open errors in the MassHealth encounter error tables. Records that voided during the process could be canceled in this fashion. After closing the open errors for a claim line that was adjusted, new record could then be submitted. Cancel records can also be submitted in an initial submission or error submission file.

The Zip File should contain:

The Encounter Data file
The Provider data file
The Provider specialty file
The Manual Override file (if applicable)
The Cancel 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 include an additional file on the CD called **metadata.txt** which contains the following Key Value Pairs. A regular submission, error submission or cancel 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
Mco_Id="Value" (FLN,NHP,BMC,CHA,MBH,HNE,CAR)	Mandatory
Date_Created=" YYYYMMDD"	Mandatory
Data_File_Name="Value"	Mandatory
Pro_File_Name="Value"	Mandatory
Pro_Spec_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, a Cancel file or an Amendment file. All these types of submissions should use ENC as the type of feed.

Secure FTP Server
MassHealth has set up a Secure FTP server for exchanging data with the MCOs. 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: FLN, NHP, BMC, CHA & MBHP.
Home directory: /home/<mco> : 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 mco 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 *mco_done.txt.*. MassHealth jobs that will sweep the server looking for new data will first look for the existence of this done file, move data files and rename the done file to *mco_done.txt.old*. 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. Due to occasional issues with email system, if you post a file and do not receive email message about the error file back in 3 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. 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 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
Table K	Bill Classifications – (UB Bill Classification, 3rd digit)

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

For Newborns

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

TABLE C
Place of Service (HCFA 1500)
last updated March 22, 2006

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)

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.
16-19	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.
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 AbuseTreatment 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 AbuseTreatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (effective 10/1/03)
58-59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A

71	Public Health Clinic	A facility maintained by either State or local health departments that provides 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 (continued)

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
-4	Incomplete/No information
00	Placeholder PCP
01	Acute Care Hospital-Inpatient
02	Acute Care Hospital-Outpatient
03	Chronic Hospital-Inpatient
04	Chronic Hospital-Outpatient
05	Ambulatory Surgery Centers
06	Trauma Center
10	Birthing Center
15	Treatment Center
20	Mental Health/Chemical Dep. (NEC)
21	Mental Health Facilities
22	Chemical Dependency Treatment Ctr.
23	Mental Health/Chem Dep Day Care
25	Rehabilitation Facilities
30	Long-Term Care (NEC)
31	Extended Care Facility
32	Geriatric Hospital
33	Convalescent Care Facility
34	Intermediate Care Facility
35	Residential Treatment Center
36	Cont. Care Retirement Community
37	Day/Night Care Center
38	Hospice
40	Facility (NEC)
41	Infirmary
42	Special Care Facility (NEC)
50	Physician
51	Medical Doctor MD
52	Osteopath DO
53	Allergy & Immunology
54	Anesthesiology
55	Colon & Rectal Surgery
56	Dermatology
57	Emergency Medicine
58	Family Practice
59	Geriatric Medicine
60	Internist (NEC)
61	Cardiovascular Diseases
62	Critical Care Medicine
63	Endocrinology/Metabolism
64	Gastroenterology

TABLE G

Servicing Provider Type (continued)

Value	Description
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
165	Therapy (physical)
170	Therapists (supportive)
171	Psychologist
175	Therapists (alternative)

TABLE G

Servicing Provider Type (continued)

Value	Description
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

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
16	Obstetrics / Gynecology
18	Ophthalmology
19	Oral Surgery (Dentists Only)
20	Orthopedic Surgery
22	Pathology
24	Plastic & Reconstructive Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
28	Colorectal Surgery
29	Pulmonary Disease
30	Diagnostic Radiology
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery
41	Optometrist
42	Certified Nurse Midwife
43	CRNA, Anesthesia Assistant
44	Infectious Diseases
45	Mammography Screening Center
46	Endocrinology

TABLE H

Servicing Provider Specialty (continued)

Value	Description
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
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
80	Licensed Clinical Social Worker
81	Critical Care (Intersivists)
82	Hemotoloty
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

TABLE H

Servicing Provider Specialty (continued)

Value	Description
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Interventional Radiology
95	Independent Physiological Lab
96	Optician
97	Physician Assistant
98	Gyneologist/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

TABLE I

Service Category
(Using the 4B reporting groups)

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 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/cancel 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/cancel
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/Cancel a prior abbreviated encounter submission
Y	Replacement of a prior abbreviated encounter submission
Z	New abbreviated encounter submission

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

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	Recipient Medicaid ID (RID)	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	Recipient Historical Number (RHN)	100% present; Check the percent match to eligibility file.
14	Claim Type	100% present and valid for MBHP only

#	Field Name	MassHealth Standard
15	Admission Date	100% present and valid date, falls within submitted date range, prior to "Discharge Date", only on Inpatient Claims. Inpatient claims are defined as those with a Facility claim category an inpatient place of service.
16	Discharge Date	100% present and valid date, falls within submitted date range, after "Admission Date", only on Inpatient Claims. Inpatient claims are defined as those with a Facility claim category an inpatient place of service.
17	From Service Date	100% present and valid date, dates should be evenly distributed across time
18	To Service Date	100% present and valid date
19	Primary Diagnosis	98% present and valid ICD-9-CM codes, excluding drug, vision and dental records. Not routinely coded on LTC. E-codes not valid as primary diagnosis.
20	Secondary Diagnosis	60% present and valid ICD-9-CM codes on inpatient facility and 20% present and valid on other records, again excluding drug, vision and dental records.
21	Tertiary Diagnosis	Provide if available
22	Other Diagnosis 4	Provide if available
23	E-Code or Other Diagnosis 5	Provide if available
24	Type of Admission	100% present and valid value *(Admit Type, Table A),* for inpatient claims. Inpatient claims are defined as those with a Facility claim category an inpatient place of service.
25	Source of Admission	100% present and valid value (*Admit Source, Table B*), only on Inpatient Claims, percentage of distribution. Inpatient claims are defined as those with a Facility claim category an inpatient place of service.
26	Procedure Code	98% present and valid on professional claims and inpatient surgical procedure claims; Claim Category match (i.e., Inpatient claims should only have ICD-9-CM codes, Dental claims should only have ADA codes), Procedure Code Indicator match (i.e., if the code is an ICD-9-CM then the Procedure code indicator should be "1").
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 facility claims only

#	Field Name	MassHealth Standard
32	Place of Service	100% present and valid value (*Place of Service, Table C)*
33	Place of Service Type	100% present and valid, based on Place of Service field
34	Discharge Status	100% present and valid value (*Discharge Status, Table E)*, only on Inpatient claims, percentage of distribution, with the most common code being "Discharged to Home" . Inpatient claims are defined as those with a Facility claim category an inpatient place of service.
35	Type of Service	100% present and valid value (*Type of Service, Table F)*
36	Quantity	100% present, should be (-) negative for adjustment records. Should represent number of days of care for inpatient records. Values of 30, 60 or 100 most common on drug records.
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 Pharmacy claims, reasonability of values (number of days)
40	Refill Indicator	100% present and valid values, only on Pharmacy claims
41	Dispense As Written Indicator	100% present and valid value (1 - 10), only on 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	100% present, should be an enrolled provider listed in provider enrollment file.
50	Servicing Provider ID	100% present, should be an enrolled provider listed in provider enrollment file.
51	Servicing Provider ID Type	100% present and valid, based on Servicing Provider ID field

#	Field Name	MassHealth Standard
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, 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(1 - 495), only on Inpatient facility records, 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	Filler	
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	Claim 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 prescription drug records. Should be an enrolled provider listed in provider enrollment file.
82	Date Script Written	100% present and valid on prescription drug records
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 in inpatient records
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	
89	E-Code	100 % valid
90	Claim Received Date	100% present and valid date
91	Frequency	100% present and valid in inpatient records
92	IPA/PMG ID_Type	100% present, and valid

#	Field Name	MassHealth Standard
93	Billing Provider ID _Type	100% present, and valid
94	Prescribing Prov. ID _Type	100% present and valid on prescription drug records
95	Attending Prov. ID _Type	100% present, and valid
96	Admission Time	100% present and valid value only on Inpatient facility records
97	Discharge Time	100% present and valid value only on Inpatient facility records
98	Diagnosis 6	Provide if available
99	Diagnosis 7	Provide if available
100	Diagnosis 8	Provide if available
101	Diagnosis 9	Provide if available
102	Diagnosis 10	Provide if available
103	ICD9/ Surgical Procedure code 1	Provide if available
104	ICD9/ Surgical Procedure code 2	Provide if available
105	ICD9/ Surgical Procedure code 3	Provide if available
106	ICD9/ Surgical Procedure code 4	Provide if available
107	ICD9/ Surgical Procedure code 5	Provide if available
108	ICD9/ Surgical Procedure code 6	Provide if available
109	ICD9/ Surgical Procedure code 7	Provide if available
110	ICD9/ Surgical Procedure code 8	Provide if available
111	ICD9/ Surgical Procedure code 9	Provide if available
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