Appendix D-2

COMMONWEALTH OF MASSACHUSETTS

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
MassHealth

Denied Claims Submission Requirements (Expanded Format)

Version 2.4

Date: October 01, 2021

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Acronyms

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

1. Introduction

There has been a business need to collect denied claims to allow for accurate analysis of risk adjustment, utilization, and healthcare quality measurement. EOHHS is adding a requirement to have all MCOs and the BH Vendor submit denied claims.

Denied claim lines should be included, even if they are part of the paid claim.

Please note that denied claims process is independent of paid claims process. Denied and Paid claims are submitted in separate files on different schedules and posted in different directories on SFTP server. Current process of paid claims continues to exist as usual, where the MCOs submit voids and replacements to paid claims loaded in MH DW.

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

2. Logic and Input:

2.1 DW Design Requirements

2.1.1 DW implements minimal editing logic since denied claims can be denied for many reasons.

2.1.2 Individual claim lines might have several denial reasons.

2.1.3 When Billing Provider internal ID is not known, submit NPI number in place of Billing Provider ID with Billing Provider ID Type = 1. Billing Provider ID field should never be null.

2.1.4 Claims with invalid "New Member ID" values must not be submitted.

2.1.5 The following fields are critical for the load process and must have valid values:

#	Field Name	Field Number
1	Org. Code	# 1
2	Entity PIDSL	# 3
3	Claim Number	# 5
4	Claim Suffix	# 6
5	Billing Provider ID	# 58
6	Billing Provider ID Type	# 93
7	Billing Provider ID Address Location Code	# 223
8	New Member ID	# 76
9	Adjudication date	# 229

2.1.6 Format standards should be followed for all fields.

2.1.7 Email notifications will be sent to the MCOs with the status of submission.

2.2 File Submission Requirements

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

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

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

2.2.4 All the subsequent submissions should have denied claims adjudicated in the prior **quarter** with a 3 month lag.

For example, October 6, 2017, submission files contained denied claims with adjudication date from April 1, 2017, through June 30, 2017.

Few other examples

Submission Date	Claims Adjudication Dates
04/06/2018	10/01/2017 – 12/31/2017
07/06/2018	01/01/2018 – 03/31/2018
10/06/2018	04/01/2018 – 06/30/2018
01/06/2019	07/01/2018 – 09/30/2018

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

#	Field #	Field Name	Error	Result
1	1	Org. Code	Null or Invalid	File rejection
2	3	Entity PIDSL	Null or Invalid	Record rejection
3	5	Claim Number	Null	Record rejection
4	6	Claim Suffix	Null	Record rejection
5	58	Billing Provider ID	Null	Record rejection
6	223	Billing Provider ID Address Location Code	Null	Record rejection
7	93	Billing Provider ID Type	Null	Record rejection
8	76	New Member ID	Null	Record rejection
9	229	Adjudication Date	Null *or* Less than DOS *or* less than DOB *or* invalid format	Record rejection

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

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

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

2.3 Submission Files Format (claims and metadata)

2.3.1 Format

2.3.1.1 MCOs should submit Zip file named in **"MCO_Denied_Claims_YYYYMMDD.zip"** format where "MCO" stands for the plans' name (i.e. "BMC_Denied_Claims_20170716")

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

2.3.1.3 Denied Claims zip files should contain the following:

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

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

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

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

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

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

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

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

Metadata File Format:

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

Time_Period_To="Value" (YYYYMMDD)	End date of Quarter based on Adjudication date
Return_To="email address"	List of MCO email addresses for notifications
Type_Of_Feed="DENIED"	Type of feed is always 'DENIED'

2.3.2 Denied Claims Reason Code File Format

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

#	Field Name	Length	Data Type/Format
1	Org. Code	3	N
2	Claim Number	19	C
3	Claim Suffix	4	C
4	Denial Reason Code	10	C

2.3.3 Denial Reason Codes Reference File Format

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

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

2.3.4 Denied Claims Data Set Elements

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

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

For the information on Tables A, B, C, D, F, F, G, H, I-A, I-B1, I-B2, I- C, K, M please refer to "Paid Encounter Data Set Request V4.8" specifications.

Demographic Data

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

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
3	Entity PIDSL	ACO PIDSL on the ACO claims or MCO PIDSL on the MCO claims Example: 999999999A	X	X	X	X	X	10	C
4	Record Indicator	This information refers to the payment arrangement under which the rendering provider was paid. Value identifies whether the record was a fee-for-service claim, or a service provided under a capitation arrangement (encounter records). For encounter records, indicate whether there are Fee-For-Service (FFS) equivalents and payment amounts on the record. 0 Artificial record – Refers to a line item inserted to hold amounts / quantities available only at a summary (claim) level. 1 Claim Record – Refers to a claim paid on a Fee-For- Service (FFS) basis	X	X	X	X	X	1	C

Demographic Data (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
	Record Indicator (Continued)	2 Encounter Record with FFS equivalent - Refers to services provided under a capitation arrangement and for which an FFS equivalent is given 3 Encounter Record w/out FFS equivalent - Refers to services provided under a capitation arrangement but for which no FFS equivalent is available 4 Per Diem Payment - Refers to a record for an inpatient stay paid on a per diem basis. 5 DRG Payment - Refers to a record for an inpatient stay paid on a DRG basis 6 Bundled Summary-Level Line; this value refers to the amounts/quantities available in the MCE's source system. Use this value when none of the above Record Indicator values applies. 7 Bundled detail line with 0-dollar amount – Refers to a bundled detail claim line where the dollar amounts are 0 or not available at the detail level. Use this value when none of the above values apply ***See discussion under <u>Dollar Amounts</u> in the Data Elements Clarification Section.***							

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
5	Claim Number	A unique number assigned by the administrator to this claim (e.g., ICN, TCN, DCN). It is very important to include a Claim Number on each record since this will be the key to summarizing from the service detail to the claim level. ***See discussion under Claim Number/Suffix in the Data Elements Clarification Section***	X	X	X	X	X	19	C
6	Claim Suffix	This field identifies the line or sequence number in a claim with multiple service lines. ***See discussion under Claim Number/Suffix in the Data Elements Clarification Section***	X	X	X	X	X	4	C
7	Pricing Indicator	Pricing Indicator; currently it is a subject of internal discussion. *A notification will be sent to the MCEs when decision is made.	X	X	X	X	X	20	C
8	Recipient DOB	The birth date of the patient expressed as YYYYMMDD. For example, August 31, 1954 would be coded "19540831".	X	X	X	X	X	8	D/YYYYMMDD
9	Recipient Gender	The gender of the patient: 1= Male 2=Female 3=Other	X	X	X	X	X	1	C
10	Recipient ZIP Code	The ZIP Code of the patient's residence as of the date of service.	X	X	X	X	X	5	N
11	Medicare Code	A code indicating if Medicare coverage applies and, if so, the type of Medicare coverage. 0= No Medicare 1 = Part A Only 2 = Part B Only 3 = Part A and B	X	X	X	X	X	1	N

Service Data

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
12	Other Insurance Code	A Yes/No flag that indicates whether third party liability exists. 1 = Yes; 2 = No	X	X	X	X	X	1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
13	Submission Clarification Code	420-DK- Code indicating that the pharmacist is clarifying the submission. Values from 1 to 36 should be sent on pharmacy claims when available. The values and descriptions of the Submission Clarification Code are in Table N of the Paid Encounter Data Set Requirements specifications V 4.8				X		7	N
14	Claim Type	BH Vendor Specific field	X	X	X	X	X	18	C
15	Admission Date	For facility services, the date the recipient was admitted to the facility. The format is YYYYMMDD.	X		X			8	D/YYYYMMDD
16	Discharge Date	For facility services, the date the recipient was discharged from the facility. The format is YYYYMMDD. Cannot be prior to Admission Date	X		X			8	D/YYYYMMDD
17	From Service Date	The actual date the service was rendered; if services were rendered over a period of time, this is the date of the first service for this record. The format is YYYYMMDD.	X	X	X	X	X	8	D/YYYYMMDD
18	To Service Date	The last date on which a service was rendered for this record. The format is YYYYMMDD.	X	X	X		X	8	D/YYYYMMDD
19	Primary Diagnosis	The ICD diagnosis code chiefly responsible for the hospital confinement or service provided. The code should be left justified, coded to the fifth digit when applicable (blank filled when less than five digits are applicable). *DO NOT include decimal points in the code.* ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		X	7	C/ No decimal points (780.31 must be entered as 78031)
20	Secondary Diagnosis	The ICD diagnosis code explaining a secondary or complicating condition for the service. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/ No decimal points
21	Tertiary Diagnosis	The tertiary ICD diagnosis code. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/ No decimal points
22	Diagnosis 4	The fourth ICD diagnosis code. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/ No decimal points

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
23	Diagnosis 5	The fifth ICD diagnosis code. See above for format. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/ No decimal points
24	Type of Admission	Should be valid and present on all Hospital and Long Term Care claims with hospital admission. For the UB standard values see Table A.	X		X			1	C
25	Source of Admission	Should be valid and present on all Hospital and Long Term Care claims with hospital admission. For the UB standard values see Table B	X		X			1	C
26	Procedure Code	A code explaining the procedure performed. This code may be any valid code included in the coding systems identified in the Procedure Type field below. *Any internal coding systems used must be translated to one of the coding systems identified in field #**30** below.* Should not contain ICD procedure codes. All ICD procedure codes should be submitted in the surgical procedure code fields (#101 – #113) ***including the ICD-treatment procedure codes*** ***See discussion in Data Element Clarifications section.***	X	X	X		X	6	C
27	Procedure Modifier 1	A current procedure code modifier (CPT or HCPCS) corresponding to the procedure coding system used, when applicable.	X	X	X		X	2	C
28	Procedure Modifier 2	Second procedure code modifier, required, if used.	X	X	X		X	2	C
29	Procedure Modifier 3	Third procedure code modifier, required, if used.	X	X	X		X	2	C
30	Procedure Code Indicator	A code identifying the type of procedure code used in field#26: 2= CPT or HCPCS Level 1 Code 3= HCPCS Level II Code 4= HCPCS Level III Code (State Medicare code). 5= American Dental Association (ADA) Procedure Code (Also referred to as CDT code.) 6= State defined Procedure Code 7= Plan specific Procedure Code ICD procedure codes should go in surgical procedure code fields (Field # 103 – 111)	X	X	X		X	1	N

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		State defined procedure codes should be used, when coded, for services such as EPSDT procedures. ***See discussion in the Data Element Clarifications section.***							
31	Revenue Code	For facility services, the UB Revenue Code associated with the service. *Only standard UB92 Revenue Codes values are allowed; plans may* ***not*** *use "in house" codes. Revenue code less than 4 digits long should be submitted with one leading zero. For Example:* *a. Revenue code 1 should be submitted as '01';* *b. Revenue Code 23 - as '023;* *c. Revenue code 100 - as '0100';* *Revenue Code 2100 – as '2100'*	X		X			4	C
32	Place of Service	This field hosts Place of Service (POS) that comes on the Professional claim). See Table C for CMS 1500 standard		X			X	2	C
33	Type Of Bill	For encounter data, supporting UB claims submission the Type of Bill is submitted as a 3-digit bill type in accordance with national billing guideline. The first two digits denote the place of services and the third digits denotes the frequency. See Table D for UB Type of Bill values indicating place. ***Note*****:** for UB Type of Bill, use the 1st and 2nd positions only.) Frequency values can be found in Table K of the Data Set Requirements Specifications V 4.8	X		X			3	C
34	Patient Discharge Status	This is 2-digit Discharge Status Code (UB Patient Status) for hospital admissions. Values from 1 to 9 should always be entered with leading '0'. *Examples:* a. Patient Discharge Status '1' should be submitted as '01'; B. Patient Discharge Status '19' should be submitted as '19'.	X		X			2	C
35	FILLER							2	C
36	Quantity	This value represents the actual quantity and should be submitted with decimal point when applicable. For inpatient admissions, the number of days of confinement. Count the day of admission but not the day of discharge (for admission and discharge on the same day, Quantity is counted as 1). For all other procedures, the number of units performed for this procedure. For	X	X	X		X	9	SN

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		most procedures, this number should be "1". In some cases, a procedure may be repeated, in which case this number should reflect the number of times the procedure was performed. For anesthesia services, this should be the total number of minutes that make up the beginning and ending clock time of anesthesia service administered. Please make sure that the Quantity corresponds to the procedure code. For example, if the psychiatric code 90844 is used (Individual psychotherapy, 45-50 minutes), the Quantity should be "1" NOT "45" or "50". For Inpatient records, it should represent number of days of care. Values of 30, 60, or 100 are most common on drug records. *Note:* Length of this field has been increased to accommodate the actual quantity. Quantity=10 should be submitted as 10; Quantity=10.5 should be submitted as 10.5; Quantity=10.55 should be submitted as 10.55							
37	NDC Number	For prescription drugs, the valid National Drug Code number assigned by the Food and Drug Administration (FDA). For Compound drugs claims submit NDC Number for the primary drug, If primary drug is unknown, submit NDC Number for most expensive drug. NDC codes having less than 11 digits should be submitted with leading 0's. For Example NDC "603373932" should be submitted as "00603373932".	X	X		X		11	N
38	Metric Quantity	For prescription drugs, the total number of units or volume (e.g., tablets, milligrams) dispensed. Should be submitted with decimal point when applicable. *Note:* Length of this field has been increased to accommodate the actual Metric Quantity. Metric Quantity=10 should be submitted as 10; Metric Quantity=10.5 should be submitted as 10.5; Metric Quantity=10.55 should be submitted as 10.55	X	X		X		9	N
39	Days Supply	The number of days of drug therapy covered by this prescription.				X		3	N
40	Refill Indicator	A number indicating whether this is an original prescription (0) or a refill number (e.g., 1, 2, 3, etc.) on Pharmacy claims.				X		2	N
41	Dispense As Written Indicator	An indicator specifying why the product dispensed was selected by the pharmacist and should be entered in a 2 digit format with leading zero: 00 = No DAW 01 = Physician DAW 02 = Patient DAW 03 = Pharmacist DAW 04 = Generic Not In Stock				X		2	N

#	Field Name	Definition/Description	H	P	L	R	D	Length		Data Type
		05 = Brand Dispensed as Generic 06 = Override 07 = Brand Mandated by Law 08 = No Generic Available 09 = Other								
42	Dental Quadrant	One of the four equal sections into which the dental arches can be divided; begins at the midline of the arch and extends distally to the last tooth. 1 = Upper Right 2 = Upper Left 3 = Lower Left 4 = Lower Right						X	1	N
43	Tooth Number	The number or letter assigned to a tooth for identifications purposes as specified by the American Dental Association. A - T (for primary teeth) 1 - 32 (for secondary teeth)						X	2	C
44	Tooth Surface	The tooth surface on which the service was performed: M = Mesial D = Distal O = Occlusal L = Lingual I = Incisal F = Facial B = Buccal A = All 7 surfaces This field can list up to six values. When multiple surfaces are involved, please list the value for each surface without punctuation between values. For example, work on the mesial, occlusal, and lingual surfaces should be listed as "MOL "(three spaces following the third value).						X	6	C
45	Paid Date	For encounter records, the date on which the record was processed. For services performed on a fee-for-service basis, the date on which the claim was paid. The format is YYYYMMDD.	X	X	X	X	X	X	8	D/YYYYMMDD
46	Service Class	BH Vendor Specific field	X	X	X	X	X	X	23	C

Provider Data

#	Field Name	Definition/Description	H	P	L	R		Length	Data Type
47	PCP Provider ID	A unique identifier for the Primary Care Physician selected by the patient as of the date of service. ***See discussion in the Data Element Clarifications section.***	X	X	X		X	15	C
48	PCP Provider ID Type	A code identifying the type of ID provided in PCP Provider ID above. For example, *6 = Internal ID (Plan Specific)*	X	X	X		X	1	N
49	PCC Internal Provider ID	PCC Internal ID	X	X	X	X	X	15	C
50	Servicing Provider ID	A unique identifier for the provider performing the service. ***See discussion in the Data Element Clarifications section.***	X	X	X	X	X	15	C
51	Servicing Provider ID Type	A code identifying the type of ID provided in Servicing Provider ID above. For example, *6 = Internal ID (Plan Specific)* *9 = NAPB Number (for pharmacy claims only)*	X	X	X	X	X	1	N
52	Referring Provider ID	A unique identifier for the provider. ***See discussion in the Data Element Clarifications section.***	X	X	X	X	X	15	C
53	Referring Provider ID Type	A code identifying the type of ID provided in Referring Provider ID above. For example, 1 = NPI *6 = Internal ID (Plan Specific)* *8 = DEA Number (for pharmacy claims only)*	X	X	X	X	X	1	N

#	Field Name	Definition/Description	H	P	L	R		Length	Data Type
54	Servicing Provider Class	A code indicating the class for this provider: 1 = Primary Care Provider 2 = In plan provider, non PCP 3 = Out of plan provider *Note*: This code relates to the class of the provider and a PCP does not necessarily indicate the recipient has selected or assigned PCP. PCP class should be assigned only to those physicians whom the plan considers to be a participating PCP.	X	X	X	X	X	1	C
55	Servicing Provider Type	A code indicating the type of provider rendering the service represented by this encounter or claim. (Use Servicing Provider Type values, see Table G)	X	X	X	X	X	3	N
56	Servicing Provider Specialty	The specialty code of the servicing provider. (Use CMS 1500 standard, see Table H)	X	X	X		X	3	C
57	Servicing Provider ZIP Code	The servicing provider's ZIP code. The ZIP code where the service occurred is preferred.	X	X	X	X	X	5	N
58	Billing Provider ID	A unique identifier for the provider billing for the service.	X	X	X	X	X	15	C
59	Authorization Type	BH Vendor Specific field	X	X	X	X	X	25	C

Financial Data

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

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
60	Billed Charge	The amount the provider billed for the service.	X	X	X	X	X	9	SN
61	Gross Payment Amount	The amount that the provider was paid in total by all sources for this service. *NOTE: This field should include any withhold amount, if applicable.*						9	SN

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
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 discussion under Dollar Amounts in the Data Elements Clarification Section.***	X	X	X	X	X	9	SN
63	Medicare Amount	Any amount paid by Medicare for this service.	X	X	X	X	X	9	SN
64	Copay/ Coinsurance	Any co-payment amount the member paid for this service.	X	X	X	X	X	9	SN
65	Deductible	Any deductible amount the member paid for this service.	X	X	X	X	X	9	SN
66	Ingredient Cost	The cost of the ingredients included in the prescription.				X		9	SN
67	Dispensing Fee	The dispensing fee charged for filling the prescription.				X		9	SN
68	Net Payment	The amount the Medicaid MCE paid for this service. (Should equal Eligible Charges less COB, Medicare, Copay/Coinsurance, and Deductible.)	X	X	X	X	X	9	SN
69	Withhold Amount	Any amount withheld from fee-for-service payments to the provider to cover performance guarantees or as incentives.						9	SN
70	Record Type	A code indicating the type of record: O = Original V = Void or Back Out R = Replacement A = Amendment ***See discussion under 'Former Claim Number / Suffix' in the Data Elements Clarification Section***	X	X	X	X	X	1	C
71	Group Number	For non-MHSA MCEs 1 = MCO MassHealth 2 = MCO Commonwealth Care 3 = SCO 5 = CarePlus 6 = One Care (ICO) 7 = ACO-A 8 = ACO-B 9 = ACO-C						25	C

Medicaid Program-Specific Data

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

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
76	New Member ID	The ***"Active" Medicaid*** identification number assigned to the individual. This number is assigned by MassHealth and may change.	X	X	X	X	X	25	C

Other Fields

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

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
89	External Injury Diagnosis 1	If there is an External Injury Diagnosis code 1 (ICD E-Code) present on the claim, it should be submitted in this field. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C
90	Claim Received Date	Date claim received by Health Plan, if processed by a PBM.				X		8	D/YYYYMMDD
91	Frequency	The third digit of the UB92 Bill Classification field.	X		X			1	C
92	PCC Internal Provider ID_Type	A code identifying the type of ID provided in PCC Internal Provider ID in field #49 above: *Example:* *6 = Internal ID (Plan Specific)* 8 = DEA Number 9 = NABP Number 1 = NPI	X	X	X	X	X	1	N
93	Billing Provider ID _Type	A code identifying the type of ID provided in Billing Provider ID above. For example, *6 = Internal ID (Plan Specific)* 9 = NABP Number *(for pharmacy claims only)*	X	X	X	X	X	1	N
94	Prescribing Prov. ID _Type	A code identifying the type of ID provided in Prescribing Provider ID above. For example, 1 = NPI *6 = Internal ID (Plan Specific)* *8 = DEA Number*				X		1	N
95	Attending Prov. ID _Type	A code identifying the type of ID provided in Attending Prov. ID above. For example, *6 = Internal ID (Plan Specific)*	X					1	N
96	Admission Time	For inpatient facility services, the time the recipient was admitted to the facility. If not an inpatient facility, the value should be missing. This field ***must*** be in HH24MI format. For example, 10:30AM would be 1030 and 10:30PM would be 2230.	X		X			4	N/HH24MI
97	Discharge Time	For inpatient facility services, the time the recipient was discharged from the facility. If not an inpatient facility, the value should be missing. This field ***must*** be in HH24MI format. For example, 10:30AM would be 1030 and 10:30PM would be 2230.	X		X			4	N/HH24MI
98	Diagnosis 6	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/No decimal points
99	Diagnosis 7	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/No decimal points
100	Diagnosis 8	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/No decimal points

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
101	Diagnosis 9	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/No decimal points
102	Diagnosis 10	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/No decimal points
103	Surgical Procedure code 1	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
104	Surgical Procedure code 2	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
105	Surgical Procedure code 3	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
106	Surgical Procedure code 4	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
107	Surgical Procedure code 5	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
108	Surgical Procedure code 6	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
109	Surgical Procedure code 7	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
110	Surgical Procedure code 8	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
111	Surgical Procedure code 9	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
112	Employment	Is the patient's condition related to Employment Y N	X	X	X	X	X	1	C
113	Auto Accident	Is the patient's condition related to an Auto Accident Y N	X	X	X	X	X	1	C
114	Other Accident	Is the patient's condition related to Other Accident Y N	X	X	X	X	X	1	C
115	Total Charges	This field represents the total charges, covered, and uncovered related to the current billing period.	X	X	X	X	X	9	N
116	Non Covered charges	This field represents the uncovered charges by the payer related to the revenue code. This is the amount, if any, that is not covered by the primary payer for this service.	X	X	X	X	X	9	N
117	Coinsurance	Any coinsurance amount the member paid for this service.	X	X	X	X	X	9	N
118	Void Reason Code	The reason the claim line was voided 1 TPL 2 accident recovery 3 provider audit recoveries 4 Other						1	C
119	DRG Description	Description of DRG Code	X		X			132	C
120	DRG Type	*Values:* 1=Medicare CMS-DRG 2=Medicare MS-DRG 3=Refined DRGs (R-DRG) 4=All Patient DRGs (AP-DRG) 5=Severity DRGs (S-DRG) 6=All Patient, Severity-Adjusted DRGs (APS-DRG) 7=All Patient Refined DRGs (APR-DRG) 8=International-Refined DRGs (IR-DRG) 9=Other ***Please use the accurate and specific DRG type and avoid using the value "Other". Please communicate to MassHealth any DRG types you are using that are missing from the above list***	X		X			1	C
121	DRG Version	DRG Version number associated with DRG type	X		X			3	C/ No decimal points (26.1 must be entered as 261)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
122	DRG Severity of Illness Level	A code that describes the Severity of the claim with the assigned DRG: Valid values are: 1 = minor 2 = moderate 3 = major 4 = extreme ***Associated with DRG Type=APR-DRG (DRT Type =7) or any other DRG that has these fields***	X		X			1	C
123	DRG Risk of Mortality Level	A code that describes the Mortality of the patient with the assigned DRG code. Valid values are: 1 = minor 2 = moderate 3 = major 4 = extreme ***Associated with DRG Type=APR-DRG (DRT Type =7) or any other DRG that has these fields.***	X		X			1	C
124	Patient Pay Amount	Patient paid amount for nursing facility stays and hospitals	X		X			9	SN
125	Patient Reason for Visit Diagnosis 1	ICD diagnosis code describing the patient's (or patient representative's) stated reason for seeking care at the time of outpatient (ER) visit ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
126	Patient Reason for Visit Diagnosis 2	ICD diagnosis code describing the patient's (or patient representative's) stated reason for seeking care at the time of outpatient (ER) visit ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
127	Patient Reason for Visit Diagnosis 3	ICD diagnosis code describing the patient's (or patient representative's) stated reason for seeking care at the time of outpatient (ER) visit ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
128	Present on Admission (POA) 1	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
129	Present on Admission (POA) 2	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
130	Present on Admission (POA) 3	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
131	Present on Admission (POA) 4	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C

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

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
148	Diagnosis 16	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
149	Present on Admission (POA) 16	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
150	Diagnosis 17	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
151	Present on Admission (POA) 17	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
152	Diagnosis 18	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
153	Present on Admission (POA) 18	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
154	Diagnosis 19	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
155	Present on Admission (POA) 19	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
156	Diagnosis 20	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
157	Present on Admission (POA) 20	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
158	Diagnosis 21	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
159	Present on Admission (POA) 21	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
160	Diagnosis 22	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
161	Present on Admission (POA) 22	This indicator clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
162	Diagnosis 23	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points

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

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		See discussion in Data Element Clarifications section, including clarification on ICD-10							
176	Present on Admission (POA) EI 4	This indicator is associated with External Injury Diagnosis 4 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
177	External Injury Diagnosis 5	If there is an External Injury Diagnosis code 5 (ICD- E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
178	Present on Admission (POA) EI 5	This indicator is associated with External Injury Diagnosis 5 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
179	External Injury Diagnosis 6	If there is an External Injury Diagnosis code 6 (ICD- E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
180	Present on Admission (POA) EI 6	This indicator is associated with External Injury Diagnosis 6 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
181	External Injury Diagnosis 7	If there is an External Injury Diagnosis code 7 (ICD- E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
182	Present on Admission (POA) EI 7	This indicator is associated with External Injury Diagnosis 7 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
183	External Injury Diagnosis 8	If there is an External Injury Diagnosis code 8 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
184	Present on Admission (POA) EI 8	This indicator is associated with External Injury Diagnosis 8 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
185	External Injury Diagnosis 9	If there is an External Injury Diagnosis code 9 (ICD E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points

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

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

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
206	Surgical Procedure Code 10	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
207	Surgical Procedure Code 11	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
208	Surgical Procedure Code 12	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
209	Surgical Procedure Code 13	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
210	Surgical Procedure Code 14	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
211	Surgical Procedure Code 15	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
212	Surgical Procedure Code 16	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
213	Surgical Procedure Code 17	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
214	Surgical Procedure Code 18	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
215	Surgical Procedure Code 19	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank.	X					7	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		See discussion in Data Element Clarifications section, including clarification on ICD-10							
216	Surgical Procedure Code 20	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
217	Surgical Procedure Code 21	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
218	Surgical Procedure Code 22	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
219	Surgical Procedure Code 23	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
220	Surgical Procedure Code 24	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
221	Surgical Procedure Code 25	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
222	Attending Prov. ID Address Location Code	Code to identify address location of Attending Provider ID in field #87	X					15	C
223	Billing Provider ID Address Location Code	Code to identify address location of Billing Provider ID in field # 58	X	X	X	X	X	15	C
224	Prescribing Prov. ID Address Location Code	Code to identify address location of Prescribing Provider ID Provider ID in field # 81				X		15	C
225	PCP Provider ID Address Location Code	Code to identify address location of PCP Provider ID in field # 47	X	X	X	X	X	15	C
226	Referring Provider ID	Code to identify address location of Referring Provider ID in filed # 52	X	X	X			15	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
	Address Location Code								
227	Servicing Provider ID Address Location Code	Code to identify address location of Servicing Provider ID in field # 50	X	X	X	X	X	15	C
228	PCC Provider ID Address Location Code	Code to identify address location of PCC Internal Provider ID in field # 49	X	X	X	X	X	15	C
229	Adjudication Date	The date when the record was adjudicated	X	X	X	X	X	8	D/YYYYMMDD

3. Error Handling Section

The submission will be rejected if:

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

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

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

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

4. Error Reports and Notifications to the Plans

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

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

4.1 Error Denied Claims Summary Report Format

Example:

MCO_Denied_Claims_20180716.zip file processed on MM/DD/YYYY (07/18/2018)
Report Name - "err_MCO.2018.07.18.13.41.01.denied_claim_summary.txt"

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

4.2 Error Denied Claims Details Report Format

MCO_Denied_Claims_20180716.zip file processed on MM/DD/YYYY (07/18/2018)
Report Name - "err_MCO.2018.07.18.13.41.02.denied_claim_detail.txt"

The report consists of 14 fields:

1. MCO
2. ORG. Code
3. Entity PIDSL
4. Claim Number
5. Claim Suffix
6. Billing Provider ID
7. Billing Provider ID Type
8. Billing Provider ID Address Location Code
9. Medicaid ID (New Member ID)
10. Adjudication Date
11. Field #
12. Field Name
13. Error Code
14. Error Description

4.3 Error Denial Reason Code Report Format

Example:

MCO_Denied_Claims_20180716.zip file processed on MM/DD/YYYY (07/18/2018)
Report Name - "err_MCO.2018.07.18.13.41.03.rsnm2m.txt"

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

MCO	CLAIM_NUMBER	CLAIM_FUFFIX	Denial Reason Code	Error Code	Error Description
CAR	5555555555RX	25	DINCORRT	72	Claim Number/Suffix in Denied_Claims_Reason_Code file not in Denied_Claims file