MARYLAND HEALTH CARE COMMISSION

COMAR 10.25.06 – *Maryland Medical Care Data Base and Data Collection*

MCDB

Formatted for the MHCC
2014 MEDICAL CARE DATA BASE

DATA BASE SUBMISSION MANUAL

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MARYLAND HEALTH CARE COMMISSION

COMAR 10.25.06 – MARYLAND MEDICAL CARE DATA BASE (MCDB) SUBMISSION MANUAL

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MARYLAND HEALTH CARE COMMISSION

DATA SUBMISSION MANUAL

PURPOSE: The 2014 Medical Care Data Base (MCDB) Data Submission Manual is designed to provide reporting entities with guidelines of technical specifications, layouts, and definitions necessary for filing the Professional Services Data, Pharmacy Data, Provider Directory, Institutional Services Data, Eligibility Data, and Dental Data reports required under COMAR 10.25.06.04. This manual incorporates new information, and all recent updates and modifications outlined in the 2013 MCDB Data Submission Manual released after the January 9, 2014 AELR Committee meeting. Only items that are new or modified in this version are so indicated. The manual is available in electronic form on the Commission's website at:
http://mhcc.dhmh.maryland.gov/payercompliance/Pages/payercompliance/default.aspx

PAYOR ID #: Each payor that is required to file reports for inclusion in the MCDB will be notified of its identification number, which will also be posted on the Commission's website. The ID number assigned is required on all submission media and documentation.

Questions regarding the information in this manual should be directed to:

Mr. Larry Monroe
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For information on the MCDB SFTP submission process contact:

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DATA SUMMARY WORKSHEETS (DSW)

Payors who contributed to the 2013 Medical Care Data Base (submissions received July 2014) will be mailed Data Summary Worksheets that show total number of users, services, and payments for the claims files, and enrollees and member months for the eligibility file for prior submissions.

Please use these Data Summary Worksheets to calculate and evaluate changes between your prior data and this 2014 MCDB data submission by inserting the 2014 reported data in the appropriate column. Differences greater than 10% should be resolved or explained in the Comments Section of the Data Summary Worksheets. Payors are required to return the Data Summary Worksheets with the 2014 MCDB data submission.

If your company did not receive the 2013 Data Summary Worksheets, please contact Larry Monroe at larry.monroe@maryland.gov.

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SUMMARY INFORMATION REGARDING REPORTS AND DATES

KEY DEFINITIONS –

The following definitions apply to those entities designated to provide data to the Maryland Medical Care Data Base:

Payor means: (a) an insurer or nonprofit health service plan that holds a certificate of authority and provides health insurance policies or contracts in Maryland; or (b) a health maintenance organization (HMO) that holds a certificate of authority in Maryland, whose total covered lives exceeds 1,000 as reported to the Maryland Insurance Administration.

Qualified Health Plan (QHP) means a general health benefit plan that has been certified by the Maryland Health Benefit Exchange to meet the criteria for certification described in §1311(c) of the Affordable Care Act and Insurance Article, §31-115, Annotated Code of Maryland.

Qualified Dental Plan (QDP) means a dental plan certified by the Maryland Health Benefit Exchange that provides limited scope dental benefits, as described in § 1311(c) of the Affordable Care Act and Insurance Article, §31-115, Annotated Code of Maryland.

Qualified Vision Plan (QVP) means a vision plan certified by the Maryland Health Benefit Exchange that provides limited scope vision benefits, as described in the Insurance Article, §31-108(b)(3) Annotated Code of Maryland.

Managed Care Organization (MCO) means a certified health maintenance organization or a corporation that is a managed care system that is authorized to receive medical assistance prepaid capitation payments, enrolls only program recipients or individuals or families served under the Maryland Children's Health Program, and is subject to the requirements of Health-General Article §15-102.4, Annotated Code of Maryland.

Third Party Administrator (TPA) means a person (entity, etc.) that is registered as an administrator under Title 8, Subtitle 3 of the Insurance Article, whose total lives covered on behalf of Maryland employers exceeds 1,000, as reported to the Maryland Insurance Administration.

A Pharmacy Benefit Manager (PBM) means a person (entity, etc.) that performs pharmacy benefit management services, a term that includes: the procurement of prescription drugs at a negotiated rate for dispensation to beneficiaries; the administration or management of prescription drug coverage, including mail service pharmacies, claims processing, clinical formulary development, rebate administration, patient compliance programs, or disease management programs.

REPRORTING ENTITIES and REQUIRED REPORTS –

Reporting Entities	Professional Services	Pharmacy Services	Provider Directory	Institutional Services	Eligibility	Dental Services	Plan Benefit Design	Non-FFS Medical Expenses
Payors	**X**	**X**	**X**	**X**	**X**	-	Testing only	Testing only
Qualified Health Plans	**X**	**X**	**X**	**X**	**X**	-		
Qualified Dental Plans	-	-	**X**	-	**X**	**X**		
Qualified Vision Plans	**X**	-	**X**	-	**X**	-		
Medicaid Managed Care Organizations	**X**	**X**	**X**	**X**	**X**	-		
Third Party Administrators (General Benefit Plans)	**X**	**X**	**X**	**X**	**X**	-	Testing only	Testing only
Third Party Administrators (Behavioral Health Services)	**X**	**X**	**X**	**X**	**X**	-	Testing only	Testing only
Pharmacy Benefit Managers	-	**X**	-	-	**X**	-	Testing only	Testing only

2014 MCDB DATA SUBMISSION SCHEDULE –

2014 Medical Care Data Base Submission Schedule				
MCDB Data Reporting	Quarter 1: 01/01/14 – 03/31/14	Quarter 2: 04/01/14 – 06/30/14	Quarter 3: 07/01/14 – 09/30/14	Quarter 4: 10/01/14 – 12/31/14
Data Submission Due Date	**09/30/14** for claims adjudicated thru 03/31/14	**09/30/14** for claims adjudicated thru 06/30/14	**11/30/14** for claims adjudicated thru 09/30/14	**02/28/15** for claims adjudicated thru 12/31/14
Annual Waiver Request Due Date *(formerly referred to as a full exemption)*	03/15/2014	03/15/2014	03/15/2014	03/15/2014
Format Modifications Request Due Date *(formerly referred to as data element waivers and format modifications)*	08/31/2014	08/31/2014	10/31/2014	01/31/2015
30-day Submission Extension Request Due Date	08/31/2014	08/31/2014	10/31/2014	01/31/2015
Data Submission Due Date with 30-day Extension	10/31/2014	10/31/2014	12/31/2014	03/31/2015

MARYLAND HEALTH CARE COMMISSION

DATA SET GLOSSARY

I. First Quarter Reporting: **Claims adjudicated** between January 1, 2014 and March 31, 2014. First Quarter submission is due by September 30, 2014.

II. Second Quarter Reporting: **Claims adjudicated** between April 1, 2014 and June 30, 2014. Second Quarter submission is due by September 30, 2014.

III. Third Quarter Reporting: **Claims adjudicated** between July 1, 2014 and September 30, 2014. Third Quarter submission is due by November 30, 2014.

IV. Fourth Quarter Reporting: **Claims adjudicated** between October 1, 2014 and December 31, 2014. Fourth Quarter submission is due by February 28, 2015.

Each reporting entity shall provide the required reports and include all services provided to each Maryland resident insured under a fully insured contract or a self-insured contract, and to each non-Maryland resident insured under a Maryland contract. Include claims for all Maryland residents covered by your company regardless of where the contract is written; for example, if your company covers Maryland residents under a contract written in California, the claims for these residents should be included in your submission.

V. Eligibility Data Report: This data report details information on the characteristics of all enrollees covered for medical services under the plan for the quarterly reporting periods designated – First Quarter: January 1, 2014 through March 31, 2014; Second Quarter: April 1, 2014 through June 30, 2014; Third Quarter: July 1, 2014 through September 30, 2014; and Fourth Quarter: October 1, 2014 through December 31, 2014. Please provide an entry for each month that the enrollee was covered by a general health benefit plan regardless of whether or not the enrollee received any covered services during the reporting quarter.

(Based on quarterly reporting, an enrollee with 3 months of coverage will have 3 eligibility records; an enrollee with 1 month of coverage will only have 1 record.)

VI. Professional Services Data Report: Fee-for-service encounters and capitated encounters provided by health care practitioners and office facilities (i.e., CMS 1500 claims).

This does not include hospital facility services documented on UB-04 claims forms.

The following medical services must be included:

- Physician services
- Non-physician health care professionals
- Freestanding Office Facilities (radiology centers, ambulatory surgical centers, birthing centers, etc.)
- Durable Medical Equipment (DME)
- Prescription Drug (in a separate file)
- Dental – if services are provided under a medical benefit package
- Vision - if services are provided under a medical benefit package

VII. Pharmacy Data Report: This data file details prescription drugs services only.

VIII. Provider Directory Report: This data report details all health care practitioners and suppliers who provided services to enrollees during the reporting period. Each service submission should be accompanied by a Provider Directory Report. In instances where the data come from different sources, a separate Provider Directory Report must be provided (with a crosswalk of every practitioner ID listed in the Professional Services Report) for each health care practitioner or supplier who provided services.

DATA SET GLOSSARY (cont.)

IX. INSTITUTIONAL SERVICES DATA REPORT: This data file reports all institutional health care services provided to Maryland residents, whether those services were provided by a health care facility located in-State or out-of-State. These services include all payments made by the plan to the institutional provider summarized on the final bill for the given stay or visit. This summary record should reflect all charges and payments from an interim or final claim. To avoid sending duplicate charges and payments, submit summaries from interim claims only when a final claim does not exist for a visit or stay.

X. DENTAL SERVICES DATA REPORT: This data report details all dental health care services provided to persons enrolled in Qualified Dental Health Plans certified by the Maryland Health Benefit Exchange (MHBE). The format for this report is designed to be consistent with professional services claims and encounters, but modified to be specific to dental services.

XI. PLAN BENEFIT DESIGN REPORT – This data file will report details of coverage and benefits for all enrollees. This report is under development. Reporting entities, who are required to provide this report, will be provided an opportunity to participate in the development and testing of this report for the 2014 data submission. The report will be required for the 2015 submission and onward.

XII. NON-FEE-FOR-SERVICE MEDICAL EXPENSES REPORT – This data file will report details of non-fee-for-service payments made to providers. These may include, shared savings payments, incentive or performance payments, fixed transformation payments, etc. This report is under development. Reporting entities, who are required to provide this report, will be provided an opportunity to participate in the development and testing of this report for the 2014 data submission. The report will be required for the 2015 submission and onward.

XIII. REPORTING DEADLINES: For the quarterly reporting periods designated – First Quarter: January 1, 2014 through March 31, 2014 due by September 30, 2014; Second Quarter: April 1, 2014 through June 30, 2014 due September 30, 2014; Third Quarter: July 1, 2014 through September 30, 2014 due by November 30, 2014; and Fourth Quarter: October 1, 2014 through December 31, 2014 due by February 28, 2015.

XIV. NUMBER (#) OF SERVICES: Any health or medical care procedure or service rendered by a health care practitioner documented by CPT, HCPCS or locally defined code (i.e., homegrown medical procedure code).

- **Fixed Format** – 1 service corresponds to 1 record/service. If a service includes more than 1 unit, it is still counted as 1 service.
- **Variable Format** – 1 service is equal to 1 line item, multiple line items can appear on a single record/claim.

XV. NUMBER (#) OF CLAIMS:

- **Fixed Format** – Claims are equal to the number of CMS 1500 encounters (bills) or UB-04 claims originally received. Please note that when using the fixed format this number will not conform with the number of records submitted because multiple services may be reported on a single claim.
- **Variable Format** – Number of claims is equal to the number of CMS 1500 encounters (bills) or UB-04 claims submitted.

MARYLAND HEALTH CARE COMMISSION

OVERVIEW OF DATA SUBMISSION GUIDELINES

GENERAL –

- The 2014 MCDB data submission marks the second phase of compliance under **COMAR 10.25.06 Maryland Medical Care Data Base and Data Collection**, proposed regulations adopted by the Commission on October 17, 2013 and approved by the AELR Committee as emergency regulations on January 9, 2014.

- The **Professional Services** Data Report should include all fee-for-service and specialty capitated care encounters for services provided by health care practitioners and office facilities to applicable insureds during the reporting period. (**COMAR 10.25.06.07**)

- The **Pharmacy** Data Report should include all pharmacy services provided to applicable insureds during the reporting period, whether the services were provided by a pharmacy located in Maryland or out-of State. (**COMAR 10.25.06.08**)

- The **Provider Directory** Report should include information on all Maryland and out-of-State health care practitioners and suppliers that provided services to applicable insureds during the reporting period. (**COMAR 10.25.06.09**)

- The **Institutional Services** Data Report should include all institutional health care services provided to applicable insureds during the reporting period. (**COMAR 10.25.06.10**)

- The **Eligibility** Data Report should include information on the characteristics of all enrollees covered for medical services under the plan during the reporting period. (**COMAR 10.25.06.11**)

- The **Dental** Data Report should include all dental services provided to applicable insureds enrolled in Qualified Dental Plans (certified by the MHBE) during the reporting period, whether the services were provided by a practitioner or office facility located in Maryland or out-of State. (**COMAR 10.25.06.13**)

- The **Plan Benefit Design** Report **(COMAR 10.25.06.12)** will report details of coverage and benefits for all enrollees. This report is under development.

- The **Non-Fee-for-Service Medical Expenses** Report **(COMAR 10.25.06.14)** will report details of non-fee-for-service payments made to providers. These may include, shared savings payments, incentive or performance payments, fixed transformation payments, etc. This report is under development.

- Reporting entities **MUST** provide **ALL** National Provider Identifier (NPI) numbers where the threshold value has been established. Reporting of key NPI numbers is required for the development of a provider performance measurement system.

- Mandatory NPI numbers requested include: **Servicing Practitioner** Individual NPI number and **Practitioner NPI used for Billing** on the Professional Services and Dental Services files; the **Prescribing Practitioner** Individual NPI on the Pharmacy file; and, the **Attending Practitioner** Individual NPI on the Institutional Services file.

- For new reporting entities, information on submission of MCDB files to the Commission's **Secure File Transfer Protocol (SFTP)** Server and other media format and transmission information can be found in Appendix A.

- For payors submitting the MCDB data files directly to the **MHCC Secure FTP site**, the **Internet Protocol (IP) Address** for the SFTP site is **184.80.193.37**.

KEY SPECIFICATIONS and SUBMISSION REQUIREMENTS –

- **New!** The **Reporting Quarter** Indicator has been added to all file layouts. Specify the quarter for which the data is being submitted (1st, 2nd, 3rd, or 4th).

- **Modified!** The **Coverage Type** field on the Professional Services, Eligibility, and Dental Services files has been expanded (and modified) to include Individual and Small Business Options Program (SHOP) plans purchased in the Maryland Health Benefit Exchange (MHBE).

- **New!** The **Health Insurance Oversight System (HIOS) ID Number** is a field on the Eligibility file to indicate the HIOS ID number supplied by the federal government, where available.

- **New!** The **Master Patient Index (MPI)** field has been added to the Eligibility file. This field indicates the unique patient identifier assigned by Maryland's Health Information Exchange, Chesapeake Regional Information System for our Patients (CRISP). Payors will be required to provide limited identifiable data to CRISP, who will generate the MPI and return to the payor. Payors will be required to submit the MPI in the Eligibility file once testing has been completed. Additional information on the MPI will be available on the following Commission website in sufficient time before the 4th Quarter data submission:
  http://mhcc.dhmh.maryland.gov/payercompliance/Pages/payercompliance/default.aspx

- The **Assignment of Benefits Indicator** is a field on the Professional Services file. For out-of-network services please provide information on whether or not the patient assigned benefits to the servicing physician for an out-of-network service. Assignments of Benefits is defined as the transfer of health care coverage reimbursement benefits or other rights to a non-participating provider as defined in Insurance Article §14-201(c), Annotated Code of Maryland.

- The **Diagnosis Code Indicator** (International Classification of Diseases) is a field on the Professional Services file. The **Diagnosis Code Indicator** and **Procedure Code Indicator** are fields on the Institutional Services files. The ICD-9 code sets will transition to the ICD-10 code sets beginning in October, 2014.

- The **Revenue Codes** is a field on the Institutional Services file. Please provide the codes used to identify specific accommodation and/or ancillary charges. This field will improve identification of Emergency Room visits, for use in practitioner performance measurement system, and for pricing of procedures and treatment of chronic conditions.

- The **CPT Category II** codes (Current Procedure Terminology II) is a field on the Professional Services file. The CPT Category II codes will facilitate data collection about the quality of care rendered and for the purposes of performance measurement.

- The **Claim Paid Date** field has been added to the Pharmacy and Institutional Services files. This field indicates the date a claim was authorized for payment.

- The **Practitioner Specialty Code** fields on the Provider Directory file have been replaced with reference to the National Uniform Claim Committee Health Care Provider Taxonomy Code, Version 13.0, January, 2013. The document is available on the Commission's website at:
  http://mhcc.dhmh.maryland.gov/payercompliance/Documents/Taxonomy_13_0.pdf

- The **Patient/Enrollee Zip Code** field on the Professional Services, Pharmacy, Institutional Services, and Eligibility files includes the 5-digit US Postal Service code plus the 4-digit add-on code and hyphen (e.g., 24681-3579).

- The **Participating Provider Status** flag on the Professional Services file includes an option for **"No network for this plan"** (code #9).

- The **Diagnosis Code** field on the Professional Services and Institutional Services files is **7 digits** to accommodate the ICD-10 codes.

- The **Source of Direct Reporting of Enrollee Race** is a field on the Eligibility file to indicate the source used in direct reporting of enrollee race.

KEY SPECIFICATIONS and SUBMISSION REQUIREMENTS (cont.) –

- The Race Category **White or Caucasian** – **Direct** is a field on the Eligibility file to indicate whether the self-defined race of the enrollee is White or Caucasian.

- The Race Category **Black or African American** – **Direct** is a field on the Eligibility file to indicate whether the self-defined race of the enrollee is Black or African American.

- The Race Category **American Indian or Alaska Native** – **Direct** is a field on the Eligibility file to indicate whether the self-defined race of the enrollee is American Indian or Alaska Native.

- The Race Category **Asian** – **Direct** is a field on the Eligibility file to indicate whether the self-defined race of the enrollee is Asian.

- The Race Category **Native Hawaiian or Other Pacific Islander** – **Direct** is a field on the Eligibility file to indicate whether the self-defined race of the enrollee is Native Hawaiian or Other Pacific Islander.

- The Race Categories **Other**, **Declined to Answer**, and **Unknown or Cannot be Determined** – **Direct** are fields on the Eligibility file.

- The **Imputed Race** with the Highest Probability is a field on the Eligibility file to indicate race of the enrollee.

- The **Probability of Imputed Race Assignment** is a field on the Eligibility file to indicate the probability used in race determination.

- The **Source of Direct Reporting of Enrollee Ethnicity** is a field on the Eligibility file to indicate the source used in reporting enrollee ethnicity.

- The **Imputed Ethnicity** with the Highest Probability is a field on the Eligibility file to indicate the ethnicity of the enrollee.

- The **Probability of Imputed Ethnicity Assignment** is a field on the Eligibility file to indicate the probability used in ethnicity determination.

- The **Enrollee Preferred Spoken Language for a Healthcare Encounter** is a field on the Eligibility file to indicate the preferred spoken language of the enrollee during a healthcare encounter.

- The **Coverage Period End Date** is a field on the Eligibility file to indicate the contract renewal date, after which benefits, such as deductibles and out of pocket maximums reset

- The **Grandfathered Plan Indicator** is a field on the Eligibility file to indicate if the plan qualifies as a "Grandfathered or Transitional Plan" under the Affordable Care Act (ACA).

- The **Plan or Product ID Number** is a field on the Eligibility file to indicate the Plan or Product ID number associated with the enrollee's coverage and benefits in the payor's adjudication system.

- The **Subscriber ID Number** is a field on the Eligibility file to indicate the Subscriber ID number, or policy number, associated with an individual or family enrollment to allow for linking all members on a given policy.

- The **Record Identifier** field is used to identify the data report file: 1 – Professional Services; 2 – Pharmacy; 3 – Provider Directory; 4 – Institutional Services; 5 – Eligibility; 6 – Dental Services; 7 – Plan Benefit Design; 8 – Non-Fee-for-Service Medical Expenses.

- The Commission requests that payors continue to provide the **Patient/Enrollee IdentifierU** using the **Universally Unique Identifier (UUID)** algorithm to uniquely encrypt patient/enrollee identifiers, as required under **COMAR 10.25.06.06**. This unique identifier enables the Commission to identify patients across payors over time.

KEY SPECIFICATIONS and SUBMISSION REQUIREMENTS (cont.) –

- The full **Universally Unique Identifier (UUID)** encryption software documentation, source code, and executables are bundled into a ZIP file. That software can be downloaded directly from the Commission's website at http://mhcc.dhmh.maryland.gov/payercompliance/Pages/mcdb-uuid.aspx. The file is password protected. The password will be forwarded to the payor contact in an e-mail.

- Carriers are required to continue to use their current encrypted identifier, **Patient/Enrollee IdentifierP**, coincident with the UUID and MPI. Using multiple identifiers will: 1) provide the means to perform trend analysis by cross referencing the two identifiers, and 2) increase the efficacy of the identifiers in the event encryption of one of the algorithms is compromised.

- The **Payor ID Number** and **Source System** fields, on the Professional Services, Pharmacy, Provider Directory, Institutional Services, Eligibility and Dental Services data reports, allow the Commission to identify the **payor platforms** or **business units** from which the data was obtained.

- The **Source Company** variable on the Professional Services and Eligibility files defines the **payor company** that holds the beneficiary's contract; for use in characterizing contract requirements under Maryland law.

- The **Product Type** field on the Professional Services and Eligibility files classifies the **benefit plan** by key product characteristics (scope of coverage, size of network, coverage for out-of-network benefits).

- Total Patient Liability should equal the sum of **Patient Deductible**, **Patient Coinsurance/Co-payment**, and **Other Patient Obligations**. These three financial fields **must be reported when available**. Please make an effort to provide this financial information.

- The **Plan Liability** flag is configured into three categories: (1) Risk – under a Maryland contract; (2) Risk under a non-Maryland contract; or (3) Administrative Services Only.

- On the Institutional Services file, the **Record Status** field will be determined using the **third digit** in the "Type of Bill" field, so please fill this field. To avoid sending duplicate charges and payments, submit summaries from interim claims only when a final claim does not exist for a visit or stay.

- Payors are reminded to **NOT encrypt** the **Employer Federal Tax ID** on the Eligibility file. The data base contractor **will encrypt** the Employer Federal Tax ID prior to creating the MCDB files. Under this encryption protocol, an employer will have the same encrypted ID across all payor records.

- **Patient Date of Enrollment** in plan – Date is the first day of the reporting period if patient is enrolled at that time. Enter other date if patient **not enrolled** at start of reporting period, but enrolled during the reporting period.

- **Patient Date of Disenrollment** in plan **– Leave blank** if patient is **still enrolled** on the last day of the reporting period. If patient **disenrolled** before end of the reporting period, enter date disenrolled.

- The **Date of FIRST Enrollment** on the Eligibility file should reflect the date that the patient was **initially enrolled** in the plan.

- On the Eligibility file, the **Start Date of Coverage (in the month)** represents the **start date for benefits** in the month. (For example, if the enrollee was insured at the start of the month of January in 2014, the start date is 20140101.)

- Also, the **End Date of Coverage (in the month)** on the Eligibility file represents the **end date for benefits** in the month. (For example, if the enrollee was insured for the entire month of January in 2014, the end date is 20140131.)

- The Commission requests that payors pay considerable attention to **Section II: File Documentation** and the **Data Summary Worksheets** which serve as the point of reference for the submission. The goal of the documentation and worksheets is to ensure that the appropriate data is received and to support data cleaning and auditing. The Commission has made significant reductions in documentation tables to reduce administrative burdens on payors. Note that data submitted without proper documentation and worksheets will be returned.

ANNUAL WAIVER or FORMAT MODIFICATION REQUESTS –

- The deadline for filing requests for an annual waiver *(formerly referred to as a full exemption)* as required under COMAR 10.25.06.17A is **March 15, 2014**. Under COMAR 10.25.06.17B, requests for report file and data element format modifications *(formerly referred to as data element waivers and format modifications)* must be submitted by **August 31, 2014**. An extension request will be granted only if the payor can demonstrate extraordinary cause. The data base contractor is not authorized to grant exceptions.

- Payors are reminded to submit format modification requests only for those data elements that have an **assigned threshold value**.

- The MHCC staff assesses each payor's request(s) based on that **payor's particular circumstances**, including specific claims information provided to or retained by the payor, and changes in staffing or claims processing and storage systems that may impact information the payor can submit or when the submission can be completed.

- It is important that payors reference the MCDB **Quality Review Statement** (QRS) before submitting their data element and modified threshold requests. The Quality Review Statement is designed to provide payors with a comparison of information reported and threshold values assigned.

- Payors should not submit requests for data elements for which the **payor exceeded** or **met** the edit threshold for the previous year's submission. Unless the payor has supporting documentation that their circumstances have changed, the Commission will only consider a request regarding a data element which the payor fell below the threshold in the preceding year. Failure to consult the QRS in advance will result in the entire request being returned.

- Submissions that do not meet the specific thresholds listed in the File Layouts Section will be returned unless a waiver was obtained. (Note: If you cannot meet the minimum thresholds, you must request a format modification prior to submission.)

MCDB DATA SUMMARY WORKSHEETS and QUALITY REVIEW SUMMARY REPORTS –

- MHCC provides payors with Data Summary Worksheets and Quality Review Statements with comments for review by payors. The Quality Review Statement is designed to provide payors with a comparison of information reported and threshold values assigned. The Data Summary Worksheets detail changes in key measures including total number of recipients, services, and payments from the previous submissions.

- In an effort to reduce back and forth communications and re-submissions, payors are asked to use the Data Summary Worksheets to compare key measures from the current submission to the value for the same measures in their prior submissions and calculate percent changes before submitting data.

- Payors are required to screen results for noteworthy changes (decreases or increases above 10%) in all key variable categories, and provide information/documentation on significant changes in the Comments Section of the Data Summary Worksheets. This documentation will confirm if the reported differences are legitimate as opposed to data submission errors. Payors are **required** to return the completed Data Summary Worksheets with the current submission.

- For payors submitting data for the first time, there will be no prior data presented. Only data for the current period of reporting is required.

FORMATTING NOTES –

- Match the **layout of the file submission** with the appropriate data report specifications.
- **RIGHT** justify all NUMERIC fields *(Pharmacy NCPDP is the only numeric field that is "exclusively left justified).*
- **POPULATE** any NUMERIC field for which you have no data to report with **ZEROS**—except the financial fields for capitated/global contract services.
- **Financial fields** for capitated or global contract services that lack data are to be filled with -999. If you have the patient liability information for these services, you must report the patient liability values, even though the other financial fields (billed charge, allowed amount, reimbursement amount) are lacking data.
- Leave **BLANK** the positions in NUMERIC fields for which the entry is less than the allowed field length.
- **DO NOT** add leading zeroes to amount/financial fields.
- **LEFT** justify all ALPHANUMERIC fields.
- Leave **BLANK** any ALPHANUMERIC fields for which you have no data to report.

MARYLAND HEALTH CARE COMMISSION

PAYOR SUBMISSION AND DOCUMENTATION CHECKLIST

Please use this checklist as a guideline for your data submission.

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In order to read your data, please include the necessary documentation:

☐ Payor ID# on all Media & Documentation

☐ Copies of File Layouts

☐ File Documentation – All Reports

DATA WITHOUT PROPER DOCUMENTATION WILL BE RETURNED!

MARYLAND HEALTH CARE COMMISSION

SECTION I

FILE DOCUMENTATION FORM

- PROFESSIONAL SERVICES FILE
- PHARMACY SERVICES FILE
- PROVIDER DIRECTORY
- INSTITUTIONAL SERVICES FILE
- ELIGIBILITY FILE
- DENTAL SERVICES FILE

FORMATTED FOR THE 2014 MARYLAND MEDICAL CARE DATA BASE (MCDB) SUBMISSION

MARYLAND HEALTH CARE COMMISSION

MEDICAL CARE DATA BASE DOCUMENTATION FORM [Excel worksheet – Documentation_Form]

PAYOR NAME (S):_____

PAYOR ID #: _____ **REPORTING PERIOD:** _____

CONTACT NAME/TITLE: _____

ADDRESS: _____

PHONE NUMBER: _____ **FAX NUMBER:** _____ **E-MAIL ADDRESS:** _____

PROFESSIONAL SERVICES
MEDIA TYPE:
☐ IBM 3480/3480E Cartridge ☐ IBM 3490/3490E Cartridge
☐ CD-ROM/DVD ☐ DLT Tape IV
☐ Secure FTP

Number of Media: _____ Number of Records *(if variable format)*: _____
Blocking Factor: _____ Number of Services *(if fixed format)*: _____
Logical Record Length: _____

Fixed Format ☐ Variable Format ☐

Computer Operating System: _____ Recording Format: ASCII ☐ EBCDIC ☐

PROVIDER DIRECTORY
MEDIA TYPE:
☐ IBM 3480/3480E Cartridge ☐ IBM 3490/3490E Cartridge
☐ CD-ROM/DVD ☐ DLT Tape IV
☐ Secure FTP

Number of Media: _____ Number of Records: _____
Blocking Factor: _____ Logical Record Length: _____

Computer Operating System: _____ Recording Format: ASCII ☐ EBCDIC ☐

PHARMACY SERVICES
MEDIA TYPE:
☐ IBM 3480/3480E Cartridge ☐ IBM 3490/3490E Cartridge
☐ CD-ROM/DVD ☐ DLT Tape IV
☐ Secure FTP

Number of Media: _____ Number of Prescriptions:_____
Blocking Factor: _____ Logical Record Length:_____

Computer Operating System: _____ Recording Format: ASCII ☐ EBCDIC ☐

INSTITUTIONAL SERVICES ☐ IBM 3480/3480E Cartridge ☐ IBM 3490/3490E Cartridge
MEDIA TYPE: ☐ CD-ROM/DVD ☐ DLT Tape IV
☐ Secure FTP

Number of Media: _____ Number of Claims: _____
Blocking Factor: _____ Logical Record Length: _____
Computer Operating System: _____ Recording Format: ASCII ☐ EBCDIC ☐

ELIGIBILITY FILE ☐ IBM 3480/3480E Cartridge ☐ IBM 3490/3490E Cartridge
MEDIA TYPE: ☐ CD-ROM/DVD ☐ DLT Tape IV
☐ Secure FTP

Number of Media: _____ Number of Enrollee Months: _____
Blocking Factor: _____ Logical Record Length: _____
Computer Operating System: _____ Recording Format: ASCII ☐ EBCDIC ☐

DENTAL SERVICES ☐ IBM 3480/3480E Cartridge ☐ IBM 3490/3490E Cartridge
MEDIA TYPE: ☐ CD-ROM/DVD ☐ DLT Tape IV
☐ Secure FTP

Number of Media: _____ Number of Claims: _____
Blocking Factor: _____ Logical Record Length: _____
Computer Operating System: _____ Recording Format: ASCII ☐ EBCDIC ☐

DATA SUBMISSION SOURCE SYSTEM

Please identify the **Source System** (platforms or business units) from which the data was obtained by using an alphabet letter indicating which system each letter represents. Leave the field **blank** if submitting data from **one (1) platform or business unit only.**

(Note: This information will allow the data base contractor to more efficiently identify the source of problems in a payor's submission.)

Label	**Source System** *(platform or business unit)*
A	
B	
C	
D	
E	

(Note: If using the Secure File Transfer Process (SFTP), please provide documentation with your SFTP transmission. If submitting a physical media please provide an electronic version of this documentation with the required keyable pages submission.)

Please forward physical media and accompanying documentation to:

Mr. Adrien Ndikumwami • Social & Scientific Systems, Inc. • 8757 Georgia Avenue, 12th Floor • Silver Spring, MD 20910

MARYLAND HEALTH CARE COMMISSION

SECTION II

PROFESSIONAL SERVICES DATA REPORT

- DATA SUBMISSION DOCUMENTATION
- FILE LAYOUT
- DATA DICTIONARY

FORMATTED FOR THE 2014 MARYLAND MEDICAL CARE DATA BASE (MCDB) SUBMISSION

PROFESSIONAL SERVICES FILE – Data Submission Documentation

1. SERVICE THRU DATE Frequency [Excel worksheet – ProfServ_Services_thru_Date]

Please complete the table below using the month and year segments for **Service Thru Date** (data element number 30 on the Professional Services **fixed** file layout). If the Service Thru Date is not reported, then assume that the Service From Date (data element number 29) and the Service Thru Date are the same. This table will provide an assessment of your data submission.

Service Thru Date Month/Year	# Services
First Quarter	
Jan 2014	
Feb 2014	
Mar 2014	
Second Quarter	
Apr 2014	
May 2014	
Jun 2014	

Service Thru Date Month/Year	# Services
Third Quarter	
Jul 2014	
Aug 2014	
Sept 2014	
Fourth Quarter	
Oct 2014	
Nov 2014	
Dec 2014	

A. Is this service volume distribution consistent with your experience?

☐ Yes ☐ **If no**, please explain _____

2. Homegrown Procedure Codes/Capitation Questions
[Excel worksheet – ProfServ_Homegrown_Capitation]

A. Does this data submission include homegrown procedure codes*?

☐ No ☐ **If yes**, please provide in a separate electronic file a list of codes and definitions applicable to this submission.

** Note: Submissions that do not meet the 95% threshold for this variable will be returned unless the payor has obtained a waiver.*

* If your company is not a Staff Model Health Maintenance Organization (HMO), please answer the following:

B. What types of services in your data submission do not have payment information (billed charge, allowed amount, reimbursement amount) because they are capitated or reimbursed through a global contract with an intermediary organization?

	Health **M**aintenance **O**rganization		**P**referred **P**rovider **O**rganization
	Capitated	Global contract	Global contract
Primary Care	☐	☐	☐
Specialty Care	☐	☐	☐
Mental Health Services	☐	☐	☐
Physical Therapy Services	☐	☐	☐
Laboratory Services	☐	☐	☐
Radiology Services	☐	☐	☐
Optometry Services	☐	☐	☐
Other (specify) _____	☐	☐	☐

If a health maintenance organization (HMO) is not one of your product lines, and you are providing capitated services, please explain. (attach additional sheets if needed)

_____

C. Does your organization contract with an "external provider network" to serve your enrolled population in Maryland? [Excel worksheet – ProfServ_External_Prov_Network]

☐ No ☐ **If yes,** please indicate all networks under contract.

☐ ChoiceCare Network ☐ Integrated Health Plan, Inc. (IHP) ☐ PlanCare America

☐ Devin Health Services, Inc. ☐ MultiPlan Network ☐ United Healthcare

☐ First Health Network ☐ OneNet PPO Network ☐ UnitedHealthOne

☐ Galaxy Health Network ☐ PHCS PPO Network ☐ USA Health & Wellness Network

☐ Other (specify) _____

3. Anesthesia Services [Excel worksheet – ProfServ_Anesthesia]

Restrict to: CPT 00100-01999
99100-99140

Value	Service Unit Indicator	# Services	# Units
2	Anesthesia Time Units *		
8	Minutes of Anesthesia *		
1	Transportation (ambulance air or ground) miles		
3	Services		
4	Oxygen Units		
5	Units of Blood		
6	Allergy Tests		
7	Laboratory Tests		

** Note: For Anesthesia Services, we would expect the Service Unit Indicator to have a value of "2" or "8".*

A. Are base units included in the units field for these services?

☐ Yes ☐ No

B. Are anesthesia units associated with physical status modifiers counted when anesthesia payments are calculated?

(Physical status modifiers are used by some payors to compensate anesthesiology providers when the patient is very young, old, or frail. The modifiers are reported in the CPT modifier field.)

☐ Yes ☐ No

If yes, please supply the additional anesthesia units in the table below.

Physical Status Modifiers	**Anesthesia Units**
P1 – A normal healthy patient.	0
P2 – A patient with mild systemic disease.	
P3 – A patient with severe systemic disease.	
P4 – A patient with severe systemic disease that is a constant threat to life.	
P5 – A moribund patient who is not expected to survive without the operation.	
P6 – A declared brain-dead patient whose organs are being removed for donor purposes.	

PROFESSIONAL SERVICES DATA REPORT SUBMISSION – File Layout

This report details all fee-for-service and capitated encounters provided by health care practitioners and office facilities for the quarterly reporting period designated – First Quarter: January 1, 2014 through March 31, 2014; Second Quarter: April 1, 2014 through June 30, 2014; Third Quarter: July 1, 2014 through September 30, 2014; and Fourth Quarter: October 1, 2014 through December 31, 2014. Please provide information on all health care services provided to applicable insureds whether those services were provided by a practitioner or office facility located in-State or out-of-State.

*(Reminder: **Patient Liability** is calculated using these three financial fields: **Patient Deductible**, **Patient Coinsurance/Co-payment**, and **Other Patient Obligations**. Total Patient Liability **should equal the sum** of Patient Deductible + Patient Coinsurance/Co-payment + Other Patient Obligations.)*

Payors are permitted to submit the data in either of the following formats:

Option 1, FIXED FORMAT: (preferred)

Using the fixed format, it is possible that multiple services will be reported for each claim. Count each reported health care service even though documented on a single claim. The number of line items will always equal one (1) because one service is written per row.

FIXED FORMAT

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Start	End	Threshold
1.	Record Identifier	1	N		1	1	100%
2.	Patient Identifier**P** (payor encrypted)	12	A		2	13	100%
3.	Patient Identifier**U** (UUID encrypted)	12	A		14	25	
4.	Patient Year and Month of Birth (CCYYMM00)	8	N		26	33	99%/99%/ 100%('00')
5.	Patient Sex	1	N		34	34	99%
6.	Consumer Directed Health Plan (CDHP) with HSA or HRA Indicator	1	N		35	35	95%
7.	Patient Zip Code+4digit add-on code (include hyphen)	10	N		36	45	99%
8.	Patient Covered by Other Insurance Indicator	1	N		46	46	95%
9.	Coverage Type **Modified!**	1	A		47	47	99%
10.	Source Company	1	N		48	48	99%
11.	Claim Related Condition	1	N		49	49	
12.	Practitioner Federal Tax ID	9	A		50	58	100%
13.	Participating Provider Status	1	N		59	59	95%
14.	Record Status	1	A		60	60	95%
15.	Claim Control Number (Include on each record as this is the key to summarizing service detail to claim level)	23	A		61	83	95%
16.	Claim Paid Date (CCYYMMDD)	8	N		84	91	95%
17.	Number of Diagnosis Codes	2	N		92	93	
18.	Number of Line Items (always **= 01** for fixed format – see pg. 26)	2	N		94	95	
19.	Diagnosis Code 1 **Remove imbedded decimal points**	7	A		96	102	99%
20.	Diagnosis Code 2	7	A		103	109	
21.	Diagnosis Code 3	7	A		110	116	
22.	Diagnosis Code 4	7	A		117	123	
23.	Diagnosis Code 5	7	A		124	130	
24.	Diagnosis Code 6	7	A		131	137	
25.	Diagnosis Code 7	7	A		138	144	
26.	Diagnosis Code 8	7	A		145	151	
27.	Diagnosis Code 9	7	A		152	158	

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Start	End	Threshold
28.	Diagnosis Code 10	7	A		159	165	
29.	Service From Date (CCYYMMDD)	8	N		166	173	100%
30.	Service Thru Date* (CCYYMMDD)	8	N		174	181	100%*
31.	Place of Service	2	N		182	183	99%
32.	Service Location Zip Code +4digit add-on code (include hyphen)	10	A		184	193	95%
33.	Service Unit Indicator	1	N		194	194	95%
34.	Units of Service	3	N	1 implied**	195	197	95%
35.	Procedure Code	6	A		198	203	95%
36.	Modifier I (This field must be mapped – see pg. 28)	2	A		204	205	
37.	Modifier II (specific to Modifier I)	2	A		206	207	
38.	Servicing Practitioner ID	11	A		208	218	100%
39.	Billed Charge (line item amounts required – see pg. 95)	9	N		219	227	
40.	Allowed Amount (line item amounts required – see pg. 95)	9	N		228	236	
41.	Reimbursement Amount (line item amounts required – see pg. 95)	9	N		237	245	
42.	Date of Enrollment	8	N		246	253	99%
43.	Date of Disenrollment	8	N		254	261	99%
44.	Patient Deductible (line item amounts required – see pg. 95)	9	N		262	270	
45.	Patient Coinsurance or Patient Co-payment (line item amounts required – see pg. 95)	9	N		271	279	
46.	Other Patient Obligations (line item amounts required– see pg. 95)	9	N		280	288	
47.	Plan Liability	1	N		289	289	95%
48.	Servicing Practitioner Individual National Provider Identifier (NPI) number	10	A		290	299	95%
49.	Practitioner National Provider Identifier (NPI) number used for Billing	10	A		300	309	95%
50.	Product Type	1	N		310	310	95%
51.	Payor ID Number	4	A		311	314	100%
52.	Source System	1	A		315	315	
53.	Assignment of Benefits	1	A		316	316	100%
54.	Diagnosis Code Indicator	1	N		317	317	99%
55.	CPT Category II Code 1	5	A		318	322	
56.	CPT Category II Code 2	5	A		323	327	
57.	CPT Category II Code 3	5	A		328	332	

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Start	End	Threshold
58.	CPT Category II Code 4	5	A		333	337	
59.	CPT Category II Code 5	5	A		338	342	
60.	Reporting Quarter New!	1	N		343	343	

** If the Service thru Date is not reported, then assume that the Service from Date (data element #29) and the Service thru Date are the same. ** Implied decimal should only be used for anesthesia time units; all other units should be submitted as integers.*

The Professional Services data must link to the Pharmacy, Institutional Services, and Eligibility data by Encrypted Patient Identifier. Encryption of Patient ID must be consistent with encryption of Patient ID in the Pharmacy, Institutional Services, and Eligibility files.

PROFESSIONAL SERVICES DATA REPORT SUBMISSION – File Layout (cont.)

Option 2, VARIABLE FORMAT:

Count each reported service as a health care claim even though the claim may contain multiple services. For example, if a claim documents three (3) services then three (3) occurrences in the line item section must be reported.

*(Reminder: **Patient Liability** is calculated using these three financial fields: **Patient Deductible**, **Patient Coinsurance/Co-payment**, and **Other Patient Obligations**. Total Patient Liability **should equal the sum** of Patient Deductible + Patient Coinsurance/Co-payment + Other Patient Obligations.)*

VARIABLE FORMAT

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Occurs	Start	End	Threshold
1.	Record Identifier	1	N			1	1	100%
2.	Patient Identifier**P** (payor encrypted)	12	A			2	13	100%
3.	Patient Identifier**U** (UUID encrypted)	12	A			14	25	
4.	Patient Year and Month of Birth (CCYYMM00)	8	N			26	33	99%/99%/ 100%('00')
5.	Patient Sex	1	N			34	34	99%
6.	Consumer Directed Health Plan (CDHP) with HSA or HRA Indicator	1	N			35	35	95%
7.	Patient Zip Code+4digit add-on code (include hyphen)	10	N			36	45	99%
8.	Patient Covered by Other Insurance Indicator	1	N			46	46	95%
9.	Coverage Type **Modified!**	1	A			47	47	99%
10.	Source Company	1	N			48	48	99%
11.	Claim Related Condition	1	N			49	49	
12.	Practitioner Federal Tax ID	9	A			50	58	100%
13.	Participating Provider Status	1	N			59	59	95%
14.	Record Status	1	A			60	60	95%
15.	Claim Control Number (This is the key to summarizing service detail to claim level & must be included on each record.)	23	A			61	83	95%
16.	Claim Paid Date (CCYYMMDD)	8	N			84	91	95%
17.	Date of Enrollment	8	N			92	99	99%
18.	Date of Disenrollment	8	N			100	107	99%
19.	Number of Line Items (see pg. 26 for clarification)	2	N			108	109	
▸	**Items 20-40, 44-51 represent line items only. Repeat format 20-40, 44-51 for each additional line item.**	162			26	110		
20.	Number of Diagnosis Codes	2	N					
21.	Diagnosis Field will hold up to 10 diagnosis codes (Leave fields blank if not available.) **Remove imbedded decimal points**	7	A		10			99%
22.	Service From Date (CCYYMMDD)	8	N					100%
23.	Service Thru Date* (CCYYMMDD)	8	N					100%*
24.	Place of Service	2	N					99%

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Occurs	Start	End	Threshold
25.	Service Location Zip Code	10	A					95%
26.	Service Unit Indicator	1	N					95%
27.	Units of Service	3	N	1 implied**				95%
28.	Procedure Code	6	A					95%
29.	Modifier I (This field must be mapped – see pg. 28)	2	A					
30.	Modifier II (specific to Modifier I)	2	A					
31.	Servicing Practitioner ID	11	A					100%
32.	Billed Charge (line item amounts required – see pg. 95)	9	N					
33.	Allowed Amount (line item amounts required – see pg. 95)	9	N					
34.	Reimbursement Amount (line item amounts required – see pg. 95)	9	N					
35.	Patient Deductible (line item amounts required – see pg. 95)	9	N					
36.	Patient Coinsurance or Co-payment (line item amounts required – see pg. 95)	9	N					
37.	Other Patient Obligations (line item amounts required– see pg. 95)	9	N					
38.	Plan Liability	1	N					95%
39.	Servicing Practitioner Individual National Provider Identifier (NPI) number	10	A					95%
40.	Practitioner National Provider Identifier (NPI) number used for Billing	10	A					95%
41.	Product Type	1	N					95%
42.	Payor ID Number	4	A					100%
43.	Source System	1	A					
44.	Assignment of Benefits	1	A					100%
45.	Diagnosis Code Indicator	1	N					99%
46.	CPT Category II Code 1	5	A					
47.	CPT Category II Code 2	5	A					
48.	CPT Category II Code 3	5	A					
49.	CPT Category II Code 4	5	A					
50.	CPT Category II Code 5	5	A					
51.	Reporting Quarter **New!**	1	N					

(/** See notes page 22)*

Data Dictionary – PROFESSIONAL SERVICES DATA REPORT – COMAR 10.25.06.07

Field Name	Description	Field Contents
Record Identifier	The value is 1	**1 Professional Services**
Patient Identifier**P** (payor encrypted)	Patient's unique identification number assigned by payor and encrypted.	The unique ID for each person on this file should correspond to the same unique Patient ID used for all other files (Pharmacy Claims and Institutional Services)
Patient Identifier**U** (UUID encrypted)	Patient's universally unique identification (UUID) number generated using an encryption algorithm provided by MHCC.	Refer to the UUID summary description sheet on page 92. A full description is available in the UUID Users' Manual.
Patient Year and Month of Birth	Date of patient's birth using 00 instead of day.	CCYYMM00
Patient Sex	Sex of the patient.	1 Male 2 Female 3 Unknown
Consumer Directed Health Plan (CDHP) with HSA or HRA Indicator	Consumer Directed Health Plan (CDHP) with Health Savings Account (HSA) or Health Resources Account(HRA)	0 No 1 Yes
Patient Zip Code+4-digit add-on	Zip code of patient's residence.	5-digit US Postal Service code plus 4-digit add-on code.
Patient Covered by Other Insurance Indicator	Indicates whether patient has additional insurance coverage.	0 No 1 Yes, other coverage is primary 2 Yes, other coverage is secondary 9 Unknown
Coverage Type **Modified!**	Patient's type of insurance coverage.	1 Medicare Supplemental (i.e., Individual, Group, WRAP) 2 Medicare Advantage Plan 3 Individual Market (not MHIP; not sold in MHBE) 4 Maryland Health Insurance Plan (MHIP) 5 Private Employer Sponsored or Other Group (i.e. union or association plans) 6 Public Employee – Federal (FEHBP) 7 Public Employee – Other (state, county, local/municipal government and public school systems) 8 Comprehensive Standard Health Benefit Plan (not sold in MHBE) [a self employed individual or small businesses (public or private employers) with 2-50 eligible employees] 9 Health Insurance Partnership (HIP) A Student Health Plan B Individual Market sold in MHBE C Small Business Options Program (SHOP) sold in MHBE Z Unknown

Field Name	Description	Field Contents
Source Company	Defines the payor company that holds the beneficiary's contract; for use in characterizing contract requirements under Maryland law.	1 Health Maintenance Organization 2 Life & Health Insurance Company or Not-for-Profit Health Benefit Plan 3 Third-Party Administrator (TPA) Unit
Claim Related Condition	Describes connection, if any, between patient's condition and employment, automobile accident, or other accident.	0 Non-accident (default) 1 Work 2 Auto Accident 3 Other Accident 9 Unknown
Practitioner Federal Tax ID	Employer Tax ID of the practitioner, practice or office facility receiving payment for services.	
Participating Provider Status	Indicates if the service was provided by a provider that participates in the payor's network.	1 Participating 2 Non-Participating 3 Unknown/Not Coded 9 No Network for this Plan
Record Status	Describes payment and adjustment status of a claim. Adjustments include paying a claim more than once, paying additional services that may have been denied, or crediting a provider due to overpayment or paying the wrong provider.	1 Final Bill 8 Capitated or Global Contract Services
Claim Control Number	Internal payor claim number used for tracking.	A credit should have the same claim number as the original debit record.
Claim Paid Date	The date a claim was authorized for payment.	CCYYMMDD
Number of Diagnosis Codes	The number of diagnosis codes, up to ten.	1 through 10. Maximum is 10.
Number of Line Items	If using **Variable Format**, the # of line items completed in the variable portion (data elements 20-40, 44-51) must match the value entered for this data element, maximum value for this data and # of line items is 26. If using **Fixed Format**, the number of line items is always equal to one (1) because only one service is written per row.	

Field Name	Description	Field Contents
Diagnosis Codes	The primary ICD-9-CM or ICD-10-CM Diagnosis Code followed by a secondary diagnosis (up to 9 codes), if applicable at time of service. **Remove embedded decimal point.**	
Service From Date	First date of service for a procedure in this line item.	CCYYMMDD
Service Thru Date	Last date of service for this line item.	CCYYMMDD
Place of Service	Two-digit numeric code that describes where a service was rendered.	**CMS definitions:** 11 Provider's Office 12 Patient's Home 13 Assisted Living Facility 17 Walk-in Retail Health Clinic 18 Place of Employment - Worksite 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room – Hospital 24 Ambulatory Surgical Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance – Land 42 Ambulance – Air or Water 51 Inpatient Psychiatric Facility 52 Psychiatric Facility – Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 57 Non-residential Substance Abuse Treatment Facility 60 Mass Immunization Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End-Stage Renal Disease Treatment Facility 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory & Imaging 99 Other Place of Service

Field Name	Description	Field Contents
Service Location Zip Code+4-digit add-on	Zip code for location where service described was provided.	5-digit US Postal Service code plus 4-digit add-on code
Service Unit Indicator	Category of service as it corresponds to Units data element.	0 Values reported as zero (no allowed services) 1 Transportation (ambulance air or ground) Miles 2 Anesthesia Time Units 3 Services 4 Oxygen Units 5 Units of Blood 6 Allergy Tests 7 Lab Tests 8 Minutes of Anesthesia (waiver required)
Units of Service	Quantity of services or number of units for a service or minutes of anesthesia.	One (1) implied decimal for anesthesia time units; all other units submit as integers.
Procedure Code	Describes the health care service provided (i.e., CPT-4, HCPCS, ICD-9-CM, ICD-10-CM)	
Modifier I	Discriminate code used by practitioners to distinguish that a health care service has been altered [by a specific condition] but not changed in definition or code. A modifier is added as a suffix to a procedure code field.	MHCC accepts national standard modifiers approved by the American Medical Association as published in the 2008 Current Procedure Terminology. Modifiers approved for Hospital Outpatient use: Level I (CPT) and Level II (HCPCS/National) modifiers. Nurse Anesthetist services are to be reported using the following Level II (HCPCS) modifiers: • **QX** – Nurse Anesthetist service; under supervision of a doctor • **QZ** – Nurse Anesthetist service; w/o the supervision of a doctor
Modifier II	Specific to Modifier I.	
Servicing Practitioner ID	Payor-specific identifier for the practitioner rendering health care service(s).	
Billed Charge	A practitioner's billed charges rounded to whole dollars. **DO NOT USE DECIMALS**	
Allowed Amount	Total patient and payor liability. **DO NOT USE DECIMALS**	
Reimbursement Amount	Amount paid to Employer Tax ID # of rendering physician as listed on claim. **DO NOT USE DECIMALS**	

Field Name	Description	Field Contents
Date of Enrollment	The first day of the reporting period the patient is in this delivery system (in this data submission time period). (see Source Company on page 26)	CCYYMMDD Date is the first day of the reporting period if patient is enrolled at that time. Enter other date if patient **not enrolled** at start of reporting period, but enrolled during reporting period.
Date of Disenrollment	The end date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 26)	CCYYMMDD **Leave blank** if patient is still enrolled on the last day of the reporting period. If patient disenrolled before end of reporting period enter date disenrolled.
Patient Deductible	The fixed amount that the patient must pay for covered medical services before benefits are payable. **DO NOT USE DECIMALS**	
Patient Coinsurance or Patient Co-payment	The specified amount or percentage the patient is required to contribute towards covered medical services after any applicable deductible. **DO NOT USE DECIMALS**	
Other Patient Obligations	Any patient obligations other than the deductible or coinsurance/co-payment. This could include obligations for out-of-network care (balance billing net of patient deductible, patient coinsurance/co-payment and payor reimbursement), non-covered services, or penalties. **DO NOT USE DECIMALS**	
Plan Liability	Indicates if insurer is at risk for the patient's service use or the insurer is simply paying claims as Administrative Services Only (ASO)	1 Risk (under Maryland contract) 2 Risk (under non-Maryland contract) 3 ASO (employer self-insured)
Servicing Practitioner Individual National Provider Identifier (NPI) number	Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf
Practitioner National Provider Identifier (NPI) number used for Billing.	Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner or an organization for billing purposes.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf

Field Name	Description	Field Contents
Product Type	Classifies the benefit plan by key product characteristics (scope of coverage, size of network, coverage for out-of-network benefits). (Please code based on how the product is primarily marketed, and most importantly be consistent from year to year. If not sure, send an e-mail describing the product to Larry Monroe at larry.monroe@maryland.gov)	1 Exclusive Provider Organization (in any form) 2 Health Maintenance Organization 3 Indemnity 4 Point of Service (POS) 5 Preferred Provider Organization (PPO) 6 Limited Benefit Plan (Mini-Meds) 7 Student Health Plan 8 Catastrophic
Payor ID Number	Payor assigned submission identification number.	
Source System	Identify the source system (platforms or business units) *from which the data was obtained* by using an alphabet letter (A, B, C, D, etc…) (Note: In your documentation on page 15, please be sure to list the source system that corresponds with the letter assigned.) For payors with all data coming from one system only, leave the field blank.	A – Z Leave the field **blank** if submitting data from **one (1)** platform or business unit only.
Assignment of Benefits Indicator	For out-of-network services please provide information on whether or not the patient assigned benefits to the servicing physician for an out-of-network service.	0 No, Assignment of Benefits not accepted and Practitioner Not in Network 1 Yes, Assignment of Benefits Accepted and Practitioner Not in Network 2 N/A, Practitioner is In Network 9 Unknown
Diagnosis Code Indicator	Indicates the volume of the International Classification of Diseases, Clinical Modification system used in assigning codes to diagnoses.	1 ICD-9-CM 2 ICD-10-CM 3 Missing/Unknown
CPT Category II code 1	Provide any applicable CPT Category II codes.	
CPT Category II code 2		
CPT Category II code 3		
CPT Category II code 4		
CPT Category II code 5		
Reporting Quarter **New!**	Indicate the quarter number for which the data is being submitted.	1 First Quarter = January 1 thru March 31 2 Second Quarter = April 1 thru June 30 3 Third Quarter = July 1 thru September 30 4 Fourth Quarter = October 1 thru December 31

MARYLAND HEALTH CARE COMMISSION

SECTION III

PHARMACY SERVICES DATA REPORT

- DATA SUBMISSION DOCUMENTATION
- FILE LAYOUT
- DATA DICTIONARY

FORMATTED FOR THE 2014 MARYLAND MEDICAL CARE DATA BASE (MCDB) SUBMISSION

PHARMACY FILE – Data Submission Documentation

1. Date Filled Frequency (Pharmacy) [Excel worksheet – Pharmacy_Date_Filled]

Please complete the table below using the quarter and month segments for **Date Filled** (data element number 15 on the file layout). This table will provide an assessment of your data submission.

Quarter/Month	# Prescriptions
First Quarter	
Jan 2014	
Feb 2014	
Mar 2014	
Second Quarter	
Apr 2014	
May 2014	
Jun 2014	

Month	# Prescriptions
Third Quarter	
Jul 2014	
Aug 2014	
Sep 2014	
Fourth Quarter	
Oct 2014	
Nov 2014	
Dec 2014	

2. Mail Order Pharmacy Information [Excel worksheet – Pharmacy_Mail_Order]

Mail Order Pharmacy NCPDP#	Name of Pharmacy

Note: *Attach additional sheets if needed or provide a separate electronic file.*

PHARMACY DATA REPORT SUBMISSION – File Layout

This report details all prescription drug encounters for your enrollees for the quarterly reporting period designated – First Quarter: January 1, 2014 through March 31, 2014; Second Quarter: April 1, 2014 through June 30, 2014; Third Quarter: July 1, 2014 through September 30, 2014; and Fourth Quarter: October 1, 2014 through December 31, 2014. Please provide information on all pharmacy services provided to applicable insureds whether the services were provided by a pharmacy located in-State or out-of-State. **Do not include pharmacy supplies or prosthetics.**

COMAR 10.25.06 specifies the Pharmacy Data Report be submitted separately from the Professional Services Data Report.

*(Reminder: **Patient Liability** is calculated using these three financial fields: **Patient Deductible**, **Patient Coinsurance/Co-payment**, and **Other Patient Obligations**. Total Patient Liability **should equal the sum** of Patient Deductible + Patient Coinsurance/Co-payment + Other Patient Obligations.)*

File Layout for the Pharmacy Data Report is a 211 byte **fixed format.** The file layout is as follows:

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Start	End	Threshold
1.	Record Identifier	1	N		1	1	100%
2.	Patient Identifier**P** (payor encrypted)	12	A		2	13	100%
3.	Patient Identifier**U** (UUID encrypted)	12	A		14	25	
4.	Patient Sex	1	N		26	26	99%
5.	Patient Zip Code +4digit add-on code (include hyphen)	10	N		27	36	99%
6.	Patient Year and Month of Birth (CCYYMM00)	8	N		37	44	99%/99%/ 100%('00')
7.	Pharmacy NCPDP Number **(left justified)**	7	N		45	51	100%
8.	Pharmacy Zip Code +4digit add-on code (include hyphen) (location where prescription was filled and dispensed)	10	N		52	61	95%
9.	Practitioner DEA # (left justified; for many payors the last 2 positions on the right will be blank)*	11	A		62	72	99%
10.	Fill Number	2	N		73	74	
11.	NDC Number	11	N		75	85	100%
12.	Drug Compound	1	N		86	86	
13.	Drug Quantity	5	N		87	91	99%
14.	Drug Supply	3	N		92	94	99%
15.	Date Filled (CCYYMMDD)	8	N		95	102	100%/95%/ 95%
16.	Date Prescription Written (CCYYMMDD)	8	N		103	110	
17.	Billed Charge (line item amounts required – see pg. 95)	9	N	2	111	119	
18.	Reimbursement Amount (line item amounts required – see pg. 95)	9	N	2	120	128	
19.	Prescription Claim Number	15	N		129	143	
20.	Prescription Claim Paid Date (CCYYMMDD)	8	N		144	151	95%
21.	Prescribing Practitioner Individual National Provider Identifier (NPI)#	10	A		152	161	95%

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Start	End	Threshold
22.	Patient Deductible (line item amounts required – see pg. 95)	9	N	2	162	170	
23.	Patient Coinsurance or Patient Co-payment (line item amounts required – see pg. 95)	9	N	2	171	179	
24.	Other Patient Obligations (line item amounts required – see pg. 95)	9	N	2	180	188	
25.	Date of Enrollment	8	N		189	196	95%
26.	Date of Disenrollment	8	N		197	204	95%
27.	Source of Processing	1	A		205	205	100%
28.	Payor ID Number	4	A		206	209	100%
29.	Source System	1	A		210	210	
30.	Reporting Quarter **New!**	1	N		211	211	

** Please note which of the following you are using to link the Pharmacy Data Report with the Provider Directory Report:*

☐ DEA (Drug Enforcement Agency) # ☐ Other (exception waiver from MHCC required)

The Pharmacy data must link to Professional Services, Institutional Services, and Eligibility data by Encrypted Patient Identifier. Encryption of Patient ID must be consistent with encryption of Patient ID in Professional Services, Institutional Services, and Eligibility files. MHCC will return files that do not link.

Data Dictionary – PHARMACY DATA REPORT – COMAR 10.25.06.08

Field Name	Description	Field Contents
Record Identifier	The value is 2	**2 Pharmacy Services**
Patient Identifier**P** (payor encrypted)	Patient's unique identification number assigned by payor and encrypted.	The unique ID for each person on this file should correspond to the same unique Patient ID used for all other files (Professional Services and Institutional Services)
Patient Identifier**U** (UUID encrypted)	Patient's universally unique identification (UUID) number generated using an encryption algorithm provided by MHCC.	Refer to the UUID summary description sheet on page 92. A full description is available in the UUID Users' Manual.
Patient Sex	Sex of Patient.	1 Male 2 Female 3 Unknown
Patient Zip Code+4-digit add-on	Zip code of patient's residence.	5-digit US Postal Service code plus 4-digit add-on code.
Patient Year and Month of Birth	Date of patient's birth using 00 instead of day.	CCYYMM00
Pharmacy NCPDP Number	Unique 7 digit number assigned by the National Council for Prescription Drug Program (NCPDP).	
Pharmacy Zip Code+4-digit add-on	Zip code of pharmacy where prescription was filled and dispensed.	5-digit US Postal Service code plus 4-digit add-on code.
Practitioner DEA #	Drug Enforcement Agency number assigned to an individual registered under the Controlled Substance Act.	Same as DEA # in Provider File.
Fill Number	The code used to indicate if the prescription is an original prescription or a refill. Use '01' for all refills if the specific number of the prescription refill is not available.	00 New prescription/Original 01 – 99 Refill number
NDC Number	National Drug Code 11 digit number.	
Drug Compound	Indicates a mix of drugs to form a compound medication.	1 Non-compound 2 Compound
Drug Quantity	Number of units of medication dispensed.	
Drug Supply	Estimated number of days of dispensed supply.	
Date Filled	Date prescription was filled.	CCYYMMDD

Field Name	Description	Field Contents
Date Prescription Written	Date prescription was written.	CCYYMMDD
Billed Charge	Retail amount for drug including dispensing fees and administrative costs. **MUST INCLUDE 2 IMPLIED DECIMAL PLACES.**	
Reimbursement Amount	Amount paid to the pharmacy by payor. Do not include patient copayment or sales tax. **MUST INCLUDE 2 IMPLIED DECIMAL PLACES.**	
Prescription Claim Number	Internal payor claim number used for tracking.	A credit should have the same claim number as the original debit record.
Prescription Claim Paid Date	The date a claim was authorized for payment.	CCYYMMDD
Prescribing Practitioner Individual National Provider Identifier (NPI) number	Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf
Patient Deductible	The fixed amount that the patient must pay for covered pharmacy services before benefits are payable. **MUST INCLUDE 2 IMPLIED DECIMAL PLACES.**	
Patient Coinsurance/ Patient Co-payment	The specified amount or percentage the patient is required to contribute towards covered pharmacy services after any applicable deductible. **MUST INCLUDE 2 IMPLIED DECIMAL PLACES.**	
Other Patient Obligations	Any patient obligations other than the deductible or coinsurance/co-payment. This could include obligations for non-formulary drugs, non-covered pharmacy services, or penalties. **MUST INCLUDE 2 IMPLIED DECIMAL PLACES.**	
Date of Enrollment	The first day of the reporting period the patient is in this delivery system (in this data submission time period). (see Source Company on page 26)	CCYYMMDD Date is the first day of the reporting period if patient is enrolled at that time. Enter other date if patient **not enrolled** at start of reporting period, but enrolled during reporting period.
Date of Disenrollment	The end date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 26)	CCYYMMDD **Leave blank** if patient is still enrolled on the last day of the reporting period. If patient disenrolled before end of reporting period enter date disenrolled.

Field Name	Description	Field Contents
Source of Processing	The source processing the pharmacy claim.	1 Processed Internally by Payor 2 Argus Health Systems, Inc. 3 Caremark, LLC 4 Catalyst Rx, Inc. 5 Envision Pharmaceutical Services, Inc. 6 Express Scripts, Inc. 7 Medco Health, LLC 8 National Employee Benefit Companies, Inc. dba/Ideal Scripts 9 NextRx Services, Inc. A Atlantic Prescription Services, LLC B Benecard Services, Inc. C BioScrip PBM Services, LLC D Futurescripts, LLC E Health E Systems F HealthTran, LLC G Innoviant, Inc. H MaxorPlus I Medical Security Card Company J MedImpact Healthcare Systems, Inc. K MemberHealth, LLC L PharmaCare Management Services, LLC M Prime Therapeutics, LLC N Progressive Medical, Inc. O RxAmerica, LLC P RxSolutions, Inc. Q Scrip World, LLC R Tmesys, Inc. S WellDynerx, Inc. T Other Source Not Listed Z Unknown
Payor ID Number	Payor assigned submission identification number.	
Source System	Identify the source system (platforms or business units) *from which the data was obtained* by using an alphabet letter (A, B, C, D, etc…) (Note: In your documentation on page 15, please be sure to list the source system that corresponds with the letter assigned.)	A – Z Leave the field **blank** if submitting data from **one (1)** platform or business unit only.
Reporting Quarter **New!**	Indicate the quarter number for which the data is being submitted.	1 First Quarter = January 1 thru March 31 2 Second Quarter = April 1 thru June 30 3 Third Quarter = July 1 thru September 30 4 Fourth Quarter = October 1 thru December 31

MARYLAND HEALTH CARE COMMISSION

SECTION IV

PROVIDER DIRECTORY REPORT

- FILE LAYOUT
- DATA DICTIONARY

FORMATTED FOR THE 2014 MARYLAND MEDICAL CARE DATA BASE (MCDB) SUBMISSION

PROVIDER DIRECTORY REPORT SUBMISSION – File Layout

This report details all health care Practitioners *(including other health care professionals, dental/vision services covered under a general health benefit plan, and office facilities)* and Suppliers that provided services to your enrollees for the reporting period designated – First Quarter Reporting: January 1, 2014 through March 31, 2014; Second Quarter Reporting: April 1, 2014 through June 30, 2014; Third Quarter Reporting: July 1, 2014 through September 30, 2014; Fourth Quarter Reporting: October 1, 2014 through December 31, 2014. Please provide information for all in-State Maryland practitioners/suppliers and all out-of-State practitioners/suppliers serving applicable insureds.

File Layout for the Provider Directory Report is a 149 byte **fixed format.** The file layout is as follows:

	Field Name	Length	Type A= alphanumeric N=numeric	Dec	Start	End	Threshold
1.	Record Identifier	1	N		1	1	100%
2.	Practitioner/Supplier ID (payor encrypted)	11	A		2	12	100%
3.	Practitioner/Supplier Federal Tax ID (without embedded dashes)	9	A		13	21	100%
4.	Practitioner/Supplier Last Name or Multi-practitioner Health Care Organization (Truncate if over 31 characters)	31	A		22	52	99%
5.	Practitioner/Supplier First Name	19	A		53	71	99%
6.	Practitioner Middle Initial	1	A		72	72	
7.	Practitioner Name Suffix	4	A		73	76	
8.	Practitioner Credential	5	A		77	81	
9.	Practitioner/Supplier Specialty – 1*	10	A		82	91	100%*
10.	Practitioner/Supplier Specialty – 2*	10	A		92	101	
11.	Practitioner/Supplier Specialty – 3*	10	A		102	111	
12.	Practitioner DEA #	11	A		112	122	99%
13.	Indicator for Multi-Practitioner Health Care Organization	1	A		123	123	99%
14.	Practitioner Individual National Provider Identifier (NPI) number	10	A		124	133	
15.	Practitioner Organizational National Provider Identifier (NPI) number	10	A		134	143	
16.	Payor ID Number	4	A		144	147	100%
17.	Source System	1	A		148	148	
18.	Reporting Quarter **New!**	1	N		149	149	

REMINDERS !!!

- Use specific (separate) fields for practitioner First Name and Last Name.
- Confirm **Practitioner/Supplier ID #** matches **Servicing Practitioner ID #** in the Professional Services and Dental Services File Layouts. Confirm **Practitioner DEA #** matches **Practitioner DEA #** in the Pharmacy File Layout.
- If the practice is a Multi-Practitioner Health Care Organization, then **Practitioner Organizational NPI #** (data element #15) should be filled.
- * Note: If the Practitioner Individual NPI (field #14) or the Practitioner Organizational NPI numbers (field #15) are not provided, then the Practitioner Specialty code (field #9) must be filled using the NUCC Health Care Provider Taxonomy codes available at: http://mhcc.dhmh.maryland.gov/payercompliance/Documents/Taxonomy_13_0.pdf
- If a payor requests to provide internal practitioner specialty coding, then a crosswalk of the internal practitioner specialty codes to the appropriate taxonomy specialty codes must be provided.

Data Dictionary – PROVIDER DIRECTORY REPORT – COMAR 10.25.06.09

Field Name	Description	Field Contents
Record Identifier	The value is 3	**3 Provider Services**
Practitioner/Supplier ID	Payor-specific identifier for a practitioner, practice, or office facility rendering health care service(s).	
Practitioner/Supplier Federal Tax ID (without embedded dashes)	Employer Tax ID # of the practitioner, practice or office facility receiving payment for services.	Same as Federal Tax ID # in Professional Services and Dental Services File.
Practitioner/Supplier Last Name or Multi-practitioner Health Care Organization	Last name of practitioner or complete name of multi-practitioner health care organization.	**Please truncate if name of practitioner or medical organization exceeds 31 characters.**
Practitioner/Supplier First Name	Practitioner's first name.	Individual provider's first name.
Practitioner Middle Initial		First letter of individual provider's middle name.
Practitioner Name Suffix		Individual provider's name suffix, such as Jr., Sr., II, III, IV, or V.
Practitioner Credential		Abbreviations for professional degrees or credentials used or held by an individual provider, such as MD, DDS, CSW, CNA, AA, NP, PSY.
Practitioner/Supplier Specialty – 1 Practitioner/Supplier Specialty – 2 Practitioner/Supplier Specialty – 3	The health care field in which a practitioner is licensed, certified, or otherwise authorized under Health Occupations Article, Annotated Code of Maryland, to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program. Up to 3 codes may be listed.	Please reference the National Uniform Claim Committee (NUCC) Health Care Provider Taxonomy, Version 13.0, January 2013 Code Book available on the MHCC website at: http://mhcc.dhmh.maryland.gov/payercompliance/Documents/Taxonomy_13_0.pdf
Practitioner DEA #	Drug Enforcement Agency number assigned to an individual registered under the Controlled Substance Act.	Same as DEA# in Pharmacy File.
Indicator for Multi-Practitioner Health Care Organization		0 Solo Practitioner 1 Multiple Practitioners

Field Name	Description	Field Contents
Practitioner Individual National Provider Identifier (NPI) number	Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf
Practitioner Organizational National Provider Identifier (NPI) number	Federal identifier assigned by the federal government for use in all HIPAA transactions to an organization for billing purposes.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf
Payor ID Number	Payor assigned submission identification number.	
Source System	Identify the source system (platforms or business units) *from which the data was obtained* by using an alphabet letter (A, B, C, D, etc…) (Note: In your documentation on page 15, please be sure to list the source system that corresponds with the letter assigned.) For payors with all data coming from one system only, leave the field blank.	A – Z Leave the field **blank** if submitting data from **one (1)** platform or business unit only.
Reporting Quarter **New!**	Indicate the quarter number for which the data is being submitted.	1 First Quarter = January 1 thru March 31 2 Second Quarter = April 1 thru June 30 3 Third Quarter = July 1 thru September 30 4 Fourth Quarter = October 1 thru December 31

MARYLAND HEALTH CARE COMMISSION

SECTION V

INSTITUTIONAL SERVICES DATA REPORT

- DATA SUBMISSION DOCUMENTATION
- FILE LAYOUT
- DATA DICTIONARY

FORMATTED FOR THE 2014 MARYLAND MEDICAL CARE DATA BASE (MCDB) SUBMISSION

INSTITUTIONAL SERVICES FILE – Data Submission Documentation

1. DATE OF DISCHARGE or END OF SERVICE Frequency
[Excel worksheet – InstServ_Date_Discharge]

Please complete the table below using the quarter and month segments for **Date of Discharge or End of Service** (data element number 20 on the Institutional Services file layout). If the Date of Discharge or End of Service date is not reported, then assume that the Date of Admission or Start of Service (data element number 19) and the Date of Discharge or End of Service are the same. This table will provide an assessment of your data submission.

Quarter/Month	# Hospital Inpatient Discharges	# Hospital Outpatient / Non-Hospital Visits	Quarter/Month	# Hospital Inpatient Discharges	# Hospital Outpatient / Non-Hospital Visits
First Quarter			Third Quarter		
Jan 2014			Jul 2014		
Feb 2014			Aug 2014		
Mar 2014			Sept 2014		
Second Quarter			Fourth Quarter		
Apr 2014			Oct 2014		
May 2014			Nov 2014		
Jun 2014			Dec 2014		

A. Is this service volume distribution consistent with your experience?

☐ Yes ☐ **If no**, please explain _____

INSTITUTIONAL SERVICES DATA REPORT SUBMISSION – File Layout

This report details all institutional health care services *(including hospital inpatient, outpatient, and emergency department services)* provided to your enrollees quarterly reporting period designated – First Quarter: January 1, 2014 through March 31, 2014; Second Quarter: April 1, 2014 through June 30, 2014; Third Quarter: July 1, 2014 through September 30, 2014; and Fourth Quarter: October 1, 2014 through December 31, 2014. Please provide information on all institutional services provided to applicable insureds whether by a health care facility located in-State or out-of-State.

*(Reminder: **Patient Liability** is calculated using these three financial fields: **Patient Deductible**, **Patient Coinsurance/Co-payment**, and **Other Patient Obligations**. Total Patient Liability **should equal the sum** of Patient Deductible + Patient Coinsurance/Co-payment + Other Patient Obligations.)*

This summary record should reflect all charges and payments from an interim or final claim. To avoid sending duplicate charges and payments, submit summaries from interim claims only when a final claim does not exist for a visit or stay.

	Field Name	Length	Type A= alphanumeric N=numeric	Dec	Start	End	Threshold
1.	Record Identifier	1	N		1	1	100%
2.	Patient Identifier**P** (payor encrypted)	12	A		2	13	100%
3.	Patient Identifier**U** (UUID encrypted)	12	A		14	25	
4.	Patient Year and Month of Birth (CCYYMM00)	8	N		26	33	99% /99%/ 100%('00')
5.	Patient Sex	1	N		34	34	99%
6.	Patient Zip Code +4digit add-on code (include hyphen)	10	N		35	44	99%
7.	Date of Enrollment	8	N		45	52	99%
8.	Date of Disenrollment	8	N		53	60	99%
9.	Hospital/Facility Federal Tax ID	9	A		61	69	100%
10.	Hospital/Facility National Provider Identifier (NPI) Number	10	A		70	79	95%
11.	Hospital/Facility Medicare Provider Number	6	A		80	85	
12.	Hospital/Facility Participating Provider Flag	1	N		86	86	95%
13.	Claim Control Number (This is the key to summarizing service detail to claim level & must be included on each record.)	23	A		87	109	95%
14.	Claim Paid Date (CCYYMMDD)	8	N		110	117	95%
15.	Record Type	2	N		118	119	
16.	Type of Admission	1	N		120	120	95%
17.	Point of Origin for Admission or Visit	1	N		121	121	95%
18.	Patient Discharge Status	2	N		122	123	
19.	Date of Admission or Start of Service	8	N		124	131	99%
20.	Date of Discharge or End of Service*	8	N		132	139	99%*
21.	Diagnosis Code Indicator	1	N		140	140	
22.	Primary Diagnosis **Remove embedded decimal points**	7	A		141	147	99%
23.	Primary Diagnosis present on Admission	1	A		148	148	
24.	Other Diagnosis Code 1	7	A		149	155	

	Field Name	Length	Type A= alphanumeric N=numeric	Dec	Start	End	Threshold
25.	Other Diagnosis Code 1 present on Admission 1	1	A		156	156	
26.	Other Diagnosis Code 2	7	A		157	163	
27.	Other Diagnosis Code 2 present on Admission 2	1	A		164	164	
28.	Other Diagnosis Code 3	7	A		165	171	
29.	Other Diagnosis Code 3 present on Admission 3	1	A		172	172	
30.	Other Diagnosis Code 4	7	A		173	179	
31.	Other Diagnosis Code 4 present on Admission 4	1	A		180	180	
32.	Other Diagnosis Code 5	7	A		181	187	
33.	Other Diagnosis Code 5 present on Admission 5	1	A		188	188	
34.	Other Diagnosis Code 6	7	A		189	195	
35.	Other Diagnosis Code 6 present on Admission 6	1	A		196	196	
36.	Other Diagnosis Code 7	7	A		197	203	
37.	Other Diagnosis Code 7 present on Admission 7	1	A		204	204	
38.	Other Diagnosis Code 8	7	A		205	211	
39.	Other Diagnosis Code 8 present on Admission 8	1	A		212	212	
40.	Other Diagnosis Code 9	7	A		213	219	
41.	Other Diagnosis Code 9 present on Admission 9	1	A		220	220	
42.	Other Diagnosis Code 10	7	A		221	227	
43.	Other Diagnosis Code 10 present on Admission 10	1	A		228	228	
44.	Other Diagnosis Code 11	7	A		229	235	
45.	Other Diagnosis Code 11 present on Admission 11	1	A		236	236	
46.	Other Diagnosis Code 12	7	A		237	243	
47.	Other Diagnosis Code 12 present on Admission 12	1	A		244	244	
48.	Other Diagnosis Code 13	7	A		245	251	
49.	Other Diagnosis Code 13 present on Admission 13	1	A		252	252	
50.	Other Diagnosis Code 14	7	A		253	259	
51.	Other Diagnosis Code 14 present on Admission 14	1	A		260	260	
52.	Other Diagnosis Code 15	7	A		261	267	
53.	Other Diagnosis Code 15 present on Admission 15	1	A		268	268	
54.	Other Diagnosis Code 16	7	A		269	275	

	Field Name	Length	Type A= alphanumeric N=numeric	Dec	Start	End	Threshold
55.	Other Diagnosis Code 16 present on Admission 16	1	A		276	276	
56.	Other Diagnosis Code 17	7	A		277	283	
57.	Other Diagnosis Code 17 present on Admission 17	1	A		284	284	
58.	Other Diagnosis Code 18	7	A		285	291	
59.	Other Diagnosis Code 18 present on Admission 18	1	A		292	292	
60.	Other Diagnosis Code 19	7	A		293	299	
61.	Other Diagnosis Code 19 present on Admission 19	1	A		300	300	
62.	Other Diagnosis Code 20	7	A		301	307	
63.	Other Diagnosis Code 20 present on Admission 20	1	A		308	308	
64.	Other Diagnosis Code 21	7	A		309	315	
65.	Other Diagnosis Code 21 present on Admission 21	1	A		316	316	
66.	Other Diagnosis Code 22	7	A		317	323	
67.	Other Diagnosis Code 22 present on Admission 22	1	A		324	324	
68.	Other Diagnosis Code 23	7	A		325	331	
69.	Other Diagnosis Code 23 present on Admission 23	1	A		332	332	
70.	Other Diagnosis Code 24	7	A		333	339	
71.	Other Diagnosis Code 24 present on Admission 24	1	A		340	340	
72.	Other Diagnosis Code 25	7	A		341	347	
73.	Other Diagnosis Code 25 present on Admission 25	1	A		348	348	
74.	Other Diagnosis Code 26	7	A		349	355	
75.	Other Diagnosis Code 26 present on Admission 26	1	A		356	356	
76.	Other Diagnosis Code 27	7	A		357	363	
77.	Other Diagnosis Code 27 present on Admission 27	1	A		364	364	
78.	Other Diagnosis Code 28	7	A		365	371	
79.	Other Diagnosis Code 28 present on Admission 28	1	A		372	372	
80.	Other Diagnosis Code 29	7	A		373	379	
81.	Other Diagnosis Code 29 present on Admission 29	1	A		380	380	
82.	Attending Practitioner Individual National Provider Identifier (NPI) #	10	A		381	390	95%
83.	Operating Practitioner Individual National Provider Identifier (NPI) #	10	A		391	400	

	Field Name	Length	Type A= alphanumeric N=numeric	Dec	Start	End	Threshold
84.	Procedure Code Indicator	1	N		401	401	
85.	Principal Procedure Code 1	6	A		402	407	
86.	Procedure Code 1 Modifier I	2	A		408	409	
87.	Procedure Code 1 Modifier II	2	A		410	411	
88.	Other Procedure Code 2	6	A		412	417	
89.	Procedure Code 2 Modifier I	2	A		418	419	
90.	Procedure Code 2 Modifier II	2	A		420	421	
91.	Other Procedure Code 3	6	A		422	427	
92.	Procedure Code 3 Modifier I	2	A		428	429	
93.	Procedure Code 3 Modifier II	2	A		430	431	
94.	Other Procedure Code 4	6	A		432	437	
95.	Procedure Code 4 Modifier I	2	A		438	439	
96.	Procedure Code 4 Modifier II	2	A		440	441	
97.	Other Procedure Code 5	6	A		442	447	
98.	Procedure Code 5 Modifier I	2	A		448	449	
99.	Procedure Code 5 Modifier II	2	A		450	451	
100.	Other Procedure Code 6	6	A		452	457	
101.	Procedure Code 6 Modifier I	2	A		458	459	
102.	Procedure Code 6 Modifier II	2	A		460	461	
103.	Other Procedure Code 7	6	A		462	467	
104.	Procedure Code 7 Modifier I	2	A		468	469	
105.	Procedure Code 7 Modifier II	2	A		470	471	
106.	Other Procedure Code 8	6	A		472	477	
107.	Procedure Code 8 Modifier I	2	A		478	479	
108.	Procedure Code 8 Modifier II	2	A		480	481	
109.	Other Procedure Code 9	6	A		482	487	
110.	Procedure Code 9 Modifier I	2	A		488	489	
111.	Procedure Code 9 Modifier II	2	A		490	491	
112.	Other Procedure Code 10	6	A		492	497	
113.	Procedure Code 10 Modifier I	2	A		498	499	
114.	Procedure Code 10 Modifier II	2	A		500	501	
115.	Other Procedure Code 11	6	A		502	507	
116.	Procedure Code 11 Modifier I	2	A		508	509	
117.	Procedure Code 11 Modifier II	2	A		510	511	
118.	Other Procedure Code 12	6	A		512	517	
119.	Procedure Code 12 Modifier I	2	A		518	519	
120.	Procedure Code 12 Modifier II	2	A		520	521	
121.	Other Procedure Code 13	6	A		522	527	
122.	Procedure Code 13 Modifier I	2	A		528	529	
123.	Procedure Code 13 Modifier II	2	A		530	531	
124.	Other Procedure Code 14	6	A		532	537	
125.	Procedure Code 14 Modifier I	2	A		538	539	

	Field Name	Length	Type A= alphanumeric N=numeric	Dec	Start	End	Threshold
126.	Procedure Code 14 Modifier II	2	A		540	541	
127.	Other Procedure Code 15	6	A		542	547	
128.	Procedure Code 15 Modifier I	2	A		548	549	
129.	Procedure Code 15 Modifier II	2	A		550	551	
130.	Diagnosis Related Groups (DRGs) Number	3	A		552	554	
131.	DRG Grouper Name	1	N		555	555	
132.	DRG Grouper Version	2	N		556	557	
133.	Billed Charge	9	N		558	566	
134.	Allowed Amount	9	N		567	575	
135.	Reimbursement Amount	9	N		576	584	
136.	Total Patient Deductible	9	N		585	593	
137.	Total Patient Coinsurance or Patient Co-payment	9	N		594	602	
138.	Total Other Patient Obligations	9	N		603	611	
139.	Coordination of Benefit Savings or Other Payor Payments	9	N		612	620	
140.	Type of Bill	3	A		621	623	99%
141.	Patient Covered by Other Insurance Indicator	1	N		624	624	
142.	Payor ID Number	4	A		625	628	100%
143.	Source System	1	A		629	629	
144.	Revenue Code 1	4	N		630	633	95%
145.	Other Revenue Code 2	4	N		634	637	
146.	Other Revenue Code 3	4	N		638	641	
147.	Other Revenue Code 4	4	N		642	645	
148.	Other Revenue Code 5	4	N		646	649	
149.	Other Revenue Code 6	4	N		650	653	
150.	Other Revenue Code 7	4	N		654	657	
151.	Other Revenue Code 8	4	N		658	661	
152.	Other Revenue Code 9	4	N		662	665	
153.	Other Revenue Code 10	4	N		666	669	
154.	Other Revenue Code 11	4	N		670	673	
155.	Other Revenue Code 12	4	N		674	677	
156.	Other Revenue Code 13	4	N		678	681	
157.	Other Revenue Code 14	4	N		682	685	
158.	Other Revenue Code 15	4	N		686	689	

	Field Name	Length	Type A= alphanumeric N=numeric	Dec	Start	End	Threshold
159.	Other Revenue Code 16	4	N		690	693	
160.	Other Revenue Code 17	4	N		694	697	
161.	Other Revenue Code 18	4	N		698	701	
162.	Other Revenue Code 19	4	N		702	705	
163.	Other Revenue Code 20	4	N		706	709	
164.	Other Revenue Code 21	4	N		710	713	
165.	Other Revenue Code 22	4	N		714	717	
166.	Other Revenue Code 23	4	N		718	721	
167.	Reporting Quarter New!	1	N		722	722	

** If the Date of Discharge or End of Service (data element #20) is not reported, then assume that the Date of Admission or Start of Service (data element #19) and the Date of Discharge or End of Service are the same.*

The Institutional Services data must link to Professional Services, Pharmacy, and Eligibility data by Encrypted Patient Identifier.

Encryption of Patient ID must be consistent with encryption of Patient ID in Professional Services, Pharmacy, and Eligibility files.

MHCC will return files that do not link.

Data Dictionary – INSTITUTIONAL SERVICES DATA REPORT – COMAR 10.25.06.10

Field Name	Description	Field Contents
Record Identifier	The value is 4	**4 Institutional Services**
Patient Identifier**P** (payor encrypted)	Patient's unique identification number assigned by payor and encrypted.	The unique ID for each person on this file should correspond to the same unique Patient ID used for all other files (Professional Services and Pharmacy Claims Files).
Patient Identifier**U** (UUID encrypted)	Patient's universally unique identification (UUID) number generated using an encryption algorithm provided by MHCC.	Refer to the UUID summary description sheet on page 92. A full description is available in the UUID Users' Manual.
Patient Year and Month of Birth	Date of patient's birth using 00 instead of day.	CCYYMM00
Patient Sex	Sex of the patient.	1 Male 2 Female 3 Unknown
Patient Zip Code+4-digit add-on	Zip code of patient's residence.	5-digit US Postal Service code plus 4-digit add-on code.
Date of Enrollment	The start date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 26)	CCYYMMDD Date is the first day of the reporting period if patient is enrolled at that time. Enter other date if patient **not enrolled** at start of reporting period, but enrolled during reporting period.
Date of Disenrollment	The end date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 26)	CCYYMMDD **Leave blank** if patient is still enrolled on the last day of the reporting period. If patient disenrolled before end of reporting period enter date disenrolled.
Hospital/Facility Federal Tax ID	Federal Employer Tax ID of the facility receiving payment for care.	
Hospital/Facility National Provider Identifier (NPI) Number	Federal identifier assigned by the federal government for use in all HIPAA transactions to an organization for billing purposes.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf
Hospital/Facility Medicare Provider Number	Federal identifier assigned by the federal government for use in all Medicare transactions to an organization for billing purposes.	Six (6) digits
Hospital/Facility Participating Provider Flag	Indicates if the service was provided at a hospital/facility that participates in the payor's network.	1 Participating 2 Non-Participating 3 Unknown/Not Coded 9 No Network for this Plan
Claim Control Number	Internal payor claim number used for tracking.	A credit should have the same claim number as the original debit record.
Claim Paid Date	The date a claim was authorized for payment.	CCYYMMDD

Field Name	Description	Field Contents
Record Type	Identifies the type of facility or department in a facility where the service was provided.	10 Hospital Inpatient – Undefined 11 Hospital Inpatient – Acute care 12 Hospital Inpatient – Children's Hospital 13 Hospital Inpatient – Mental health or Substance abuse 14 Hospital Inpatient – Rehabilitation, Long term care, SNF stay 20 Hospital Outpatient – Undefined 21 Hospital Outpatient – Ambulatory Surgery 22 Hospital Outpatient – Emergency Room 23 Hospital Outpatient – Other 30 Non-Hospital Facility
Type of Admission	Applies **only** to hospital inpatient records. All other record types code "0".	0 Not a hospital inpatient record 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma Center 6 Reserved for National Assignment 7 Reserved for National Assignment 8 Reserved for National Assignment 9 Information Not Available
Point of Origin for Admission or Visit	Applies **only** to hospital inpatient records. All other record types code "0". (Note: Assign the code where the patient originated from before presenting to the health care facility.)	0 Not a hospital inpatient record For Newborns (Type of Admission = 4) 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Not used 5 Born inside this hospital 6 Born outside of this hospital 9 Information not available Admissions other than Newborn 1 Non-Health Facility Point of Origin 2 Clinic or Physician's Office 3 Reserved for national assignment 4 Transfer from a Hospital (Different Facility) 5 Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) 6 Transfer from Another Health Care Facility 8 Court/Law Enforcement 9 Information Not Available

Field Name	Description	Field Contents
Patient Discharge Status	Indicates the disposition of the patient at discharge. Applies **only** to hospital inpatient records. All other record types code "00".	00 Not a hospital inpatient record 01 Routine (home or self care) 02 Another Short-term Hospital 03 Skilled Nursing Facility (SNF) 04 Intermediate Care Facility 05 Another type of facility (includes rehab facility, hospice, etc.) 06 Home Health Care (HHC) 07 Against medical advice (AMA)/Discontinued care 09 Missing/Unknown 20 Died/Expired
Service from date/Start of Service (if Inpatient, Date of Admission)	First date of service for a procedure in this line item.	CCYYMMDD
Service thru date/End of Service (if Inpatient, Date of Discharge)	Last date of service for a procedure in this line item.	CCYYMMDD
Diagnosis Code Indicator	Indicates the volume of the International Classification of Diseases, Clinical Modification system used in assigning codes to diagnoses.	1 ICD-9-CM 2 ICD-10-CM 3 Missing/Unknown
Primary Diagnosis	The primary ICD-9-CM or ICD-10-CM Diagnosis Code followed by a secondary diagnosis (up to 29 codes), if applicable at the time of service. Remove embedded decimal pt.	
Primary Diagnosis Present on Admission (POA)	Primary Diagnosis present on Admission. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 1	ICD-9-CM/ICD-10-CM Diagnosis Code 1 Remove embedded decimal pt.	
Other Diagnosis Code 1 Present on Admission 1 (POA)	Diagnosis Code 1 present on Admission 1. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*

Field Name	Description	Field Contents
Other Diagnosis Code 2	ICD-9-CM/ICD-10-CM Diagnosis Code 2 Remove embedded decimal pt.	
Other Diagnosis Code 2 Present on Admission 2 (POA)	Diagnosis Code 2 present on Admission 2. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 3	ICD-9-CM/ICD-10-CM Diagnosis Code 3 Remove embedded decimal pt.	
Other Diagnosis Code 3 Present on Admission 3 (POA)	Diagnosis Code 3 present on Admission 3. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 4	ICD-9-CM/ICD-10-CM Diagnosis Code 4 Remove embedded decimal pt.	
Other Diagnosis Code 4 Present on Admission 4 (POA)	Diagnosis Code 4 present on Admission 4. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 5	ICD-9-CM/ICD-10-CM Diagnosis Code 5 Remove embedded decimal pt.	
Other Diagnosis Code 5 Present on Admission 5 (POA)	Diagnosis Code 5 present on Admission 5. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 6	ICD-9-CM/ICD-10-CM Diagnosis Code 6 Remove embedded decimal pt.	
Other Diagnosis Code 6 Present on Admission 6 (POA)	Diagnosis Code 6 present on Admission 6. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 7	ICD-9-CM/ICD-10-CM Diagnosis Code 7 Remove embedded decimal pt.	
Other Diagnosis Code 7 Present on Admission 7 (POA)	Diagnosis Code 7 present on Admission 7. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*

Field Name	Description	Field Contents
Other Diagnosis Code 8	ICD-9-CM/ICD-10-CM Diagnosis Code 8 Remove embedded decimal pt.	
Other Diagnosis Code 8 Present on Admission 8 (POA)	Diagnosis Code 8 present on Admission 8. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 9	ICD-9-CM/ICD-10-CM Diagnosis Code 9 Remove embedded decimal pt.	
Other Diagnosis Code 9 Present on Admission 9 (POA)	Diagnosis Code 9 present on Admission 9. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 10	ICD-9-CM/ICD-10-CM Diagnosis Code 10 Remove embedded decimal pt.	
Other Diagnosis Code 10 Present on Admission 10 (POA)	Diagnosis Code 10 present on Admission 10. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 11	ICD-9-CM/ICD-10-CM Diagnosis Code 11 Remove embedded decimal pt.	
Other Diagnosis Code 11 Present on Admission 11 (POA)	Diagnosis Code 11 present on Admission 11. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 12	ICD-9-CM/ICD-10-CM Diagnosis Code 12 Remove embedded decimal pt.	
Other Diagnosis Code 12 Present on Admission 12 (POA)	Diagnosis Code 12 present on Admission 12. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 13	ICD-9-CM/ICD-10-CM Diagnosis Code 13 Remove embedded decimal pt.	
Other Diagnosis Code 13 Present on Admission 13 (POA)	Diagnosis Code 13 present on Admission 13. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*

Field Name	Description	Field Contents
Other Diagnosis Code 14 Other Diagnosis Code 14 Present on Admission 14 (POA)	ICD-9-CM/ICD-10-CM Diagnosis Code 14 Remove embedded decimal pt. Diagnosis Code 14 present on Admission 14. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 15 Other Diagnosis Code 15 Present on Admission 15 (POA)	ICD-9-CM/ICD-10-CM Diagnosis Code 15 Remove embedded decimal pt. Diagnosis Code 15 present on Admission 15. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 16 Other Diagnosis Code 16 Present on Admission 16 (POA)	ICD-9-CM/ICD-10-CM Diagnosis Code 16 Remove embedded decimal pt. Diagnosis Code 16 present on Admission 16. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 17 Other Diagnosis Code 17 Present on Admission 17 (POA)	ICD-9-CM/ICD-10-CM Diagnosis Code 17 Remove embedded decimal pt. Diagnosis Code 17 present on Admission 17. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 18 Other Diagnosis Code 18 Present on Admission 18 (POA)	ICD-9-CM/ICD-10-CM Diagnosis Code 18 Remove embedded decimal pt. Diagnosis Code 18 present on Admission 18. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 19 Other Diagnosis Code 19 Present on Admission 19 (POA)	ICD-9-CM/ICD-10-CM Diagnosis Code 19 Remove embedded decimal pt. Diagnosis Code 19 present on Admission 19. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*

Field Name	Description	Field Contents
Other Diagnosis Code 20	ICD-9-CM/ICD-10-CM Diagnosis Code 20 Remove embedded decimal pt.	
Other Diagnosis Code 20 Present on Admission 20 (POA)	Diagnosis Code 20 present on Admission 20. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 21	ICD-9-CM/ICD-10-CM Diagnosis Code 21 Remove embedded decimal pt.	
Other Diagnosis Code 21 Present on Admission 21 (POA)	Diagnosis Code 21 present on Admission 21. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 22	ICD-9-CM/ICD-10-CM Diagnosis Code 22 Remove embedded decimal pt.	
Other Diagnosis Code 22 Present on Admission 22 (POA)	Diagnosis Code 22 present on Admission 22. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 23	ICD-9-CM/ICD-10-CM Diagnosis Code 23 Remove embedded decimal pt.	
Other Diagnosis Code 23 Present on Admission 23 (POA)	Diagnosis Code 23 present on Admission 23. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 24	ICD-9-CM/ICD-10-CM Diagnosis Code 24 Remove embedded decimal pt.	
Other Diagnosis Code 24 Present on Admission 24 (POA)	Diagnosis Code 24 present on Admission 24. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 25	ICD-9-CM/ICD-10-CM Diagnosis Code 25 Remove embedded decimal pt.	
Other Diagnosis Code 25 Present on Admission 25 (POA)	Diagnosis Code 25 present on Admission 25. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*

Field Name	Description	Field Contents
Other Diagnosis Code 26	ICD-9-CM/ICD-10-CM Diagnosis Code 26 Remove embedded decimal pt.	
Other Diagnosis Code 26 Present on Admission 26 (POA)	Diagnosis Code 26 present on Admission 26. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 27	ICD-9-CM/ICD-10-CM Diagnosis Code 27 Remove embedded decimal pt.	
Other Diagnosis Code 27 Present on Admission 27 (POA)	Diagnosis Code 27 present on Admission 27. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 28	ICD-9-CM/ICD-10-CM Diagnosis Code 28 Remove embedded decimal pt.	
Other Diagnosis Code 28 Present on Admission 28 (POA)	Diagnosis Code 28 present on Admission 28. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 29	ICD-9-CM/ICD-10-CM Diagnosis Code 29 Remove embedded decimal pt.	
Other Diagnosis Code 29 Present on Admission 29 (POA)	Diagnosis Code 29 present on Admission 29. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Attending Practitioner Individual National Provider Identifier (NPI) number	Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner.	The physician responsible for the patient's medical care and treatment. If outpatient or emergency room, this data element refers to the Practitioner treating patient at time of service.
Operating Practitioner Individual National Provider Identifier (NPI) number	Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner.	This element identifies the operating physician who performed the surgical procedure.

Field Name	Description	Field Contents
Billed Charge	A provider's billed charges rounded to whole dollars. **DO NOT USE DECIMALS**	
Allowed Amount	Total patient and payor liability. **DO NOT USE DECIMALS**	
Reimbursement Amount	Amount paid by carrier to Tax ID # of provider as listed on claim. **DO NOT USE DECIMALS**	
Total Patient Deductible	The fixed amount that the patient must pay for covered medical services/hospital stay before benefits are payable.	
Total Patient Coinsurance or Patient Co-payment	The specified amount or percentage the patient is required to contribute towards covered medical services/hospital stay after any applicable deductible.	
Total Other Patient Obligations	Any patient liability other than the deductible or coinsurance/co-payment. This could include obligations for out-of-network care (balance billing net of patient deductible, patient coinsurance/co-payment and payor reimbursement), non-covered services, or penalties. **DO NOT USE DECIMALS**	
Coordination of Benefit Savings or Other Payor Payments	If you are not the primary insurer, report the amount paid by the primary payor.	

Field Name	Description	Field Contents
Type of Bill	UB 04 or UB 92 form 3-digit code = Type of Facility + Bill Classification + Frequency	**Type of Facility – 1st digit** 1 Hospital 2 Skilled Nursing 3 Home Health 4 Christian Science Hospital 5 Christian Science Extended Care 6 Intermediate Care 7 Clinic 8 Special Facility **Bill Classification – 2nd Digit if 1st Digit = 1-6** 1 Inpatient (including Medicare Part A) 2 Inpatient (including Medicare Part B Only) 3 Outpatient 4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment) 5 Nursing Facility Level I 6 Nursing Facility Level II 7 Intermediate Care – Level III Nursing Facility 8 Swing Beds **Bill Classification – 2nd Digit if 1st Digit = 7** 1 Rural Health 2 Hospital-based or Independent Renal Dialysis Center 3 Freestanding Outpatient Rehabilitation Facility (ORF) 4 Comprehensive Outpatient Rehabilitation Facilities (CORFs) 5 Community Mental Health Center 9 Other **Bill Classification – 2nd Digit if 1st Digit = 8** 1 Hospice (Non-Hospital based) 2 Hospice (Hospital-based) 3 Ambulatory Surgery Center 4 Freestanding Birthing Center 9 Other **Frequency – 3rd Digit** 1 Admit through Discharge 2 Interim – First Claim Used 3 Interim – Continuing Claims 4 Interim – Last Claim 5 Late Charge Only 6 Adjustment of Prior Claim 7 Replacement of Prior Claim 8 Void/Cancel of Prior Claim

Field Name	Description	Field Contents
Patient Covered by Other Insurance Indicator	Indicates whether patient has additional insurance coverage.	0 No 1 Yes, other coverage is primary 2 Yes, other coverage is secondary 9 Unknown
Procedure Code Indicator	Indicates the classification used in assigning codes to procedures.	1 ICD-9-CM 2 ICD-10-CM 3 CPT Code/HCPCS
Principal Procedure Code 1	The principal health care service provided, followed by a secondary procedure (up to 15 codes), if applicable at the time of service. **Remove embedded decimal pt.**	CPT Codes are required on all non-inpatient claims (ER, clinic, outpatient), but will allow ICD-9-CM or ICD-10-CM Codes for inpatient claims.
Procedure Code1 Modifier I	Discriminate code used by practitioners to distinguish that a health care service has been altered [by a specific condition] but not changed in definition or code. A modifier is added as a suffix to a procedure code field.	Modifier applies only to CPT Codes.
Procedure Code1 Modifier II	Specific to Modifier I.	
Other Procedure Code 2	Remove embedded decimal pt.	
Procedure Code2 Modifier I		Modifier applies only to CPT Codes.
Procedure Code2 Modifier II		
Other Procedure Code 3	Remove embedded decimal pt.	
Procedure Code3 Modifier I		Modifier applies only to CPT Codes.
Procedure Code3 Modifier II		
Other Procedure Code 4	Remove embedded decimal pt.	
Procedure Code4 Modifier I		Modifier applies only to CPT Codes.
Procedure Code4 Modifier II		
Other Procedure Code 5	Remove embedded decimal pt.	
Procedure Code5 Modifier I		Modifier applies only to CPT Codes.
Procedure Code5 Modifier II		
Other Procedure Code 6	Remove embedded decimal pt.	
Procedure Code6 Modifier I		Modifier applies only to CPT Codes.
Procedure Code6 Modifier II		

Field Name	Description	Field Contents
Other Procedure Code 7	Remove embedded decimal pt.	
Procedure Code7 Modifier I		Modifier applies only to CPT Codes.
Procedure Code7 Modifier II		
Other Procedure Code 8	Remove embedded decimal pt.	
Procedure Code8 Modifier I		Modifier applies only to CPT Codes.
Procedure Code8 Modifier II		
Other Procedure Code 9	Remove embedded decimal pt.	
Procedure Code9 Modifier I		Modifier applies only to CPT Codes.
Procedure Code9 Modifier II		
Other Procedure Code 10	Remove embedded decimal pt.	
Procedure Code10 Modifier I		Modifier applies only to CPT Codes.
Procedure Code10 Modifier II		
Other Procedure Code 11	Remove embedded decimal pt.	
Procedure Code11 Modifier I		Modifier applies only to CPT Codes.
Procedure Code11 Modifier II		
Other Procedure Code 12	Remove embedded decimal pt.	
Procedure Code12 Modifier I		Modifier applies only to CPT Codes.
Procedure Code12 Modifier II		
Other Procedure Code 13	Remove embedded decimal pt.	
Procedure Code13 Modifier I		Modifier applies only to CPT Codes.
Procedure Code13 Modifier II		
Other Procedure Code 14	Remove embedded decimal pt.	
Procedure Code14 Modifier I		Modifier applies only to CPT Codes.
Procedure Code14 Modifier II		
Other Procedure Code 15	Remove embedded decimal pt.	
Procedure Code15 Modifier I		Modifier applies only to CPT Codes.
Procedure Code15 Modifier II		

Field Name	Description	Field Contents
Diagnosis Related Groups (DRGs) Number	The inpatient classifications based on diagnosis, procedure, age, gender and discharge disposition.	
DRG Grouper Name	The actual DRG Grouper used to produce the DRGs.	1 All Patient DRGs (AP-DRGs) 2 All Patient Refined DRGs (APR-DRGs) 3 Centers for Medicare & Medicaid Services DRGs (CMS-DRGs) 4 Other Proprietary
DRG Grouper Version	Version of DRG Grouper used.	
Payor ID Number	Payor assigned submission identification number.	
Source System	Identify the source system (platforms or business units) *from which the data was obtained* by using an alphabet letter (A, B, C, D, etc…) (Note: In your documentation on page 15, please be sure to list the source system that corresponds with the letter assigned.) For payors with all data coming from one system only, leave the field blank.	A – Z Leave the field **blank** if submitting data from **one (1)** platform or business unit only.
Revenue Code	Provide the codes used to identify specific accommodation and/or ancillary charges.	
Other Revenue Code 1		
Other Revenue Code 2		
Other Revenue Code 3		
Other Revenue Code 4		
Other Revenue Code 5		
Other Revenue Code 6		
Other Revenue Code 7		
Other Revenue Code 8		
Other Revenue Code 9		

Field Name	Description	Field Contents
Other Revenue Code 10		
Other Revenue Code 11		
Other Revenue Code 12		
Other Revenue Code 13		
Other Revenue Code 14		
Other Revenue Code 15		
Other Revenue Code 16		
Other Revenue Code 17		
Other Revenue Code 18		
Other Revenue Code 19		
Other Revenue Code 20		
Other Revenue Code 21		
Other Revenue Code 22		
Other Revenue Code 23		
Reporting Quarter **New!**	Indicate the quarter number for which the data is being submitted.	1 First Quarter = January 1 thru March 31 2 Second Quarter = April 1 thru June 30 3 Third Quarter = July 1 thru September 30 4 Fourth Quarter = October 1 thru December 31

MARYLAND HEALTH CARE COMMISSION

SECTION VI

ELIGIBILITY DATA REPORT

- DATA SUBMISSION DOCUMENTATION
- FILE LAYOUT
- DATA DICTIONARY

FORMATTED FOR THE 2014 MARYLAND MEDICAL CARE DATA BASE (MCDB) SUBMISSION

ELIGIBILITY FILE – Data Submission Documentation

1. Eligibility File Control Total Verification – Number of ENROLLEES by Month
[Excel worksheet – Eligibility_Enrollees_Month]

Please complete the table below by supplying the number of enrollees by quarter and month. This table will provide an assessment of your submission.

Quarter/Month	# Enrollees
First Quarter	
Jan 2014	
Feb 2014	
Mar 2014	
Second Quarter	
Apr 2014	
May 2014	
Jun 2014	

Quarter/Month	# Enrollees
Third Quarter	
Jul 2014	
Aug 2014	
Sep 2014	
Fourth Quarter	
Oct 2014	
Nov 2014	
Dec 2014	

ELIGIBILITY DATA REPORT – File Layout

This report details information on the characteristics of all enrollees covered for medical services under the plan for the quarterly reporting period designated – First Quarter: January 1, 2014 through March 31, 2014; Second Quarter: April 1, 2014 through June 30, 2014; Third Quarter: July 1, 2014 through September 30, 2014; and Fourth Quarter: October 1, 2014 through December 31, 2014. Please provide an entry for each month that the enrollee was covered by a general health benefit plan regardless of whether or not the enrollee received any covered services during the reporting year.

(For example, an enrollee with 3 months of coverage will have 3 eligibility records; an enrollee with 2 months of coverage will only have 2 records.)

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Start	End	Threshold
1.	Record Identifier	1	N		1	1	100%
2.	Encrypted Enrollee's Identifier**P** (payor encrypted)	12	A		2	13	100%
3.	Encrypted Enrollee's Identifier**U** (UUID encrypted)	12	A		14	25	100%*
4.	Enrollee Year and Month of Birth (CCYYMM00)	8	N		26	33	99% / 95% / 100%('00')
5.	Enrollee Sex	1	N		34	34	99%
6.	Enrollee Zip Code of Residence +4digit add-on code (include hyphen)	10	N		35	44	99%
7.	Enrollee County of Residence	3	N		45	47	95%
8.	Source of Direct Reporting of Enrollee Race	1	N		48	48	95%
9.	Race Category White – Direct	1	N		49	49	
10.	Race Category Black or African American – Direct	1	N		50	50	
11.	Race Category American Indian or Alaska Native – Direct	1	N		51	51	
12.	Race Category Asian – Direct	1	N		52	52	
13.	Race Category Native Hawaiian or Pacific Islander – Direct	1	N		53	53	
14.	Race Category Other – Direct	1	N		54	54	
15.	Race Category Declined to Answer – Direct	1	N		55	55	
16.	Race Category Unknown or Cannot be Determined – Direct	1	N		56	56	
17.	Imputed Race with Highest Probability	1	N		57	57	
18.	Probability of Imputed Race Assignment	3	N		58	60	95%
19.	Source of Direct Reporting of Enrollee Ethnicity	1	N		61	61	95%
20.	Enrollee OMB Hispanic Ethnicity	1	N		62	62	
21.	Imputed Ethnicity with Highest Probability	1	N		63	63	

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Start	End	Threshold
22.	Probability of Imputed Ethnicity Assignment	3	N		64	66	
23.	Enrollee Preferred Spoken Language for a Healthcare Encounter	2	N		67	68	
24.	Coverage Type **Modified!**	1	A		69	69	99%
25.	Source Company	1	A		70	70	99%
26.	Product Type	1	N		71	71	95%
27.	Policy Type	1	N		72	72	95%
28.	Encrypted Contract or Group Number (payor encrypted)	20	A		73	92	95%
29.	Employer Federal Tax ID Number	9	A		93	101	95%
30.	Medical Services Indicator	1	N		102	102	95%
31.	Pharmacy Services Indicator	1	N		103	103	95%
32.	Behavioral Health Services Indicator	1	N		104	104	95%
33.	Dental Services Indicator	1	N		105	105	95%
34.	Plan Liability	1	N		106	106	95%
35.	Consumer Directed Health Plan (CDHP) with HSA or HRA Indicator	1	N		107	107	95%
36.	Start Date of Coverage (in the month CCYYMMDD)	8	N		108	115	95%
37.	End Date of Coverage (in the month CCYYMMDD)	8	N		116	123	95%
38.	Date of FIRST Enrollment **	8	N		124	131	99%
39.	Date of Disenrollment	8	N		132	139	99%
40.	Coverage Period End Date	8			140	147	
41.	Relationship to Policyholder	1	N		148	148	95%
42.	Payor ID Number	4	A		149	152	100%
43.	Source System	1	A		153	153	
44.	Grandfathered Plan Indicator	1	N		154	154	
45.	Plan or Product ID Number	20	A		155	174	
46.	Subscriber ID Number	20	A		175	194	
47.	Health Insurance Oversight System (HIOS) Number **New!**	20	A		195	214	
48.	Master Patient Index (MPI) **New!**	40	A		215	254	
49.	Reporting Quarter **New!**	1	N		255	255	

** Note: The Commission expects the algorithm to be applied to every eligibility record. ** Unlike the Date of Enrollment listed on the other files, which refers to the start date of enrollment in this data submission period, this **Date of FIRST Enrollment** should reflect the date that the patient was initially enrolled in the plan.*

The Eligibility data must link to Professional Services, Pharmacy, and Institutional Services data by Encrypted Patient Identifier.

Encryption of Patient ID must be consistent with encryption of Patient ID in Professional Services, Pharmacy, and Institutional Services files.

MHCC will return files that do not link.

Data Dictionary – ELIGIBILITY DATA REPORT – COMAR 10.25.06.11

Field Name	Description	Field Contents
Record Identifier	The value is 5	**5 Eligibility**
Encrypted Enrollee Identifier**P** (payor encrypted)	Enrollee's unique identification number assigned by payor and encrypted.	The unique ID for each person on this file would correspond to the same unique Patient/Enrollee ID used for all other files (Professional Services, Pharmacy Claims, and Institutional Services Files).
Encrypted Enrollee Identifier**U** (UUID encrypted)	Enrollee's universally unique identification (UUID) number generated using an encryption algorithm provided by MHCC.	Refer to the UUID summary description sheet on page 92. A full description is available in the UUID Users' Manual.
Enrollee Year and Month of Birth	Date of enrollee's birth using 00 instead of day.	CCYYMM00
Enrollee Sex	Sex of the enrollee.	1 Male 2 Female 3 Unknown
Enrollee Zip Code of Residence+4-digit add-on	Zip code of enrollee's residence.	5-digit US Postal Service code plus 4-digit add-on code.

Field Name	Description	Field Contents
Enrollee County of Residence	County of enrollee's residence. If known, please provide. If not known, MHCC will arbitrarily assign using Zip code of residence.	001 Allegany 003 Anne Arundel 005 Baltimore County 009 Calvert 011 Caroline 013 Carroll 015 Cecil 017 Charles 019 Dorchester 021 Frederick 023 Garrett 025 Harford 027 Howard 029 Kent 031 Montgomery 033 Prince George's 035 Queen Anne's 037 St. Mary's 039 Somerset 041 Talbot 043 Washington 045 Wicomico 047 Worcester 510 Baltimore City 999 Unknown *County codes based on the U.S. Census Bureau's Federal Information Processing Standards (FIPS).*
Source of Direct Reporting of Enrollee Race	Indicate the source of direct reporting of enrollee race.	1 Enrollee reported to payor 2 Enrollee reported to another source 9 Missing/Unknown/Not specified
Race Category White - Direct	Enter whether the self-defined race of the enrollee is White or Caucasian. White is defined as a person having lineage in any of the original peoples of Europe, the Middle East, or North Africa.	0 No 1 Yes
Race Category Black or African American - Direct	Enter whether the self-defined race of the enrollee is Black or African American. Black or African American is defined as a person having lineage in any of the Black racial groups of Africa.	0 No 1 Yes

Field Name	Description	Field Contents
Race Category American Indian or Alaska Native - Direct	Enter whether the self-defined race of the enrollee is American Indian or Alaska Native. American Indian or Alaska Native is defined as a person having lineage in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.	0 No 1 Yes
Race Category Asian - Direct	Enter whether the self-defined race of the enrollee is Asian. Asian is defined as a person having lineage in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.	0 No 1 Yes
Race Category Native Hawaiian or Other Pacific Islander - Direct	Enter whether the self-defined race of the enrollee is Native Hawaiian or Other Pacific Islander. Native Hawaiian or Other Pacific Islander is defined as a person having lineage in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.	0 No 1 Yes
Race Category Other - Direct	Enter whether the self-defined race of the enrollee is Other.	0 No 1 Yes
Race Category Declined to Answer - Direct	Enter whether the enrollee declined to disclose their race.	0 No 1 Yes
Race Category Unknown or Cannot Determined - Direct	Enter whether the race of the enrollee is unknown or cannot be determined.	0 No 1 Yes
Imputed Race with Highest Probability	Race of enrollee.	1 American Indian or Alaska Native 2 Asian 3 Black or African American 4 Native Hawaiian or Other Pacific Islander 5 White/Caucasian 6 Some Other Race 9 Missing/Unknown/Not specified
Probability of Imputed Race Assignment	Specify the probability of race assignment; probability used in race determination.	Percentage

Field Name	Description	Field Contents
Source of Direct Reporting of Enrollee Ethnicity	Indicate source of reporting enrollee ethnicity.	1 Enrollee reported to payor 2 Enrollee reported to another source 9 Missing/Unknown/Not specified
Enrollee OMB Hispanic Ethnicity (Hispanic Indicator)	Ethnicity of enrollee.	1 Hispanic or Latino or Spanish origin 2 Not Hispanic or Latino or Not of Spanish origin 9 Missing/Unknown/Not specified
Imputed Ethnicity with Highest Probability (Hispanic Indicator)	Enter the Ethnicity of the enrollee.	1 Hispanic or Latino or Spanish origin 2 Not Hispanic or Latino or Not of Spanish origin 7 Declined to Answer 9 Missing/Unknown/Not specified
Probability of Imputed Ethnicity Assignment	Specify the probability of ethnicity assignment; probability used in ethnicity determination.	Percentage
Enrollee Preferred Spoken Language for a Healthcare Encounter	A locally relevant list of languages has been developed by the Commission.	01 English 02 Albanian 03 Amharic 04 Arabic 05 Burmese 06 Cantonese 07 Chinese (simplified & traditional) 08 Creole (Haitian) 09 Farsi 10 French (European) 11 Greek 12 Gujarati 13 Hindi 14 Italian 15 Korean 16 Mandarin 17 Portuguese (Brazilian) 18 Russian 19 Serbian 20 Somali 21 Spanish (Latin America) 22 Tagalog (Pilipino) 23 Urdu 24 Vietnamese 98 Other and unspecified languages 99 Unknown

Field Name	Description	Field Contents
Coverage Type **Modified!**	Enrollee's type of insurance coverage.	1 Medicare Supplemental (i.e., Individual, Group, WRAP) 2 Medicare Advantage Plan 3 Individual Market (not MHIP; not sold in MHBE) 4 Maryland Health Insurance Plan (MHIP) 5 Private Employer Sponsored or Other Group (i.e. union or association plans) 6 Public Employee – Federal (FEHBP) 7 Public Employee – Other (state, county, local/municipal government and public school systems) 8 Comprehensive Standard Health Benefit Plan (not sold in MHBE) [a self employed individual or small businesses (public or private employers) with 2-50 eligible employees] 9 Health Insurance Partnership (HIP) A Student Health Plan B Individual Market (sold in MHBE) C Small Business Options Program (SHOP) sold in MHBE Z Unknown
Source Company	Defines the payor company that holds the beneficiary's contract; for use in characterizing contract requirements under Maryland law.	1 Health Maintenance Organization 2 Life & Health Insurance Company or Not-for-Profit Health Benefit Plan 3 Third-Party Administrator (TPA) Unit
Product Type	Classifies the benefit plan by key product characteristics (scope of coverage, size of network, coverage for out-of-network benefits). (Please code based on how the product is primarily marketed, and most importantly be consistent from year to year. If not sure, send an e-mail describing the product to Larry Monroe at larry.monroe@maryland.gov)	1 Exclusive Provider Organization (in any form) 2 Health Maintenance Organization 3 Indemnity 4 Point of Service (POS) 5 Preferred Provider Organization (PPO) 6 Limited Benefit Plan (Mini-Meds) 7 Student Health Plan 8 Catastrophic
Policy Type	Type of policy.	1 Individual 2 Any combination of two or more persons
Encrypted Contract or Group Number (payor encrypted)	Payor assigned contract or group number for the plan sponsor using an encryption algorithm generated by the payor.	This number should be the same for all family members on the same plan.

Field Name	Description	Field Contents
Employer Federal Tax ID Number	Employer Federal Tax ID number will be encrypted by the database contractor in such a way that an employer will have the same encrypted ID across all payor records and the same employer has the same encrypted number from year to year.	
Medical Services Indicator	Medical Coverage	0 No 1 Yes
Pharmacy Services Indicator	Prescription Drug Coverage	0 No 1 Yes
Behavioral Health Services Indicator	Behavioral Health Services Coverage	0 No 1 Yes
Dental Services Indicator	Dental Coverage	0 No 1 Yes
Plan Liability	Indicates if insurer is at risk for the patient's service use or the insurer is simply paying claims as an ASO.	1 Risk (under Maryland contract) 2 Risk (under non-Maryland contract) 3 ASO (employer self-insured)
Consumer Directed Health Plan (CDHP) with HSA or HRA Indicator	Consumer Directed Health Plan (CDHP) with Health Savings Account (HSA) or Health Resources Account (HRA).	0 No 1 Yes
Start Date of Coverage (in the month)	The start date for benefits in the month (for example, if the enrollee was insured at the start of the month of January in 2014, the start date is 20140101)	CCYYMMDD
End Date of Coverage (in the month)	The end date for benefits in the month (for example, if the enrollee was insured for the entire month of January in 2014, the end date is 20140131)	CCYYMMDD
Date of FIRST Enrollment	The date of that the patient was initially enrolled in the plan.	CCYYMMDD
Date of Disenrollment	The end date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 72)	CCYYMMDD **Leave blank** if patient is still enrolled on the last day of the reporting period. If patient disenrolled before end of reporting period enter date disenrolled.

Field Name	Description	Field Contents
Coverage Period End Date	Contract renewal date, after which benefits, such as deductibles and out of pocket maximums reset.	CCYYMMDD
Relationship to Policyholder	Member's relationship to subscriber/insured.	1 Self/employee 2 Spouse 3 Child 4 Other Dependent 5 Other Adult 9 Unknown
Payor ID Number	Payor assigned submission identification number.	
Source System	Identify the source system (platforms or business units) *from which the data was obtained* by using an alphabet letter (A, B, C, D, etc…) (Note: In your documentation on page 15, please be sure to list the source system that corresponds with the letter assigned.) For payors with all data coming from one system only, leave the field blank.	A – Z Leave the field **blank** if submitting data from **one (1)** platform or business unit only.
Grandfathered Plan Indicator	Indicate if the plan qualifies as a "Grandfathered or Transitional Plan" under the Affordable Care Act (ACA).	1 Grandfathered 2 Non-Grandfathered 3 Transitional 4 Not Applicable
Plan or Product ID Number	Payor ID number associated with an enrollee's coverage and benefits in the claim adjudication system.	
Subscriber ID Number	Subscriber ID number associated with individual or family enrollment.	
Health Insurance Oversight System (HIOS) ID Number New!	HIOS ID number supplied by the federal government.	
Master Patient Index New!	Indicates the unique patient identifier assigned by Maryland's Health Information Exchange, Chesapeake Regional Information System for our Patients (CRISP).	
Reporting Quarter New!	Indicate the quarter number for which the data is being submitted.	1 First Quarter = January 1 thru March 31 2 Second Quarter = April 1 thru June 30 3 Third Quarter = July 1 thru September 30 4 Fourth Quarter = October 1 thru December 31

MARYLAND HEALTH CARE COMMISSION

SECTION VII

DENTAL SERVICES DATA REPORT

- DATA SUBMISSION DOCUMENTATION
- FILE LAYOUT
- DATA DICTIONARY

FORMATTED FOR THE 2014 MARYLAND MEDICAL CARE DATA BASE (MCDB) SUBMISSION

DENTAL SERVICES FILE – Data Submission Documentation

1. SERVICE THRU DATE Frequency [Excel worksheet – Dental_Services_thru_Date]

Please complete the table below using the month and year segments for **Service thru Date** (data element number 18 on the Dental Services **fixed** file layout). If the Service Thru Date is not reported, then assume that the Service from Date (data element number 17) and the Service Thru Date are the same. This table will provide an assessment of your data submission.

Service Thru Date Month/Year	# Services
First Quarter	
Jan 2014	
Feb 2014	
Mar 2014	
Second Quarter	
Apr 2014	
May 2014	
Jun 2014	

Service Thru Date Month/Year	# Services
Third Quarter	
Jul 2014	
Aug 2014	
Sept 2014	
Fourth Quarter	
Oct 2014	
Nov 2014	
Dec 2014	

A. Is this service volume distribution consistent with your experience?

☐ Yes ☐ **If no**, please explain _____

DENTAL SERVICES DATA REPORT SUBMISSION – File Layout

This report details all dental health care services provided to your enrollees for the reporting period designated – First Quarter Reporting: January 1, 2014 through March 31, 2014; Second Quarter Reporting: April 1, 2014 through June 30, 2014; Third Quarter Reporting: July 1, 2014 through September 30, 2014; Fourth Quarter Reporting: October 1, 2014 through December 31, 2014.

Please provide information on all dental services provided to Maryland residents whether those services were provided by a practitioner or office facility located in-State or out-of-State.

*(Reminder: **Patient Liability** is calculated using these three financial fields: **Patient Deductible**, **Patient Coinsurance/Co-payment**, and **Other Patient Obligations**. Total Patient Liability **should equal the sum** of Patient Deductible + Patient Coinsurance/Co-payment + Other Patient Obligations.)*

FIXED FORMAT

	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold
1.	Record Identifier	1	N	1	1	100%
2.	Patient Identifier**P** (payer encrypted)	12	A	2	13	100%
3.	Patient Identifier**U** (UUID encrypted)	12	A	14	25	
4.	Patient Year and Month of Birth (CCYYMM00)	8	N	26	33	99%/99%/ 100%('00')
5.	Patient Sex	1	N	34	34	99%
6.	Patient Zip Code+4digit add-on code (include hyphen)	10	N	35	44	99%
7.	Patient Covered by Other Insurance Indicator	1	N	45	45	95%
8.	Coverage Type **Modified!**	1	A	46	46	99%
9.	Source Company	1	N	47	47	99%
10.	Claim Related Condition	1	N	48	48	
11.	Practitioner Federal Tax ID (TIN)	9	A	49	57	100%
12.	Participating Provider Flag	1	N	58	58	95%
13.	Record Status	1	A	59	59	95%
14.	Claim Control Number (Include on each record as this is the key to summarizing service detail to claim level)	23	A	60	82	95%
15.	Claim Paid Date (CCYYMMDD)	8	N	83	90	95%
16.	Number of Line Items (always **= 01** for fixed format – see pg. 81)	2	N	91	92	
17.	Service From Date (CCYYMMDD)	8	N	93	100	100%
18.	Service Thru Date* (CCYYMMDD)	8	N	101	108	100%*
19.	Place of Service	2	N	109	110	99%
20.	Service Location Zip Code +4digit add-on code (include hyphen)	10	A	111	120	95%
21.	Procedure Code (CDT) (Current Dental Terminology)	5	A	121	125	95%
22.	Servicing Practitioner ID	11	A	126	136	100%
23.	Billed Charge (line item amounts required – see pg. 95)	9	N	137	145	
24.	Allowed Amount (line item amounts required – see pg. 95)	9	N	146	154	

	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold
25.	Reimbursement Amount (line item amounts required – see pg. 95)	9	N	155	163	
26.	Date of Enrollment	8	N	164	171	99%
27.	Date of Disenrollment	8	N	172	179	99%
28.	Patient Deductible (line item amounts required – see pg. 95)	9	N	180	188	
29.	Patient Coinsurance or Patient Co-payment (line item amounts required– see pg. 95)	9	N	189	197	
30.	Other Patient Obligations (line item amounts required– see pg. 95)	9	N	198	206	
31.	Servicing Practitioner Individual National Provider Identifier (NPI) number	10	A	207	216	95%
32.	Practitioner National Provider Identifier (NPI) number used for Billing	10	A	217	226	95%
33.	Product Type	1	N	227	227	95%
34.	Payor ID Number	4	A	228	231	100%
35.	Source System	1	A	232	232	
36.	Encrypted Contract or Group Number (payer encrypted)	20	A	233	252	95%
37.	Relationship to Policyholder	1	N	253	253	95%
38.	Tooth Number/Letter – 1	2	A	254	255	
39.	Tooth – 1 Surface – 1	5	A	256	260	
40.	Tooth – 1 Surface – 2	5	A	261	265	
41.	Tooth – 1 Surface – 3	5	A	266	270	
42.	Tooth – 1 Surface – 4	5	A	271	275	
43.	Tooth – 1 Surface – 5	5	A	276	280	
44.	Tooth – 1 Surface – 6	5	A	281	285	
45.	Tooth Number/Letter – 2	2	A	286	287	
46.	Tooth – 2 Surface – 1	5	A	288	292	
47.	Tooth – 2 Surface – 2	5	A	293	297	
48.	Tooth – 2 Surface – 3	5	A	298	302	
49.	Tooth – 2 Surface – 4	5	A	303	307	
50.	Tooth – 2 Surface – 5	5	A	308	312	
51.	Tooth – 2 Surface – 6	5	A	313	317	
52.	Tooth Number/Letter – 3	2	A	318	319	

	Field Name	Length	Type A=alphanumeric N=numeric	Start	End	Threshold
53.	Tooth – 3 Surface – 1	5	A	320	324	
54.	Tooth – 3 Surface – 2	5	A	325	329	
55.	Tooth – 3 Surface – 3	5	A	330	334	
56.	Tooth – 3 Surface – 4	5	A	335	339	
57.	Tooth – 3 Surface – 5	5	A	340	344	
58.	Tooth – 3 Surface – 6	5	A	345	349	
59.	Tooth Number/Letter – 4	2	A	350	351	
60.	Tooth – 4 Surface – 1	5	A	352	356	
61.	Tooth – 4 Surface – 2	5	A	357	361	
62.	Tooth – 4 Surface – 3	5	A	362	366	
63.	Tooth – 4 Surface – 4	5	A	367	371	
64.	Tooth – 4 Surface – 5	5	A	372	376	
65.	Tooth – 4 Surface – 6	5	A	377	381	
66.	Dental Quadrant – 1	2	A	382	383	
67.	Dental Quadrant – 2	2	A	384	385	
68.	Dental Quadrant – 3	2	A	386	387	
69.	Dental Quadrant – 4	2	A	388	389	
70.	Orthodontics Treatment	1	N	390	390	
71.	Date Appliance Placed (CCYYMMDD)	8	N	391	398	
72.	Months of Treatment Remaining	2	N	399	400	
73.	Prosthesis Replacement	1	N	401	401	
74.	Date of Prior Placement (CCYYMMDD)	8	N	402	409	
75.	Reporting Quarter **New!**	1	N	410	410	

** If the Service thru Date is not reported, then assume that the Service from Date (data element #17) and the Service thru Date are the same.*

The Dental Services data must link to Eligibility data by Encrypted Patient Identifier.

Encryption of Patient ID must be consistent with encryption of Patient ID in the Eligibility file.

MHCC will return files that do not link.

Data Dictionary – DENTAL SERVICES – COMAR 10.25.06.13

Field Name	Description	Field Contents
Record Identifier	The value is 6	**6 Dental Services**
Patient Identifier**P** (payer encrypted)	Patient's unique identification number assigned by payer and encrypted.	The unique ID for each person on this file should correspond to the same unique Patient ID used for all other files.
Patient Identifier**U** (UUID encrypted)	Patient's universally unique identification (UUID) number generated using an encryption algorithm provided by MHCC.	Refer to the UUID summary description sheet on page 92. A full description is available in the UUID Users' Manual.
Patient Year and Month of Birth	Date of patient's birth using 00 instead of day.	CCYYMM00
Patient Sex	Sex of the patient.	1 Male 2 Female 3 Unknown
Patient Zip Code+4digit add-on code	Zip code of patient's residence.	5-digit US Postal Service code plus 4 digit add-on code
Patient Covered by Other Insurance Indicator	Indicates whether patient has additional insurance coverage.	0 No 1 Yes, other coverage is primary 2 Yes, other coverage is secondary 9 Unknown
Coverage Type **Modified!**	Patient's type of insurance coverage.	1 Medicare Supplemental (i.e., Individual, Group, WRAP) 2 Medicare Advantage Plan 3 Individual Market (not MHIP; not sold in MHBE) 4 Maryland Health Insurance Plan (MHIP) 5 Private Employer Sponsored or Other Group (i.e. union or association plans) 6 Public Employee – Federal (FEHBP) 7 Public Employee – Other (state, county, local/municipal government and public school systems) 8 Comprehensive Standard Health Benefit Plan (not sold in MHBE) [a self employed individual or small businesses (public or private employers) with 2-50 eligible employees] 9 Health Insurance Partnership (HIP) A Student Health Plan B Individual Market sold in MHBE C Small Business Options Program (SHOP) sold in MHBE Z Unknown

Field Name	Description	Field Contents
Source Company	Defines the payer company that holds the beneficiary's contract; for use in characterizing contract requirements under Maryland law.	1 Health Maintenance Organization 2 Life & Health Insurance Company or Not-for-Profit Health Benefit Plan 3 Third-Party Administrator (TPA) Unit
Claim Related Condition	Describes connection, if any, between patient's condition and employment, automobile accident, or other accident.	0 Non-accident (default) 1 Work 2 Auto Accident 3 Other Accident 9 Unknown
Practitioner Federal Tax ID (TIN)	Employer Tax ID of the practitioner, practice or office facility receiving payment for services.	
Participating Provider Flag	Indicates if the service was provided by a provider that participates in the payer's network.	1 Participating 2 Non-Participating 3 Unknown/Not Coded 9 No Network for this Plan
Record Status	Describes payment and adjustment status of a claim. Adjustments include paying a claim more than once, paying additional services that may have been denied, or crediting a provider due to overpayment or paying the wrong provider.	1 Final Bill 8 Capitated or Global Contract Services
Claim Control Number	Internal payer claim number used for tracking.	A credit should have the same claim number as the original debit record.
Claim Paid Date	The date a claim was authorized for payment.	CCYYMMDD
Number of Line Items	If using **Variable Format**, the # of line items completed in the variable portion must match the value entered for this data element, maximum value for this data and # of line items is 26. If using **Fixed Format**, the number of line items is always equal to one (1) because only one service is written per row.	
Service From Date	First date of service for a procedure in this line item.	CCYYMMDD
Service Thru Date	Last date of service for this line item.	CCYYMMDD

Field Name	Description	Field Contents
Place of Service	Two-digit numeric code that describes where a service was rendered.	**CMS definitions:** 11 Provider's Office 12 Patient's Home 13 Assisted Living Facility 17 Walk-in Retail Health Clinic 18 Place of Employment - Worksite 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room – Hospital 24 Ambulatory Surgical Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance – Land 42 Ambulance – Air or Water 51 Inpatient Psychiatric Facility 52 Psychiatric Facility – Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 57 Non-residential Substance Abuse Treatment Facility 60 Mass Immunization Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End-Stage Renal Disease Treatment Facility 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory & Imaging 99 Other Place of Service
Service Location Zip Code	Zip code for location where service described was provided.	5-digit US Postal Service code plus
Procedure Code	Describes the health care service provided (i.e., CDT).	
Servicing Practitioner ID	Payer-specific identifier for the practitioner rendering health care service(s).	
Billed Charge	A practitioner's billed charges rounded to whole dollars. **DO NOT USE DECIMALS**	

Field Name	Description	Field Contents
Allowed Amount	Total patient and payer liability. **DO NOT USE DECIMALS**	
Reimbursement Amount	Amount paid to Employer Tax ID # of rendering physician as listed on claim. **DO NOT USE DECIMALS**	
Date of Enrollment	The start date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 81)	CCYYMMDD Date is the first day of the reporting period if patient is enrolled at that time. Enter other date if patient **not enrolled** at start of reporting period, but enrolled during reporting period.
Date of Disenrollment	The end date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 81)	CCYYMMDD **Leave blank** if patient is still enrolled on the last day of the reporting period. If patient disenrolled before end of reporting period enter date disenrolled.
Patient Deductible	The fixed amount that the patient must pay for covered medical services before benefits are payable. **DO NOT USE DECIMALS**	
Patient Coinsurance or Patient Co-payment	The specified amount or percentage the patient is required to contribute towards covered medical services after any applicable deductible. **DO NOT USE DECIMALS**	
Other Patient Obligations	Any patient obligations other than the deductible or coinsurance/co-payment. This could include obligations for out-of-network care (balance billing net of patient deductible, patient coinsurance/co-payment and payer reimbursement), non-covered services, or penalties. **DO NOT USE DECIMALS**	
Servicing Practitioner Individual National Provider Identifier (NPI) number	Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf
Practitioner National Provider Identifier (NPI) number used for Billing.	Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner or an organization for billing purposes.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf

Field Name	Description	Field Contents
Product Type	Classifies the benefit plan by key product characteristics (scope of coverage, size of network, coverage for out-of-network benefits). (Please code based on how the product is primarily marketed, and most importantly be consistent from year to year. If not sure, send an e-mail describing the product to Larry Monroe at larry.monroe@maryland.gov)	1 Exclusive Provider Organization (in any form) 2 Health Maintenance Organization 3 Indemnity 4 Point of Service (POS) 5 Preferred Provider Organization (PPO) 6 Limited Benefit Plan (Mini-Meds) 7 Student Health Plan 8 Catastrophic
Payer ID Number	Payer assigned submission identification number.	
Source System	Identify the source system (platforms or business units) *from which the data was obtained* by using an alphabet letter (A, B, C, D, etc…) (Note: In your documentation on page 15, please be sure to list the source system that corresponds with the letter assigned.) For payers with all data coming from one system only, leave the field blank.	A – Z Leave the field **blank** if submitting data from **one (1)** platform or business unit only.
Encrypted Contract or Group Number *(payer encrypted)*	Payer assigned contract or group number for the plan sponsor using an encryption algorithm generated by the payer.	This number should be the same for all family members on the same plan.
Relationship to Policyholder	Member's relationship to subscriber/insured.	1 Self/employee 2 Spouse 3 Child 4 Other Dependent 5 Other Adult 9 Unknown
Tooth Number/Letter	Report the tooth identifier(s) when Current Dental Terminology Code is within given range.	Up to four (4) Tooth Number/Letter fields can be entered.
Tooth Surface	Report the tooth surface(s) that this service relates to. Provides further detail on procedure(s). Required when Tooth Number/Letter is populated.	Up to six (6) Tooth Surface fields can be entered for each Tooth Number/Letter entry.

Field Name	Description	Field Contents
Dental Quadrant	Report the standard quadrant identifier when CDT indicates procedures of 3 or more consecutive teeth. Provides further detail on procedure(s).	Up to four (4) Dental Quadrant fields can be entered.
Orthodontics Treatment	Indicate if the treatment is for Orthodontics.	0 No 1 Yes
Date Appliance Placed	If treatment is for Orthodontics, then provide the date the appliance was placed.	CCYYMMDD
Months of Treatment Remaining	If treatment is for Orthodontics, then provide the number of months of treatment remaining.	Number of months remaining for treatment.
Prosthesis Replacement	Indicate if the treatment is for the replacement of Prosthesis.	0 No 1 Yes
Date Prior Placement	If treatment is for replacement of Prosthesis, then provide the prior date of Prosthesis placement.	CCYYMMDD
Reporting Quarter New!	Indicate the quarter number for which the data is being submitted.	1 First Quarter = January 1 thru March 31 2 Second Quarter = April 1 thru June 30 3 Third Quarter = July 1 thru September 30 4 Fourth Quarter = October 1 thru December 31

MARYLAND HEALTH CARE COMMISSION

SECTION VIII

PLAN BENEFIT DESIGN REPORT

(COMAR 10.25.06.12)

This data file will report details of coverage and benefits for all enrollees. This report is under development. Reporting entities, which are required to provide this report, will be provided an opportunity to participate in the development and testing of this report for the 2014 data submission. The report will be required for the 2015 submission and onward.

MARYLAND HEALTH CARE COMMISSION

SECTION IX

NON-FEE-FOR-SERVICE MEDICAL EXPENSES REPORT

(COMAR 10.25.06.14)

This data file will report details of non-fee-for-service payments made to providers. These may include, shared savings payments, incentive or performance payments, fixed transformation payments, etc. This report is under development. Reporting entities, which are required to provide this report, will be provided an opportunity to participate in the development and testing of this report for the 2014 data submission. The report will be required for the 2015 submission and onward.

MARYLAND HEALTH CARE COMMISSION

APPENDICES

- APPENDIX A – TRANSMISSION INFORMATION
- APPENDIX B – UNIVERSALLY UNIQUE IDENTIFIER (UUID)
- APPENDIX C – FINANCIAL DATA ELEMENTS
- APPENDIX D – DATA REPORTING AND PRE-SUBMISSION DATA CHECKS

MARYLAND HEALTH CARE COMMISSION

APPENDIX A

MEDIA FORMAT/TRANSMISSION INFORMATION

(Please label all media & documentation with your assigned Payor ID #)

Secure SFTP Server

Payors have the ability to upload MCDB data files directly to the MHCC Secure FTP site. If you would like to use this submission option, please contact Mr. Marty Teramani at (410) 764-3384 or via e-mail at marty.teramani@maryland.gov.

CD-ROM/DVD

Record Type:	Fixed (preferred) or Variable length records
Recording Format:	ASCII or EBCDIC

IBM 3480/3480E or 3490/3490E Cartridge

Block Size:	16,000 bytes minimum, 32,760 bytes maximum
Record Type:	Fixed (preferred) or Variable length records
Recording Format:	ASCII or EBCDIC
Labels:	Standard IBM labels preferred
Media:	3480/3480E or 3490/3490E Cartridge
Density:	3480/3480E or 3490/3490E Cartridge – default density

DLT Tape IV

Block Size:	16,000 bytes minimum, 32,760 bytes maximum
Record Type:	Fixed (preferred) or Variable length records
Recording Format:	ASCII or EBCDIC
Media:	DLT using dd or TAR commands
Density:	1600 BPI

MARYLAND HEALTH CARE COMMISSION

APPENDIX A (cont.)

Secure SFTP Server Information

For payors submitting the MCDB data files directly to the **MHCC Secure FTP site**, the **Internet Protocol (IP) Address** for the SFTP server is **184.80.193.37**. Note that your company's assigned User ID and Password remain the same.

If your company intends to submit the 2013 Medical Care Data Base (MCDB) files via the Commission's secure FTP, the following naming convention is in effect for the five data reports. The indicators are separated by the _ (underscore) symbol: **PayorID_File_Version_Date**

Payor ID:	Appendix A assigned ID number
Files:	Professional Services Data Report = ProfServ Pharmacy Data Report = Pharm Provider Directory Report = Prov Institutional Services Data Report = InstServ Eligibility Data Report = MedElig Dental Data Report = Dental
Version:	Submission order *(Note: If the submission is returned, the following sequence should be incremented by one letter in the alphabet.)*
Date:	Month/Day/Year = MMDDYY
Example:	P123_ProfServ_A_083114 P123_ProfServ_B_091514 P123_ProfServ_C_093014 P123_Pharm_A_083114 P123_Pharm_B_091514 P123_Pharm_C_093014 P123_Prov_A_083114 P123_Prov_B_091514 P123_Prov_C_093014 P123_InstServ_A_083114 P123_InstServ_B_091514 P123_InstServ_C_093014 P123_MedElig_A_083114 P123_MedElig_B_091514 P123_MedElig_C_093014 P123_Dental_A_083114 P123_Dental_B_091514 P123_Dental_C_093014

MARYLAND HEALTH CARE COMMISSION

APPENDIX B

Explanation of Key Data Elements

- **UNIVERSALLY UNIQUE IDENTIFIER (UUID)**
- **MASTER PATIENT INDEX (MPI)**

FORMATTED FOR THE 2014 MARYLAND MEDICAL CARE DATA BASE (MCDB) SUBMISSION

UNIVERSALLY UNIQUE IDENTIFIER (UUID)

Cross Payor Encryption Algorithm

In order to maintain a consistent and unique identifier for each patient across providers, payors, and services, the MHCC shall, as necessary, provide each reporting entity with an encryption algorithm, **Universally Unique Identifier (UUID)**, using one-way hashing consistent with the Advanced Encryption Standard (AES) recognized by the National Institute of Standards and Technology. Each reporting entity shall maintain the security and preserve the confidentiality of the UUID encryption algorithms provided by MHCC.

A Universally Unique Identifier (UUID) uniquely identifies information in a decentralized system; using the same algorithm across distributed systems will result in the same unique ID for the same value; information labeled with UUIDs can be combined into a single database without needing to resolve name conflicts.

UUIDs will be 12 character positions in length and constructed from information obtained at birth including: Social Security Number, Date of Birth, Month of Birth, Year of Birth, Sex, First Name.

Each payor shall encrypt new Patient/Enrollee Identifiers **(Patient/Enrollee IdentifierU)** in such a manner that each unique value produces an identical unique encrypted data element.

Each payor shall continue to use their current encrypted identifier **(Patient/Enrollee IdentifierP)** coincident with the new identifier.

Using two identifiers will: 1) provide the means to perform trend analysis by cross referencing the two identifiers, and 2) increase the efficacy of the identifiers in the event encryption of one of the algorithms is compromised.

The full encryption software documentation, source code, and executables are bundled into a ZIP file. That software can be downloaded directly from the Commission's website at http://mhcc.dhmh.maryland.gov/payercompliance/Pages/mcdb-uuid.aspx. The file is password protected. The password will be forwarded to the payor contact in an e-mail.

The Commission is strongly encouraging all carriers to consider the simple implementation of the software for the 2014 MCDB submission. That implementation is simply a standalone program that reads in the precursor variables and outputs those same variables plus the UUID.

Questions regarding the Universally Unique Identifier (UUID) Cross Payor Encryption Algorithm should be directed to Mr. Larry Monroe at MHCC at (410) 764-3390 or via e-mail at larry.monroe@maryland.gov.

MASTER PATIENT INDEX (MPI)

CRISP Hashed Unique Identifier

Master Patient Index (MPI) is a database that maintains a unique index identifier for each patient whose protected health information may be accessible through the Maryland Health Information Exchange and is used to cross reference patient identifiers across multiple participating organizations to allow for patient search, patient matching, and consolidation of duplicate records.

This field has been added to the Eligibility File. This field indicates the unique patient identifier assigned by Maryland's Health Information Exchange, Chesapeake Regional Information System for our Patients (CRISP). Payors will be required to provide limited identifiable data to CRISP, who will generate the MPI and return it to the payor. Payors will be required to submit the MPI in the Eligibility file once testing has been completed by CRISP. Additional information on the MPI will be available on the following Commission website in sufficient time before the fourth quarter data submission: http://mhcc.dhmh.maryland.gov/payercompliance/Pages/payercompliance/default.aspx.

MARYLAND HEALTH CARE COMMISSION

APPENDIX C

SPECIAL INSTRUCTIONS for

FINANCIAL DATA ELEMENTS

FORMATTED FOR THE 2014 MARYLAND MEDICAL CARE DATA BASE (MCDB) SUBMISSION

FINANCIAL DATA ELEMENTS – Billing and Reimbursement Information

Each of the financial data elements listed must be recorded by line item.

Professional Services file – a line item is defined as a single line entry on a bill/claim for each health care service rendered. The line item contains information on each procedure performed including modifier (if appropriate), service dates, units (if applicable), and practitioner charges. The line item also includes billed charges, allowed amount, patient deductible, patient coinsurance/co-payment, other patient obligations, and reimbursement amount. The value represented by each financial field **must be rounded to whole dollars** (i.e., no decimals).

- *All Fee-for-Service ("Record Status = 1") debit and credit bills must be reconciled to final bills.*
- *For Capitated/Global Contract Services ("Record Status = 8") billed charge, allowed amount, patient deductible, patient coinsurance/co-payment, other patient obligations and reimbursement amount must be reported when available.*

Institutional Services file – a record is defined as a summary of the services received during a stay or visit at an institution. The billed charges, allowed amount, and amounts paid by the payor and patient should reflect a summary of all services provided on the claim. The value represented by each financial field **must be rounded to whole dollars** (i.e., no decimals).

Pharmacy file – a line item is defined as a single line entry on a prescription service. The line item contains information on each prescription filled, including date filled, drug quantity and supply. This line item also includes billed charge, patient deductible, patient coinsurance/co-payment, other patient obligations, and reimbursement amount for each prescription. The value of the financial field must be represented using **two implied decimal places. Use two zeros if cents are not provided.**

FINANCIAL DATA ELEMENTS	**Professional Services** and **Institutional Services Data**		**Pharmacy Data**	
Billed Charge	*Dollar amount as billed by the practitioner/institution for health care services rendered.*	*Rounded to whole dollars (no decimals)*	*Prescription retail price including ingredient cost, dispensing fee, tax, and administrative expenditures.*	*Formatted using 2 implied decimal points*
Allowed Amount	*Retail Amount for the specified procedure code.*	*Rounded to whole dollars (no decimals)*		
Patient Deductible	*Fixed amount that the patient must pay for covered services before benefits are payable.*	*Rounded to whole dollars (no decimals)*	*Fixed amount that the patient must pay for covered services before benefits are payable.*	*Formatted using 2 implied decimal points*
Patient Coinsurance/ Patient Co-payment	*Specified amount or percentage the patient is required to contribute towards covered medical services after any applicable deductible.*	*Rounded to whole dollars (no decimals)*	*Specified amount or percentage the patient is required to contribute towards covered medical services after any applicable deductible.*	*Formatted using 2 implied decimal points*
Other Patient Obligations	*Any patient liability other than deductible or coinsurance/co-payment. Includes obligations for out-of-network care (balance billing), non-covered services, or penalties.*	*Rounded to whole dollars (no decimals)*	*Any patient liability other than deductible or coinsurance/co-payment. Includes obligations for out-of-network care (balance billing), non-covered services, or penalties.*	*Formatted using 2 implied decimal points*
Note: Total Patient Liability should equal the sum of Patient Deductible, Patient Coinsurance/Patient Co-payment, and Other Patient Obligations. Please make an effort to provide this financial information.				
Reimbursement Amount	*Amount paid to a practitioner, other health professional, office facility, or institution.*	*Rounded to whole dollars (no decimals)*	*Amount paid to the pharmacy by the payor.*	*Formatted using 2 implied decimal points*

MARYLAND HEALTH CARE COMMISSION

APPENDIX D

DATA REPORTING

and

PRE-SUBMISSION DATA CHECKS

FORMATTED FOR THE 2014 MARYLAND MEDICAL CARE DATA BASE (MCDB) SUBMISSION

MOST COMMON DATA SUBMISSION ISSUES

A payor's ability to identify and document significant changes in key data elements in advance, helps to minimize the need for re-submissions and extended communications with MHCC and the MCDB data base contractor.

Below is a list of the most common data issues that center on data adequacy and data integrity, each with a brief data checks explanation. Please review the major points outlined and the minor pre-submission errors payors can avoid.

Data Issues	Data Checks
A. Data Adequacy	
1. Missing Data • Missing records • Missing values within a record	• Level 1 check: Make sure there are no missing values for the key fields in the **Data Summary Worksheet** (DSW). • Level 2 check: Create summary diagnostics for all other fields and ensure the codes or values reported are not left blank (unless they are not collected by your system). • Payor must request a waiver from MHCC, if a field with missing values does not meet threshold requirements.
2. Inconsistent financials and enrollment	• Use the Data Summary Worksheet (DSW) to compare this year's percent change (2013-2014) to last year's percent change (2012-2013). • Differences greater than 10 percent should be resolved, or explained in the Comments Section of the DSW.
3. Complete or partial duplicate records	Check for possible duplicate submission of part or the entire claim. • **Professional Services:** Ensure there is only one record for each service. Debit and credit bills must be reconciled prior to data submission. • **Institutional Services:** Ensure there is only one record for each combination of a service (visit or discharge) and a bill type. • **Pharmacy:** Ensure there is only one record for each combination of NDC and fill date unless there is a credit record involved. Any credit record must be identified by negative financial values. • **Eligibility:** Ensure there is only one record for each month a member is covered.
4. Incorrect recoding/mapping of categorical fields	• Review the algorithm for translating the internal values to MHCC required values. • Contact MHCC and validate any questionable mapping or the algorithm used for pulling certain values that do not match well with the values required in the MCDB Data Base Submission Manual. For example, the specialty code or the coverage type in the payor database may not exactly match the values required in the data submission manual.

Data Issues	Data Checks
5. Failure to meet threshold levels	• Check the frequency count for each field and ensure the thresholds required in the MCDB Data Base Submission Manual have been met. Resolution applies to all files. • If a payor definitely cannot meet the requirements, they will need to request a waiver from MHCC.
6. Inconsistent dates	Check the data for inconsistent dates: • **Professional Services**: For each patient, service from date (Field #29) must occur after enrollment date (Field #42) and before disenrollment date (Field #43). • **Institutional Services:** For each patient, start of service date (Field #19) must occur after enrollment date (Field #7) and before disenrollment date (Field #8). • **Pharmacy:** For each patient, prescription fill date (Field #15) must occur after enrollment date (Field #25) and before disenrollment date (Field #26). • **Eligibility**: For each patient, date of FIRST enrollment (Field # 37) must occur on or before the earliest start date of coverage (Field # 35). For each patient, date of disenrollment (Field # 38) must occur on or after the latest end date of coverage (Field # 36). For each patient, start date of coverage (Field # 35) must occur on or before the end date of coverage (Field # 36). • Resolve inconsistencies.
B. Data Integrity	
7. Patient Identifiers not matching the Eligibility File	• Construct a composite patient identifier by concatenating the payor-encrypted ID, the UUID, the birth year & month, and the gender for all claims files (professional services, institutional services, and pharmacy) and the eligibility file. • Query the claims files to ensure that each composite patient identifier in the claims file can be found in the eligibility file. • Resolve non-matches.
8. Multiple Payor-encrypted IDs associated with same UUID	• Construct a composite patient identifier by combining the payor-encrypted ID, the birth year & month, and the gender. • Check to ensure each UUID is associated with only one composite patient identifier. • Resolve duplicates.
9. Servicing Practitioner IDs not matching the Provider directory; missing specialty code	• Match the practitioner IDs to the same ID in the Provider Directory. • There must be a match to the Provider Directory. In addition, there must be at least one non-blank specialty code in the Provider File.

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