



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

MCDB

2015 MEDICAL CARE DATA BASE

DATA SUBMISSION MANUAL

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

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DATA SUBMISSION MANUAL

INTRODUCTION

PURPOSE: The 2015 Medical Care Data Base (MCDB) Data Submission Manual (DSM) is designed to provide designated reporting entities with guidelines of technical specifications, layouts, and definitions necessary for filing the reports required under COMAR 10.25.06. This manual incorporates new information, as well as all recent updates. Changes from the 2014 Manual are summarized in **Appendix A**. The MCDB is administered by the Maryland Health Care Commission (MHCC or Commission) and the manual and related documents are available on the Commission's website at: http://mhcc.maryland.gov/mhcc/pages/apcd/apcd_mcdb/apcd_mcdb.aspx

Questions regarding MCDB policies and submission rules should be directed to:

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Please direct data processing and MCDB portal inquiries to:

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DESIGNATED REPORTING ENTITIES

The following entities are defined in COMAR 10.25.06.03 and designated by the Commission to provide data to the MCDB:

- (1) Each payor whose total lives covered exceeds 1,000, as reported to the Maryland Insurance Administration;
- (2) Each payor offering a qualified health plan, qualified dental plan, or qualified vision plan certified by the Maryland Health Benefit Exchange (MHBE), Insurance Article, §31-115, Annotated Code of Maryland; and
- (3) Each payor that is a managed care organization participating in the Maryland Medical Assistance Program in connection with the enrollment of an individual in the Maryland Medical Assistance Program or the Maryland Children's Health Program;

The Commission will post known reporting entities on its website at http://mhcc.maryland.gov/mhcc/pages/apcd/apcd_mcdb/apcd_mcdb.aspx. Entities who meet the specifications in COMAR 10.25.06.03 are required to report, even if they are not explicitly listed on the website. A glossary of reporting entity definitions can be found in Appendix B.

REQUIRED REPORTS OVERVIEW

Each reporting entity shall provide the required reports and include all services provided to:

- (1) Each Maryland resident insured under a fully insured contract or a self-insured contract; and
- (2) Each non-Maryland resident insured under a Maryland contract.

Claims for all Maryland residents covered by your company should be included 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. Similarly, all members covered under a Maryland contract must be included, regardless of their state of residence; for example, a member residing in California and covered under a Maryland contract should be included in your submission.

Descriptions of the reports are provided below. The reports should follow the file layout and instructions provided in the 2015 Data File Record Layout Guide, available on the MHCC website at http://mhcc.maryland.gov/mhcc/pages/apcd/apcd_mcdb/apcd_mcdb.aspx. For membership information reported in the Eligibility Data Report, please provide information for all members who are eligible during the reporting period. For claims reported, please select claims based on the claims paid date. Please ensure consistency with Finance and Actuarial Departments, particularly if reports are submitted by your company to the Maryland Insurance Administration. If there are substantial lags between adjudication date and paid date, or, you would like to make a case for selecting claims based on adjudication date, please submit a format modification request. Please refer to Appendix C for guidance on patient identifiers, and Appendix D for guidance on financial data elements. All reports must be submitted via the MCDB Portal. Instructions for the MCDB Portal are provided in Appendix E.

ELIGIBILITY DATA REPORT: 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**). 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.

PROFESSIONAL SERVICES DATA REPORT: The **Professional Services** Data Report should include all fee-for-service and capitated care encounters (e.g. CMS 1500 claims, HIPPA 870P, etc.,) for services provided by health care practitioners and office facilities to applicable insureds during the reporting period, regardless of the location of the service (e.g. include out of state services). (**COMAR 10.25.06.07**). This report should include services for claims paid in the reporting period, regardless of the date of service.

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 (e.g. radiology centers, ambulatory surgical centers, birthing centers, etc.)
- Durable Medical Equipment (DME)
- Dental – if services are provided under a medical benefit package
- Vision - if services are provided under a medical benefit package
- Tests and imaging services

All members with services in the Professional Services Data Report must be represented in the Eligibility Data Report for the reporting period corresponding to the date of service reported. For example, if the service occurs during the reporting period, then the member's eligibility information must be in the accompanying Eligibility Data Report for that period. If the service occurred during a previous reporting period, then the member's eligibility information should have been reported in the previous Eligibility Data Report.

With the move to incremental (quarterly) data reports, reconciliation of claims has become more important. Fields have been added to address claims versioning. Please include original payments, adjustments, voids, replacements, etc., so that it is possible to reconcile claims.

INSTITUTIONAL SERVICES DATA REPORT: 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**). 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. This report should include services for claims paid in the reporting period, regardless of the date of service.

With the move to incremental (quarterly) data reports, reconciliation of claims has become more important. Fields have been added to address claims versioning. For institutional services, claims are rolled-up for the report, and as a result it is not possible to reconcile individual claim adjustments, voids, replacements, etc. Please submit any adjustments and amendments as voids of the entire claim roll-up and provide a replacement.

PHARMACY DATA REPORT: 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**). This report should include services for claims paid in the reporting period, regardless of the date of service.

With the move to incremental (quarterly) data reports, reconciliation of claims has become more important. Fields have been added to address claims versioning. Please include original payments, adjustments, voids, replacements, etc., so that it is possible to reconcile claims.

DENTAL SERVICES DATA REPORT: 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 format for this report is designed to be consistent with professional services claims and encounters, but modified to be specific to dental services. This report should include services for claims paid in the reporting period, regardless of the date of service.

With the move to incremental (quarterly) data reports, reconciliation of claims has become more important. Fields have been added to address claims versioning. Please include original payments, adjustments, voids, replacements, etc., so that it is possible to reconcile claims.

PROVIDER DIRECTORY REPORT: 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 Provider Directory must contain all providers identified in the Professional Services, Institutional Services, Pharmacy, and Dental Services Data Reports. The Provider Directory must have a crosswalk between your internal practitioner (individual or organization) ID and the NPI.

PLAN BENEFIT DESIGN REPORT: 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. Reporting entities that are required to provide this report will be provided an opportunity to participate in the development and testing of this report.

NON-FEE-FOR-SERVICE MEDICAL EXPENSES REPORT: 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 that are required to provide this report will be provided an opportunity to participate in the development and testing of this report.

REQUIRED REPORTS FOR REPORTING ENTITIES:

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

2015 MCDB DATA SUBMISSION SCHEDULE:

2015 Medical Care Data Base Submission Schedule				
MCDB Data Reporting	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Reporting Period (Based on Paid Date)	01/01/15 – 03/31/15	04/01/15 – 06/30/15	07/01/15 – 09/30/15	10/01/15– 12/31/15
Data Submission Due Date	05/31/2015	08/31/2015	11/30/15	02/29/16
Annual Waiver Request Due Date	01/15/2015	01/15/2015	01/15/2015	01/15/2015
Format Modifications Request Due Date	04/30/2015	07/31/2015	10/31/2015	01/31/2016
Extension Request Due Date	04/30/2015	07/31/2015	10/31/2015	01/31/2016

ANNUAL WAIVER, FORMAT MODIFICATION, and EXTENSION REQUESTS

Payors may apply for annual waivers (COMAR 10.25.06.17A) to seek exemption from reporting one or all files for the entire year; format modifications (COMAR 10.25.06.17B) to request variances on threshold requirements, modify response values, or field lengths; and extensions (COMAR 10.25.06.16) to seek a delay in the submission deadline. All requests must be submitted via the MCDB Portal. For further instructions, see MCDB Portal Instructions in Appendix D. The MHCC staff assesses each payor's request(s) based on that payor's particular circumstances. Payor's must provide detailed explanations and plans for remediation for each request.

Typically, annual waivers are only provided if the payor is able to document that they do not meet the reporting threshold or that the regulations do not apply to them. Extension requests will be considered only as exceptions and in the case of extraordinary circumstances.

Payors are reminded to submit format modification requests only for those data elements that have an assigned threshold value. It is important that payors reference the MCDB Data Quality Reports (DQR) before submitting their data element and modified threshold requests. The DQRs will be provided within the MCDB Portal and are designed to provide payors with a comparison of information reported and threshold values assigned, as well as detailed changes in key measures including total number of recipients, services, and payments from the previous submission. Payors are encouraged to respond to the DQRs on the MCDB Portal with feedback related to their data submission. Values labeled as "Unknown" or "Not Coded" do not contribute to meeting required threshold values. In the event that your submission includes enough of these values that it would fail to meet the required threshold, please request a format modification for these fields. Submissions that do not meet the specific thresholds listed in the DSM File Record Layout Guide will be rejected unless a format modification was obtained.

FORMATTING NOTES

- Match the **layout of the file submission** with the appropriate data report specifications.
- **RIGHT** justify all NUMERIC fields
- **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 (patient co-pay, patient deductible, other patient obligation) 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.
- Each record (row) must have the same length if using the flat format.
- If a delimiter is applied to a file, each record (row) must have the same count of the chosen delimiter.

Documentation for 2015 data will be submitted by an attached file to the standard MCDB Portal submission. SSS will provide a template for these attachments.

Each field will be analyzed for completion and accuracy, even those without threshold guidelines. Payors will be expected to provide explanations and plans for mitigation regarding fields which seem incomplete, as well as fields which demonstrate a trend of deterioration.

DOCUMENTATION FOR 2015 SUBMISSION DATA

Documentation for 2015 data files will be submitted via the MCDB Portal. This documentation will include any relevant information regarding homegrown procedure codes, services without payment information, organizational contracts with external provider networks, and information regarding anesthesia services.

RECORD LAYOUT and FILE SPECIFICATIONS

The record layout and data element specifications are available for download at http://mhcc.maryland.gov/mhcc/pages/apcd/apcd_mcdb/apcd_mcdb.aspx, and are an integral part of this DSM. A Frequently Asked Questions guide (FAQ) about the data submission process has been provided in Appendix F.

SPECIAL CONSIDERATIONS for 2015 MCDB DATA SUBMISSIONS

Values labeled as "Unknown" or "Not Coded" do not contribute to meeting required threshold values. In the event that your submission includes enough of these values that it would fail to meet the required threshold, please request a waiver for these fields.

Source System may no longer be left blank. If only reporting for one source system, use the default value of "A."

Date of Disenrollment should no longer be left blank if active. Instead, use the value "20991231."

APPENDICES

- APPENDIX A – CHANGE LOG (2014-2015)
 - APPENDIX B – GLOSSARY OF REPORTING ENTITY
DEFINITIONS
 - APPENDIX C – PATIENT, PLAN, AND PAYOR IDENTIFIERS
 - APPENDIX D – FINANCIAL DATA ELEMENTS
 - APPENDIX E – MCDB PORTAL INSTRUCTIONS
 - APPENDIX F – FREQUENTLY ASKED QUESTIONS (FAQ)
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Appendix A – Change Log (2014-2015)

Major Changes to 2015 Data Submission Manual:

- Removed from 2014 DSM (Page numbers reference 2014 DSM)
 - Removal of information regarding sFTP submission process. Replaced mentions of sFTP submissions with MCDB Portal submissions.
 - Removed mentions to Fixed Format/Variable Format.
 - Removed Number of Claims section (page 5).
 - Deleted key specifications related to fields (page 7-9).
 - Removed Documents Checklist (page 12).
 - Removed individual sections for each file type. Created spreadsheet for 2015 Data File Record Layout Guide to replicate this information (page 13-84). Individual Data Element changes can be found in the File Record Layout Guide.
 - Removed Data Submission Worksheets for Homegrown Codes and Anesthesia Services. This information will be communicated through the MCDB Portal (page 18-19).
 - Removed Non-Fee-For Services section (page 87).
 - Removed Media Format/Transmission Information (page 89).
 - Removed Appendix D – Data Reporting and Pre-Submission Data Checks (page 96)
- New and Modified in 2015 DSM (Page numbers reference 2015 DSM)
 - Updated submission schedule for 2015 (page 5).
 - Updated deadlines for 2015 (page 5).
 - Created spreadsheet for 2015 Data File Record Layout Guide (attached excel spreadsheet).
 - Created Appendix B for Glossary of Reporting Entity Definitions (page 10).
 - Updated Appendix C – Patient, Plan, and Payor Identifiers (page 12).
 - Created Appendix E for MCDB Portal Submission Instructions (page 16).
 - Created Appendix F for Frequently Asked Questions (page 18).

Appendix B – Glossary of Reporting Entity Definitions

Payor - (a) An insurer or nonprofit health service plan that holds a certificate of authority and provides health insurance policies or contracts in Maryland; (b) a health maintenance organization (HMO) that holds a certificate of authority in Maryland; or (c) Third Party Administrator registered as an administrator under Title 8, Subtitle 3 of the Insurance Article.

Qualified Health Plan (QHP) - 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) - 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) - 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.

Third Party Administrator (TPA) - 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. The TPA definition includes Behavioral Health Administrators and Pharmacy Benefit Managers.

Pharmacy Benefit Manager (PBM) - 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.

Managed Care Organization (MCO) - 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.

Appendix C – Patient, Plan, and Payor Identifiers

The MCDB here are several patient, plan, and payor identifiers included in the MCDB data reports. Payor ID, Plan or Product ID #, Subscriber ID #, and Encrypted Contract or Group # are defined as follows: (a) Payor ID is assigned by MHCC and helps identify the reporting company; (b) Plan or Product ID # is an internal (payor) ID for the claims adjudication system and would be the main linker to the benefit design information; (c) Encrypted Contract or Group # is the ID/number associated with the group (e.g. State of Maryland, Business ABC, etc.,) policy number (could be the individual contract number in the case of individual market); and (d) Subscriber ID # is the individual's policy number (usually the same within a family policy).

There are three patient identifiers included in the MCDB data reports: (a) Payor Encrypted Patient Identifier is the payor's internal identifier for the member; (b) the Universally Unique Identifier (UUID) is generated by the payor using an encryption algorithm provided by MHCC; and (c) the Master Patient Index (MPI) is created by the State Designated Health Information Exchange (HIE) on behalf of the MHCC based on data provided by the payor to the HIE. The payor encrypted ID and UUID are reported on the eligibility and claims files. While there is a field allocated for the MPI, payors will not be required to submit it as part of their report. Instead, payors will be required to submit a demographic file to the HIE, who will generate the MPI and provide a cross-walk of the payor-encrypted ID and MPI to the MHCC. Additional details and instructions regarding the UUID and MPI are provided below.

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.maryland.gov/mhcc/pages/apcd/apcd_mcdm/apcd_mcdm_mcdm_uuid.aspx. The file is password protected. The password will be forwarded to the payor contact via e-mail.

The Commission strongly encourages all carriers to consider the simple implementation of the software for the 2015 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. Adrien Ndikumwami at (301) 628-3262 or by email at ANDikumwami@s-3.com.

MASTER PATIENT INDEX (MPI) – CRISP Hashed Unique Identifier

The MCDB currently uses a software algorithm to generate Universally Unique ID's (UUIDs) for each person across payors; however, this algorithm is limited by its over-reliance on Social Security Number. This is particularly problematic for self-insured plans with carve-outs for pharmacy plans, where SSN is often not available. The Master Patient Index (MPI) technology used by the Chesapeake Regional Information System for Our Patients (CRISP), Maryland's statewide health information exchange (HIE), is not as reliant on the SSN and will establish a consistent patient identifier across all submitting MCDB payors.

In 2014, selected submitters were required to submit a Demographics File to CRISP, as part of a pilot test project. In 2015, all payors will be required to participate. Payors will be required to provide limited identifiable data to CRISP, who will generate the MPI and provide an MPI to payor-encrypted ID cross-walk file to MHCC. Payors will be required to submit data to CRISP following their data specifications and Carrier Onboarding Process. Unlike other MCDB reports, the demographic file submission to CRISP will only occur once at the end of the year on January 15, 2016.

The details of the file specifications and process will be available at: http://mhcc.maryland.gov/mhcc/pages/apcd/apcd_mcdm/apcd_mcdm.aspx once the pilot project is complete.

Appendix D – Special Instructions for Financial Data Elements

FINANCIAL DATA ELEMENTS – Billing and Reimbursement Information

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

Professional and Dental 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, Dental, and Institutional Services Data		Pharmacy Data	
Billed Charge	<i>Dollar amount as billed by the practitioner/institution for health care services rendered.</i>	<i>Rounded to whole dollars (no decimals)</i>	<i>Prescription retail price including ingredient cost, dispensing fee, tax, and administrative expenditures.</i>	<i>Formatted using 2 implied decimal points</i>
Allowed Amount	<i>Retail Amount for the specified procedure code.</i>	<i>Rounded to whole dollars (no decimals)</i>		
Patient Deductible	<i>Fixed amount that the patient must pay for covered services before benefits are payable.</i>	<i>Rounded to whole dollars (no decimals)</i>	<i>Fixed amount that the patient must pay for covered services before benefits are payable.</i>	<i>Formatted using 2 implied decimal points</i>
Patient Coinsurance/ Patient Co-payment	<i>Specified amount or percentage the patient is required to contribute towards covered medical services after any applicable deductible.</i>	<i>Rounded to whole dollars (no decimals)</i>	<i>Specified amount or percentage the patient is required to contribute towards covered medical services after any applicable deductible.</i>	<i>Formatted using 2 implied decimal points</i>

FINANCIAL DATA ELEMENTS	Professional, Dental, and Institutional Services Data		Pharmacy Data	
Other Patient Obligations	<i>Any patient liability other than deductible or coinsurance/co-payment. Includes obligations for out-of-network care (balance billing), non-covered services, or penalties.</i>	<i>Rounded to whole dollars (no decimals)</i>	<i>Any patient liability other than deductible or coinsurance/co-payment. Includes obligations for out-of-network care (balance billing), non-covered services, or penalties.</i>	<i>Formatted using 2 implied decimal points</i>
<p><i>Note: Total Patient Liability <u>should equal the sum</u> of Patient Deductible, Patient Coinsurance/Patient Co-payment, and Other Patient Obligations. Please make an effort to provide this financial information.</i></p>				
Reimbursement Amount	<i>Amount paid to a practitioner, other health professional, office facility, or institution.</i>	<i>Rounded to whole dollars (no decimals)</i>	<i>Amount paid to the pharmacy by the payor.</i>	<i>Formatted using 2 implied decimal points</i>
Coordination of Benefit Savings or Other Payor Payments*	<i>Amount paid by the primary payor if the patient is not the primary insurer.</i>	<i>Rounded to whole dollars (no decimals)</i>		

**Only reported in the institutional services file.*

Appendix E – MCDB Portal Instructions

MEDICAL CARE DATA BASE PORTAL SUBMISSIONS

In order to submit files to the MCDB Portal for the 2015 data submission period, each payor will need to have their primary point of contact reach out to Social & Scientific Systems, Inc. in order to request an administrative account. An administrative account will then be created for the individual designated to be the administrator in the contact email. The administrator will then receive a user name, as well as instructions with how to log-in at www.mcdbportal.com in order to submit data.

In order for data submissions to be properly processed, a payor will need to ensure that all of the following is accurate:

- File length meets specifications
- Column length meets specifications
- Line count meets specifications
- Record count matches value reported by payor
- Delimiter accurately selected (Portal accepts flat file, pipe (|), and comma (,) delimiters.
- File naming conventions are properly followed
- Each source system is reported in a separate file

Should a payor have any problems while trying to submit files, they can submit questions to: mcdbportal@s-3.com. In the event of an issue requiring immediate assistance, contact either Adrien Ndikumwami at andikumwami@s-3.com (301-628-3262) or Alexander Bruce at abruce@s-3.com (301-628-3380).

File Naming Conventions

The following naming convention is in effect for all data reports. The indicators are separated by the _ (underscore) symbol: **PayorID_File_Version_Date**

Payor ID: MHCC assigned payor 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_053115
P123_ProfServ_B_061515
P123_ProfServ_C_063015

P123_Pharm_A_053115
P123_Pharm_B_061515
P123_Pharm_C_063015

P123_Prov_A_053115
P123_Prov_B_061515
P123_Prov_C_063015

P123_InstServ_A_053115
P123_InstServ_B_061515
P123_InstServ_C_063015

P123_MedElig_A_053115
P123_MedElig_B_061515
P123_MedElig_C_063015

P123_Dental_A_053115
P123_Dental_B_061515
P123_Dental_C_063015

Appendix F – Frequently Asked Questions (FAQ)

Q. How do I submit data?

A. To submit data, you will need to access the MCDB Portal at www.mcdbportal.com. Contact SSS by email at mcdbportal@s-3.com to receive an administrative account. From there, you can log into the MCDB Portal and access the MCDB Portal User Guide under the tab “Documents.” This will provide a comprehensive guide to the various features of the MCDB Portal. Please see Appendix A for further instructions on submission requirements.

Q. What is a source system?

A. A source system is an individual business entity or platform from which data are gathered. Source systems are required so that, in the event of errors within the data, the source of the data can be accurately identified. If you only have one source for your data, or you do not need to identify the source of your data, please report your source system as “A.”

Q. How do I know if I need to request a format modification waiver?

A. Format modification waivers need to be requested in one of two instances:

- 1) If a specific field is captured in a number of characters that do not correspond with the number of characters required in the File Record Layout Guide, a waiver is required for the new character length of the field that will be submitted in the file.
- 2) If a specific field requires a certain threshold percentage of records to be filled in order to be accepted, a waiver is required if that particular threshold cannot be met. Keep in mind that unknown values do not contribute to a field meeting the required threshold percentage. Any file submission containing a number of unknown records which exceed the minimum required threshold will require a format modification waiver to be processed.

Q. What information is needed when requesting a format modification waiver?

A. When submitting a request for a format modification waiver, include the target threshold you plan to reach for the threshold in question, if applicable, or the required field length of the data element in question. Provide an explanation for why the threshold is necessary, as well as a plan for remediation for future data submissions so that the waiver will no longer be necessary.

Q. Are the terms “patient” and “enrollee” synonymous?

A. Yes. Patient is the term used in claims files, while enrollee is used in the eligibility file.

Q. Should members without activity in the submission quarter be included in the eligibility file?

A. Yes, please include all members whether they have been active during the submission quarter or not.

Q. Should files be encrypted or compressed before being submitted?

A. No, please submit all files as text documents in a flat-file format, selecting any delimiter on the MCDB Portal that may apply to your file.

Q. Should claims which were paid in a previous quarter and later voided be reported?

A. Yes, previous records need to be updated and consolidated. Please indicate if a claim has been voided in the field “Claim Line Type.”

Q. Are there any other methods to submit data to the MCDB other than using the Portal?

A. No, the MCDB Portal is the only method to submit data to the MCDB.

Q. What is Version Number?

A. Version number of a claim service line. The version begins with 1 and is incremented by 1 for each subsequent version of that service line.

Q. What is Claim Line Number?

A. Line number for the service within a claim.

Q. What is Claim Line Type?

A. Coding indicating Type of Record. For example, Original, Void, Replacement, Back Out, and Amendment.

Q. What is Former Claim Number?

A. Former claims control number or claims control number used in the original claim that corresponds to a claim line.

Q. Are the terms “claims paid date” and “adjudication date” synonymous?

A. No, Claim Paid Date is the date that the claim was paid. This date should agree with the paid date the Finance and Actuarial departments are using in your organization. Adjudication date is the date the claim was adjudicated.



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