MARYLAND HEALTH CARE COMMISSION

COMAR 10.25.06 NEW! – MARYLAND MEDICAL CARE DATA BASE AND DATA COLLECTION

(Effective April 19, 2010)

MCDB

Formatted for the MHCC
2009 MEDICAL CARE DATA BASE

DATA BASE SUBMISSION MANUAL

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Released June 15, 2010
Printed 6/16/10

MARYLAND HEALTH CARE COMMISSION

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

TABLE OF CONTENTS

SECTION

I. Introduction 1

II. File Documentation 6

III. Data Element Documentation 13

APPENDICES

A. 2009 MCDB Payers and Payer ID Numbers 25

B. Media Format Information 26

C. Explanation of Key Data Elements: Coverage Type and Practitioner Specialty 27

D. Special Instructions for Financial Data Elements 32

E. File Layouts: Professional Services, Pharmacy Services, Provider Directory, and Institutional Services Data Reports 34

F. Data Dictionary: Professional Services, Pharmacy Services, Provider Directory, and Institutional Services Data Reports 46

G. Timeline for MCDB Data Expansion 71

MARYLAND HEALTH CARE COMMISSION

DATA SUBMISSION MANUAL

PURPOSE: The Medical Care Data Base (MCDB) Data Submission Manual is designed to provide payers with guidelines of technical specifications, layouts, and definitions necessary for filing the Professional Services Data, Pharmacy Data, Provider Directory, and Institutional Services Data reports required under *COMAR 10.25.06.01B*. This manual is available in electronic form on the Commission's website at mhcc.maryland.gov.

PAYER ID #: Please see Appendix A for a list of 2009 MCDB payers and assigned Payer ID numbers. The Payer assigned ID number is required on all submission media and documentation.

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

Mr. Larry Monroe
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215
Phone: (410) 764-3390 Fax: (410) 358-1236
lmonroe@mhcc.state.md.us

Please direct data processing inquiries to:

Mr. Adrien Ndikumwami
Social & Scientific Systems, Inc.
8757 Georgia Avenue, 12th Floor
Silver Spring, MD 20910
Phone: (301) 628-3262 Fax: (301) 628-3201
andikumwami@s-3.com

For information on the MCDB SFTP submission process contact:

Mr. Lee Nelson
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215
Phone: (410) 764-3486 Fax: (410) 358-1236
lnelson@mhcc.state.md.us

DATA COMPLETENESS SUMMARY REPORT

Payers who contributed to the 2008 Medical Care Data Base (submissions received June 2009) were mailed a Data Completeness Summary Report in June 2010 that shows total number of recipients, services, and payments by delivery system, plan type, and coverage type for calendar years 2007 and 2008.

Please use this report to evaluate changes between your 2008 data (submitted in June 2009) and this 2009 MCDB data submission. If there are decreases or increases in the total number of recipients, services, or payments above 10 percent you must provide detailed documentation with your current submission.

If your company did not receive the 2008 Data Completeness Summary Report, please contact Larry Monroe at lmonroe@mhcc.state.md.us

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DATA SET GLOSSARY

REPORTING PERIOD: Claims adjudicated between January 1, 2009 through April 30, 2010 for services provided on or after January 1, 2009.

PROFESSIONAL SERVICES 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

PHARMACY REPORT: These data detail prescription drugs only.

PROVIDER DIRECTORY REPORT: These data detail all health care practitioners and suppliers who provided services to enrollees during the reporting period. Each professional 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.

INSTITUTIONAL SERVICES REPORT: These data 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.

REPORTING DEADLINE: August 31, 2010 *(extended from June 30, 2010 for the 2009 MCDB submission only)*

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.

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.

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OVERVIEW OF MODIFICATIONS AND KEY SPECIFICATIONS

GENERAL –

- The new regulations under **COMAR 10.25.06 Maryland Medical Care Data Base and Data Collection** modify and expand the reporting requirements for payers that submit health care encounters and claims data to the MHCC. These regulations became effective on April 19, 2010, and replace prior regulations. They can be accessed via the Commission's website at: http://mhcc.maryland.gov/payercompliance.

- The **Institutional Services** Claims File is **new** and **mandatory** for the 2009 MCDB Submission. This report should include all institutional health care services provided to Maryland residents during the reporting period in accordance with the new regulations under **COMAR 10.25.06.09**.

- **16-month Reporting Period –** claims adjudicated between January 1, 2009 through April 30, 2010 for services provided on or after January 1, 2009.

- The new **Record Identifier** field is used to identify the data report file: 1 – Professional Services; 2 – Pharmacy Services; 3 – Provider Directory; and 4 – Institutional Services.

- The **Delivery System Type** category was modified to include information on policies & contracts sold by a **Health Maintenance Organization** (including HMO, POS, EPO), and policies & contracts sold by a **Life & Health Insurance Company** (including PPO, POS, EPO, Indemnity Care) licensed in Maryland to provide these services. (pg. 16, pg. 47).

- The **Coverage Type** variable was reconfigured into two variables last year: Plan Liability" (risk or Administrative Services Only, pg. 15) and a *revised* **"Coverage Type"** variable (pg. 14, pg. 47) with new coding options to better match the types of coverage currently available in Maryland—including the Health Insurance Partnership plan.

- The **Record Status** field on the Professional Services file has replaced (renamed for) **"Type of Bill"** (pg. 24, pg. 48).

- On the Institutional Services File, the **Record Status** field will be determined using the **third digit** in the "Type of Bill" field (pg.24, pg.66), 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.

- 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.

- **Patient Date of Enrollment** in plan – Date is **20090101** if patient is enrolled at start of 2009. Enter other date if patient **not enrolled** at start of year but enrolled during 2009.

- **Patient Date of Disenrollment** in plan **– Leave blank** if patient is **still enrolled** on **20091231**. If patient **disenrolled** before end of year, enter date disenrolled.

- Submissions that do not meet the specific thresholds listed in the File Layouts Section II (pg. 34) will be returned unless a waiver was obtained. (Note: If you cannot meet the minimum thresholds, you must request an exemption prior to submission.)

- The deadline for filing requests for waiver exemptions or format exceptions is **August 16, 2010**. The data base contractor is not authorized to grant exceptions.

- A timeline for the MCDB Data Expansion to include the **Institutional Claims File** and **Medical Eligibility File** and **Pharmacy Eligibility File** is provided in Appendix G.

INSTITUTIONAL SERVICES DATA REPORT –

- The Institutional Services File – Data Submission Documentation – **Section 1. Institutional Services Control Total Verification table** (pg. 12) includes columns for: **Total Amount Paid (Insurer + Patient)**; **Total Insurer Reimbursement Amount**, and **Total Patient Liability**. *(Note: Total patient liability should equal the sum of patient deductible, patient coinsurance/patient co-payment, and other patient obligations.)*

- The Institutional Services File – Data Submission Documentation – **Section 2. Date of Discharge or End of Service Frequency table** (pg. 12) includes columns for: **Number (#) of Hospital Inpatient Discharges**, and **Number (#) of Hospital Outpatient or Non-hospital Visits** for the reporting period. *(Note: If the Date of Discharge or End of Service date is not reported, then assume that the Date of Admission or Start of Service, and the Date of Discharge or End of Service are the same.)*

PROFESSIONAL SERVICES DATA REPORT –

- The Professional Services File – Data Submission Documentation – **Section 1. Professional Services Control Total Verification table** (pg. 8) includes columns for: **Total Amount Paid (Insurer + Patient)**; **Total Insurer Reimbursement Amount**, and **Total Patient Liability**. *(Note: Total patient liability should equal the sum of patient deductible, patient coinsurance/patient co-payment, and other patient obligations.)*

- The Professional Services File – Data Submission Documentation – **Section 2. Service Thru Date Frequency table** (pg. 8) has replaced the Service From Date Frequency table. *(Note: If the Service Thru Date is not reported, then assume that the Service From Date and the Service Thru Date are the same.*

- The Professional Services File – Data Submission Documentation – **Section 3. Homegrown Procedure Codes / Capitation Questions** (pg. 9) has been expanded to include questions on the types of services reported that do not have payment information (capitated or global contract), and contracts with external provider networks.

- The Professional Services File Layout has been expanded to include **Practitioner National Provider Identifier (NPI) Number used for Billing**. This is in addition to the Servicing Practitioner Individual National Provider Identifier (NPI) Number.

- For the Professional Services File Layout, Variable Format, the **Date of Enrollment** and the **Date of Disenrollment** have been moved from the variable to the fixed segment of the record layout (pg. 37).

- **Patient Covered by Other Insurance Indicator** on the **Professional Services Layout** (field #7, pg. 35) and **Institutional Services Layout** (field #140, pg. 45). If you believe you are the **primary payer** then please code "0" (zero) in this field (pg. 47, pg. 67). **MHCC is asking payers to pay special attention to coding this field as it is important in many analyses of interest to payers.**

PHARMACY DATA REPORT –

- The Pharmacy Data File Layout has been expanded and reconfigured to include fields for the **Prescription Fill Number** and **Date Prescription Written**.

- The Patient **Date of Enrollment** and **Date of Disenrollment** fields have been added to the Pharmacy Data Report.

- The Pharmacy Data File Layout (pg. 39, pg. 53) was expanded to include a field for the **Prescribing Practitioner Individual National Provider Identifier (NPI) Number**.

PROVIDER DIRECTORY –

- The Provider Directory Report (pg. 40, pg. 56) has been expanded to include the **Practitioner Organizational National Provider Identifier (NPI) Number**. *(Note: If the practice is a Multi-Practitioner Health Care Organization, then this field should be filled.)*

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PAYER SUBMISSION AND DOCUMENTATION CHECKLIST

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

	Item	**Page #**
☐	Professional Services Data Report Layout ***Modified!***	35
☐	Pharmacy Data Report Layout ***Modified!***	39
☐	Provider Directory Report Layout ***Modified!***	40
☐	Institutional Services Data Report Layout ***New!***	41
☐	Media Format Information	26
☐	Payer ID# on all media & documentation	25

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

☐	Copies of File Layouts	
☐	File Documentation – Section II	6
☐	Data Element Documentation – Section III	13
☐	Coverage Type Mapping ***Modified!***	14
☐	Delivery System Mapping ***Modified!***	16
☐	Consumer Directed Health Plan Mapping	16
☐	Practitioner Specialty Mapping	20
☐	Record Status Mapping *(renamed from Type of Bill)* ***Modified!***	24

DATA WITHOUT PROPER DOCUMENTATION WILL BE RETURNED!

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SECTION II

FILE DOCUMENTATION

- PROFESSIONAL SERVICES FILE MODIFIED!
- PHARMACY FILE MODIFIED!
- PROVIDER DIRECTORY MODIFIED!
- INSTITUTIONAL SERVICES FILE **NEW!**

FORMATTED FOR THE 2009 MARYLAND MEDICAL CARE DATA BASE (MCDB) SUBMISSION

MARYLAND HEALTH CARE COMMISSION

MEDICAL CARE DATA BASE DOCUMENTATION FORM

PAYER NAME (S):_____

PAYER ID #: _____ *(See Appendix A for a complete list of 2009 MCDB payers & Payer ID #s)*

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 Claims: _____
Blocking Factor: _____ Number of Services: _____
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
MEDIA TYPE: ☐ IBM 3480/3480E Cartridge ☐ IBM 3490/3490E Cartridge
☐ CD-ROM/DVD ☐ DLT Tape IV
☐ Secure FTP

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

Please forward media and accompanying documentation to:

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

PROFESSIONAL SERVICES FILE – Data Submission Documentation

1. Professional Services Control Total Verification

Please complete the following table by indicating the number of covered lives and number of services by delivery system type for the time period January 1, 2009 through April 30, 2010. **Use the average number of covered lives** (the average number of insured individuals and their dependents) **per year as the basis for your determination of enrollment.** In addition, specify the total payment information for all delivery system types. *Please compare this report to the 2008 Data Completeness Summary Report.*

			Payment Information			
Delivery System Type	**Covered Lives**	**# Services**	**Total Allowed Amount**	**Total Patient Liability***	**Total Insurer Reimbursement Amount**	**Total Amount Paid (Insurer+Patient)**
Policies or Contracts+ sold by a **Health Maintenance Organization** licensed in Maryland to provide these services (including HMO, POS, EPO)						
Below refers to Policies or Contracts+ sold by a **Life & Health Insurance Company** licensed in Maryland to provide these services.						
PPO, POS, EPO						
Indemnity Care						
Other (specify)						
Total			**$**	**$**	**$**	**$**

* *Total patient liability should equal the sum of patient deductible, patient coinsurance/co-payment, and other patient obligations.*

+ *Includes Administrative Services Only (ASO) contracts under the delivery system under which they are sold.*

2. Service Thru Date Frequency

Please complete the table below using the month and year segments for **Service Thru Date** (data element number 29 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 28) and the Service Thru Date are the same. This table will provide an assessment of your data submission.

Service Thru Date Month/Year	# Services
Jan 2009	
Feb 2009	
Mar 2009	
Apr 2009	
May 2009	
Jun 2009	

Service Thru Date Month/Year	# Services
Jul 2009	
Aug 2009	
Sept 2009	
Oct 2009	
Nov 2009	
Dec 2009	

Service Thru Date Month/Year	# Services
Jan 2010	
Feb 2010	
Mar 2010	
Apr 2010	

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

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

3. Homegrown Procedure Codes / Capitation Questions

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 payer 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?

☐ 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 ☐ UniteHealthOne

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

☐ Other (specify) _____

4. Anesthesia Services

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 payers 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.	_____

PHARMACY FILE – Data Submission Documentation

1. Date Filled Frequency (Pharmacy)

Please complete the table below using the month and year segments for **Date Filled** (data element number 14 on the file layout). This table will provide an assessment of your data submission.

Month/Year	# Prescriptions
Jan 2009	
Feb 2009	
Mar 2009	
Apr 2009	
May 2009	
Jun 2009	
Jul 2009	
Aug 2009	

Month/Year	# Prescriptions
Sep 2009	
Oct 2009	
Nov 2009	
Dec 2009	
Jan 2010	
Feb 2010	
Mar 2010	
Apr 2010	

2. National Drug Code (NDC)

Please complete the table below with totals from your pharmacy claims data. Provide a total for NDC and all non-coded drugs. All remaining drug code totals should be summed under "Not National Drug Codes."

Code Range	Total Reimbursement Amount (data element #17)	# Prescriptions
NDC		
Not Coded		
NOT National Drug Codes		
TOTAL		

Comments:_____

3. Mail Order Pharmacy Information

Mail Order Pharmacy NCPDP#	Name of Pharmacy

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

INSTITUTIONAL SERVICES FILE – Data Submission Documentation

1. Institutional Services Control Total Verification

Please complete the following table by indicating the number of persons including covered lives and number of discharges or visits by type of facility for the time period January 1, 2009 through April 30, 2010. **Use the average number of covered lives** (the average number of insured individuals and their dependents) **per year as the basis for your determination of enrollment.** In addition, specify the total payment information for all types of facilities.

			Payment Information		
Facility Type	**# Persons** (Covered lives included)	**# Discharges** (Hospital Inpatient) or **# Visits** (Hospital Outpatient /Non-Hospital facility)	**Total Amount Paid (Insurer+Patient)**	**Total Insurer Reimbursement Amount**	**Total Patient Liability***
Hospital Inpatient					
Hospital Outpatient					
Non-Hospital Facility					
Total			**$**	**$**	**$**

** Total patient liability should equal the sum of patient deductible, patient coinsurance/co-payment, and other patient obligations.*

2. Date of Discharge or End of Service Frequency

Please complete the table below using the month and year segments for **Date of Discharge or End of Service** (data element number 18 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 17) and the Date of Discharge or End of Service are the same. This table will provide an assessment of your data submission.

Month/Year	# Hospital Inpatient Discharges	# Hospital Outpatient / Non-Hospital Visits
Jan 2009		
Feb 2009		
Mar 2009		
Apr 2009		
May 2009		
Jun 2009		
Jul 2009		
Aug 2009		

Month/Year	# Hospital Inpatient Discharges	# Hospital Outpatient / Non-Hospital Visits
Sept 2009		
Oct 2009		
Nov 2009		
Dec 2009		
Jan 2010		
Feb 2010		
Mar 2010		
Apr 2010		

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

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

MARYLAND HEALTH CARE COMMISSION

SECTION III

DATA ELEMENT DOCUMENTATION

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Coverage Type

Coverage Type: The data field that indicates type of insurance coverage (i.e., individual market, Medigap, employer sponsored, etc.).

Instructions: Please identify enrollee type of insurance coverage as mapped to the COMAR defined coverage types **and** indicate the number of services in your data set.

(See Appendix C for plans that offer coverage in the various markets.)

Coverage Type	Value	Description (describe values mapped from payer system)	# Services
Medicare Supplemental (i.e. Individual, Group, WRAP)	1		
Medicare Advantage Plan (Health plan options that are part of the Medicare program)	2		
Individual Market (not MHIP)	3		
Maryland Health Insurance Plan (MHIP) (State-managed health insurance program for MD residents unable to obtain health insurance from other sources.)	4		
Private Employer Sponsored or Other Group (i.e. union or association plans)	5		
Public Employee – Federal (FEHBP)	6		
Public Employee – Other (state, county, local/municipal government and public school systems)	7		
Comprehensive Standard Health Benefit Plan – (except HIP) (Private or Public Employee) The CSHBP applies to small businesses (i.e., public or private employers) with 2 to 50 eligible employees or a self-employed individual.	8		
Health Insurance Partnership (HIP) (State-subsidy to help MD small employers with 2 to 9 employees offer health insurance to their employees.)	9		
Unknown	Z		

Plan Liability Flag

Plan Liability Flag: This field indicates if the insurer is at risk for the patient's service use or the insurer is simply paying claims as an ASO (Administrative Services Only).

Plan Liability Flag		# Services
Risk	1	
ASO (employer self-insured)	2	
TOTAL		

Participating Provider Flag

Participating Provider Flag: This field identifies if the service was provided by a provider that participates in the payer's network. Please document why you cannot identify whether a provider does or does not participate.

Participating Provider Flag		# Services
Participating	1	
Non-Participating	2	
Not Coded	3	
TOTAL		

Delivery System Type

Delivery System Type: The data field that indicates the payer's product line.

Instructions: Please identify how your product line is mapped to the COMAR defined delivery system types **and** indicate the number of services in your data set.

COMAR delivery system types include:

Delivery System Types	Value	Product Description	# Services (see page 8)
Policies or Contracts* sold by a **Health Maintenance Organization** licensed in Maryland to provide these services (including HMO, POS, EPO)	1		
Below refers to Policies or Contracts* sold by a **Life & Health Insurance Company** licensed in Maryland to provide these services.			
PPO, POS, EPO	2		
Indemnity Care	3		
Other	4		
Not Coded	9		

** Includes Administrative Services Only (ASO) contracts under the delivery system under which they are sold.*

Consumer Directed Health Plan Indicator (0,1): A "1" indicates a Consumer Directed Health Plan alone or with Health Savings Account (HSA) or Health Resources Account (HRA).

Instructions: Please identify how your product line is mapped to this indicator **and** indicate the number of services in your data set.

Consumer Directed Health Plan Indicator	Value	Description (describe values mapped from payer system)	# Services
No	0		
Yes	1		

Place of Service

Place of Service: The location where health care services are rendered. Definitions provided on pages 18 & 19.

Instructions: In the description column, please describe the values as mapped from your system **and** indicate the number of services in your Professional Services data set.

CMS/HIPAA Information			
Place of Service	**Value**	**Description** (describe values mapped from payer system)	**# Services**
Provider's Office	11		
Patient's Home	12		
Assisted Living Facility	13		
Urgent Care Facility – please code appropriately	**20**		
Inpatient Hospital	21		
Outpatient Hospital	22		
Emergency Room – Hospital	23		
Ambulatory Surgical Center	24		
Birthing Center	25		
Military Treatment Facility	26		
Skilled Nursing Facility	31		
Nursing Facility	32		
Custodial Care Facility	33		
Hospice	34		
Ambulance – Land	41		
Ambulance – Air or Water	42		
Inpatient Psychiatric Facility	51		
Psychiatric Facility – Partial Hospitalization	52		
Community Mental Health Center	53		
Intermediate Care Facility/Mentally Retarded	54		
Residential Substance Abuse Treatment Facility	55		
Psychiatric Residential Treatment Center	56		
Non-residential Substance Abuse Treatment Facility	57		
Mass Immunization Center	60		
Comprehensive Inpatient Rehabilitation Facility	61		
Comprehensive Outpatient Rehabilitation Facility	62		
End-Stage Renal Disease Treatment Facility	65		
State or Local Public Health Clinic	71		
Rural Health Clinic	72		
Independent Laboratory & Imaging	81		
Other Place of Service	99		

Place of Service Codes for Professional Claims

Centers for Medicare & Medicaid Services (CMS)

CMS – Code	Place of Service	Description
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility that provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
41	Ambulance – Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility - Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility, which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
71	State or Local Public Health Clinic	A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
99	Other Place of Service	Other place of service not identified above.

Practitioner Specialty

Practitioner Specialty: The health care field in which a physician, licensed health care professional, dental practitioner, or office facility has been certified.

Instructions: In the description column, please list the payer specialty description(s) mapped to the COMAR defined specialties (more than one specialty can map to a COMAR defined specialty). Please indicate the number of services in your Professional Services data set that link to those specialties in the Provider Directory file.
(See Appendix C for examples of practitioner specialty expansions and/or consolidations.)

Physicians: (This list is not all inclusive.)

◆ **Indicates specialty listed alphabetically and numerically.**

COMAR Information			
Practitioner Specialty	**Value**	**Description** (payer specialty descriptions mapped to COMAR defined specialties)	**# Services**
General Practice	001		
General Surgery	002		
Allergy & Immunology	003		
Anesthesiology	004		
Cardiology	005		
Dermatology	006		
Emergency Medicine	007		
Endocrinology Medicine	008		
Family Practice	009		
Gastroenterology	010		
Geriatrics	011		
Hand Surgery	012		
Hematology	013		
Internal Medicine	014		
Infectious Disease	015		
Multi-Specialty Medical Practice ◆	101		
Nephrology	016		
Neonatology ◆	100		
Neurology	017		
Nuclear Medicine	018		
Obstetrics/Gynecology ◆	039		
Oncology	019		
Ophthalmology	020		

COMAR Information			
Practitioner Specialty	**Value**	**Description** (payer specialty descriptions mapped to COMAR defined specialties)	**# Services**
Orthopedic Surgery	021		
Osteopathy (include Manipulations)	022		
Otology, Laryngology, Rhinology, Otolaryngology	023		
Pathology	024		
Pediatrics	025		
Peripheral Vascular Disease or Surgery	026		
Plastic Surgery	027		
Physical Medicine and Rehabilitation	028		
Proctology	029		
Psychiatry	030		
Pulmonary Disease	031		
Radiology	032		
Rheumatology	033		
Surgical Specialty Not Listed Here	034		
Thoracic Surgery	035		
Urology	036		
Other Specialties not listed (public health, industrial medicine)	037		
Physician w/o Specialty Identified & Specialty not listed here	038		
Obstetrics/Gynecology ◆	039		
Neonatology ◆	100		
Multi-Specialty Medical Practice ◆	101		

◆ **Indicates specialty listed alphabetically and numerically.**

Other Health Care Professionals: **(This list is not all inclusive.)**

COMAR Information			
Practitioner Specialty	**Value**	**Description** (payer specialty descriptions mapped to COMAR defined specialties)	**# Services**
Acupuncturist	040		
Alcohol/Drug Detox Services	041		
Ambulance Services	042		
Audiologist/Speech Pathologist	043		
Chiropractor	044		
Freestanding Clinic (Not a Government Agency)	045		
Day Care Facility (Medical, Mental Health)	046		
Dietitian/Licensed Nutritionist	047		
Home Health Provider	048		
Mental Health Clinic ◆	102		
Advanced Practice Nurse: Anesthetist	049		
Advanced Practice Nurse: Midwife	050		
Advanced Practice Nurse: Nurse Practitioner	051		
Advanced Practice Nurse: Psychotherapist	052		
Nurse – Other than Advanced Practice	053		
Occupational Therapist	054		
Optometrist	055		
Podiatrist	056		
Physical Therapist	057		
Psychologist	058		
Clinical Social Worker	059		
Public Health or Welfare Agency (federal, state and local government)	060		
Respiratory Therapist	063		
Voluntary Health Agency	061		
Other Specialty (Not Listed Above)	062		
Mental Health Clinic ◆	102		

◆ **Indicates specialty listed alphabetically and numerically.**

Dental: **(This list is not all inclusive.)**

COMAR Information			
Practitioner Specialty	**Value**	**Description** (payer specialty descriptions mapped to COMAR defined specialties)	**# Services**
General Dentist	070		
Endodontist	071		
Orthodontist	072		
Oral Surgeon	073		
Pedodontist	074		
Periodontist	075		
Prosthodontist	076		

Office Facilities: **(This list is not all inclusive.)**

COMAR Information			
Practitioner Specialty	**Value**	**Description** (payer specialty descriptions mapped to COMAR defined specialties)	**# Services**
Freestanding Pharmacy (includes grocery stores)	080		
Mail Order Pharmacy	081		
Independent Laboratory	082		
Independent Medical Supply Company	083		
Optician/Optometrist (for lenses and eye glasses)	084		
Please specify whether using professional services or supplier codes for the following:			
All Other Supplies	085		
Freestanding Medical Facility	090		
Freestanding Surgical Facility	091		
Freestanding Imaging Center	092		
Other Facility	093		

Record Status *(renamed from Type of Bill)* – Professional Services File

Record Status: The data field that describes payment status.

NOTE: Capitated services on the Professional Services File are also identified as services where at least three financial variables (billed charge, allowed amount, and reimbursement amount) are equal to **–999**. **Patient deductible, patient coinsurance/co-payment, and other patient obligations must be reported when available.**

MUST SUBMIT IN REQUIRED FORMAT *(see below)*

Value	Label	Definition
1	**Final Bill**	Total adjusted amount of all credits and debits paid for a claim by the insurance company to the provider.
8	**Capitated or Global Contract Services**	Set of pre-defined services provided by the provider to the plan's enrollees under contract with an insurance company or managed care plan in exchange for a fixed and guaranteed monthly payment for each enrollee assigned to the provider, or reimbursed through a global contract with an intermediary organization.

Instructions: Identify record status in the column provided. Please indicate the number of services in your data set.

Record Status Description	# Services
1 – Final Bill	
8 – Capitated or Global Contract Services	

Record Status *(from Type of Bill 3rd digit)* – Institutional Services File

Record Status: On the Institutional Services File, this data field will be determined using the third digit in the Type of Bill field.

Instructions: Identify record status in the column provided. Please indicate the number of services in your data set.

Values	Third digit Label	# Services
1	**Admit through Discharge**	
2,3,4	**Interim – First Claim Used** **Interim – Continuing Claims** **Interim – Last Claim**	
5	**Late Charge Only**	
7,8	**Replacement of Prior Claim** **Void/Cancel of Prior Claim**	

MARYLAND HEALTH CARE COMMISSION

APPENDIX A

2009 MCDB PAYERS & PAYER ID NUMBERS

Data due August 31, 2010 (extended from June 30, 2010 for the 2009 MCDB submission only)

ORGANIZATION	Payer ID #	ORGANIZATION	Payer ID #
Aetna U.S. Healthcare	P030	Great-West Life & Annuity Ins. Co.	P330
Aetna Life & Health Insurance Co.	P020	Guardian Life Insurance Company of America	P350
American Republic Insurance Co.	P070	Kaiser Permanente Mid-Atlantic States	P480
CareFirst BlueChoice, Inc.	P130	MAMSI Life and Health Ins. Co.	P500
CareFirst of Maryland, Inc.	P131	MD-Individual Practice Association, Inc.	P520
CIGNA Healthcare Mid-Atlantic, Inc.	P160	MEGA Life & Health Insurance Co.	P530
Connecticut General Life Ins. Co.	P180	Optimum Choice, Inc.	P620
Corporate Health Insurance Co.	P220	State Farm Mutual Automobile Ins. Co.	P760
Coventry Healthcare of Delaware, Inc.	P680	Trustmark Insurance Co.	P830
Assurant Health/Time Insurance Co.	P280	UniCare Life & Health Insurance Co.	P471
Golden Rule Insurance Co.	P320	United Healthcare Insurance Co.	P820
Graphic Arts Benefit Corporation	P325	United Healthcare of the Mid-Atlantic, Inc.	P870

MARYLAND HEALTH CARE COMMISSION

APPENDIX B

MEDIA FORMAT INFORMATION

Instructions:

MHCC will permit payers to upload data to a **Secure FTP server**, provided they have a **Secure FTP client**. This is the preferred submission method. If you would like to use this submission option, please contact Larry Monroe at (410) 764-3390 or via e-mail at lmonroe@mhcc.state.md.us. Otherwise data must be provided on one of the following media using either the ASCII or EBCDIC recording format.

Please label all media & documentation with your Payer ID # (pg. 25).

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 C

Explanation of Key Data Elements

- **COVERAGE TYPE**
- **PRACTITIONER SPECIALTY**

FORMATTED FOR THE 2009 MARYLAND MEDICAL CARE DATA BASE (MCDB) SUBMISSION

COVERAGE TYPE

Coverage Type: The data field that indicates type of insurance coverage (i.e., individual market, Medigap, employer sponsored, etc.).

The following table lists COMAR Coverage Types and provides a column of mapping examples.

COMAR Coverage Type	Value	Examples of Coverage Type
Medicare Supplemental (i.e. Individual, Group, WRAP)	1	If your company provides Medicare Supplemental Insurance (Medigap)
Medicare Advantage Plan	2	• Medicare Health Maintenance Organization (HMOs) • Preferred Provider Organization (PPO) • Private Fee-for-Service Plans • Medicare Special Needs Plans • Medicare Medical Savings Account Plans (MSA)
Individual Market (not MHIP)	3	Most plans offer: • Conversion High • Conversion Standard • Direct Pay High • Direct Pay Standard • Student Health
Maryland Health Insurance Plan (MHIP)	4	• CareFirst of Maryland, Inc. • CareFirst BlueChoice, Inc.
Private Employer Sponsored or Other Group (i.e., union or association plans)	5	If your company is providing either administrative services only or standard insurance to an employer or other group in the private sector: • Commercial Basic • Commercial High • Commercial Standard • Preferred Provider Option • Triple Option • HMO • Point of Service • Triple Option HMO • Indemnity • Triple Option POS • Triple Option PPO
Public Employee - Federal	6	If your company participates in the Federal Employees Health Benefits Program
Public Employee - Other	7	If your company is providing either administrative services only or standard insurance to an employer or other group in the public sector including state, county, local/municipal government, or public school systems
Comprehensive Standard Health Benefit Plan (except HIP)	8	Participating carriers: • Aetna Life & Health Ins. Co. • Aetna US Healthcare Inc. • CareFirst BlueChoice, Inc. • CareFirst of MD, Inc. • Coventry Health & Life, Inc. • Coventry Health Care DE, Inc. • Graphic Arts Benefit Corp. • Group Hospitalization & Medical Services • Guardian Life Insurance Co. of America • Kaiser Permanente Mid-Atlantic States • MAMSI Life and Health Insurance Company • MEGA Life & Health Insurance Company • Optimum Choice, Inc. • United Healthcare Insurance Company
Health Insurance Partnership (HIP)	9	Participating carriers: • Aetna Life & Health Ins. Co. • Coventry Health & Life, Inc. • CareFirst of MD, Inc. • United Healthcare Ins. Co.

PRACTTITONER SPECIALTY

Expansions/Consolidations

Practitioner Specialty: The health care field in which a physician, licensed health care professional, dental practitioner, or office facility has been certified.

(The following table shows examples where a practitioner specialty may encompass other services and is for illustrative purposes only.)

This list is <u>not</u> all inclusive.

Practitioner Specialty	Value	Specialties Not Specifically Identified	
General Practice	001		
General Surgery	002		
Allergy & Immunology	003	Pediatric Allergy & Immunology	
Anesthesiology	004		
Cardiology	005	Pediatric Cardiology	
Dermatology	006	Dermatopathology	
Emergency Medicine	007		
Endocrinology Medicine	008	Pediatric Endocrinology	
Family Practice	009		
Gastroenterology	010	Pediatric Gastroenterology	
Geriatrics	011		
Hand Surgery	012		
Hematology	013	Pediatric Hematology/Oncology	
Internal Medicine	014	Adolescent Medicine	
Infectious Disease	015	Pediatric Infectious Disease	
Multi-Specialty Medical Practice	101	Use this code only where provider-specific identifiers are not available for physicians practicing as a group with varying specialties.	
Nephrology	016	Pediatric Nephrology	
Neonatology	100		
Neurology	017	Pediatric Neurology	
Nuclear Medicine	018		
Obstetrics/Gynecology	039		
Oncology	019	Gynecological Oncology	
Ophthalmology	020	Pediatric Ophthalmology	
Orthopedic Surgery	021	Pediatric Orthopedic Surgery	
Osteopathy	022	Include manipulations	
Otology, Laryngology, Rhinology, Otolaryngology	023		
Pathology	024	Forensic Pathology Oral Pathology	
Pediatrics	025		
Peripheral Vascular Disease/Surgery	026		
Plastic Surgery	027	Reconstructive Surgery Cosmetic Surgery	
Physical Medicine and Rehabilitation	028	Rehabilitative Sports Medicine	
Proctology	029	Colon & Rectal Surgery	
Psychiatry	030	Pediatric Psychiatry	
Pulmonary Disease	031	Pediatric Pulmonary Medicine	
Radiology	032	MRI Nuclear Radiology Pediatric Radiology	
Rheumatology	033		
Surgical Specialty Not Listed Here	034	Abdominal Surgery Head and Neck Surgery Maxillofacial Surgery	Neurological Surgery Pediatric Surgery Vascular Surgery

Practitioner Specialty	Value	Specialties Not Specifically Identified	
Thoracic Surgery	035	Cardiovascular Surgery Thoracic Surgery	
Urology	036	Urology Pediatric Urology	
Other Specialties Not Listed	037	Public Health Industrial Medicine	
Physician without a Specialty Identified and Specialty Not Listed Here	038	• Addiction Medicine • Algology/Pain Management • Aerospace Medicine • Critical Care Medicine • Genetics • Infertility	• Multiple Specialty Physician Group • Occupational Medicine • Preventative Medicine • Reproductive Endocrinology • Urgent Care Medicine

Other Health Care Professionals: **(This list is <u>not</u> all inclusive.)**

Practitioner Specialty	Value	Other Services Included
Acupuncturist	040	
Alcohol/Drug Detox Services	041	
Ambulance Services	042	
Audiologist/Speech Pathologist	043	
Chiropractor	044	
Freestanding Clinic (Not a Government Agency)	045	
Day Care Facility	046	Medical Mental Health
Dietitian/Licensed Nutritionist	047	
Home Health Provider	048	Home Infusion Therapy
Mental Health	102	Use this code only where provider-specific identifiers are not available for facilities where mental health services are provided by a psychiatrist, psychologist, or social worker.
Advanced Practice Nurse: Anesthetist	049	Nurse Anesthetist/Certified Registered Nurse Anesthetist (CRNA)
Advanced Practice Nurse: Midwife	050	Nurse Midwife
Advanced Practice Nurse: Nurse Practitioner	051	Nurse Practitioner
Advanced Practice Nurse: Psychotherapist	052	Nurse Psychotherapist
Nurse – Other than Advanced Practice	053	
Occupational Therapist	054	
Optometrist	055	
Podiatrist	056	
Physical Therapist	057	
Psychologist	058	
Clinical Social Worker	059	
Public Health or Welfare Agency	060	Federal, state, and local government
Voluntary Health Agency	061	Planned Parenthood
Other Specialty Not Listed Above	062	Hypnosis
Respiratory Therapist	063	

Dental: **(This list is not all inclusive.)**

COMAR Practitioner Specialty	Value	Other Services Included
General Dentist	070	
Endodontist	071	
Orthodontist	072	
Oral Surgeon	073	
Pedodontist	074	
Periodontist	075	
Prosthodontist	076	

Office Facilities: **(This list is not all inclusive.)**

COMAR Practitioner Specialty	Value	Other Services Included
Freestanding Pharmacy	080	Includes grocery stores
Mail Order Pharmacy	081	
Independent Laboratory	082	
Independent Medical Supply Company	083	Durable Medical Equipment Prosthetic Devices Vision Products Blood
Optician/Optometrist	084	For lenses & eye glasses
All Other Supplies	085	
Freestanding Medical Facility	090	
Freestanding Surgical Facility	091	
Freestanding Imaging Center	092	
Other Facility	093	Dialysis Center Birthing Center

MARYLAND HEALTH CARE COMMISSION

APPENDIX D

SPECIAL INSTRUCTIONS for

FINANCIAL DATA ELEMENTS

FORMATTED FOR THE 2009 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 payer 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 payer.*	*Formatted using 2 implied decimal points*

MARYLAND HEALTH CARE COMMISSION

APPENDIX E

FILE LAYOUTS

- PROFESSIONAL SERVICES DATA REPORT MODIFIED!
- PHARMACY DATA REPORT MODIFIED!
- PROVIDER DIRECTORY REPORT MODIFIED!
- INSTITUTIONAL SERVICES DATA REPORT **NEW!**

FORMATTED FOR THE 2009 MARYLAND MEDICAL CARE DATA BASE (MCDB) SUBMISSION

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 from **January 1, 2009 through April 30, 2010**. Please provide information on all health care 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.)*

Payers 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 MODIFIED!

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Start	End	Threshold
1.	Record Identifier	1	N		1	1	100%
2.	Patient Identifier (encrypted)	12	A		2	13	100%
3.	Patient Year and Month of Birth (CCYYMM00)	8	N		14	21	99%/99%/ 100%('00')
4.	Patient Sex	1	N		22	22	99%
5.	Consumer Directed Health Plan (CDHP) alone or w/ HSA or HRA Indicator	1	N		23	23	95%
6.	Patient Zip Code	5	N		24	28	99%
7.	Patient Covered by Other Insurance Indicator	1	N		29	29	95%
8.	Coverage Type (This field must be mapped – see pg. 14)	1	A		30	30	99%
9.	Delivery System Type (This field must be mapped – see pg. 16)	1	N		31	31	99%
10.	Claim Related Condition	1	N		32	32	
11.	Practitioner Federal Tax ID	9	A		33	41	100%
12.	Participating Provider Flag	1	N		42	42	95%
13.	Record Status (renamed from Type of Bill.) (This field must be mapped – see pg. 24)	1	A		43	43	95%
14.	Claim Control Number (Include on each record as this is the key to summarizing service detail to claim level)	23	A		44	66	
15.	Claim Paid Date (CCYYMMDD)	8	N		67	74	95%
16.	Number of Diagnosis Codes	2	N		75	76	
17.	Number of Line Items (always **= 01** for fixed format – see pg. 48)	2	N		77	78	
18.	Diagnosis Code 1 – **Remove imbedded decimal points**	5	A		79	83	99%
19.	Diagnosis Code 2	5	A		84	88	
20.	Diagnosis Code 3	5	A		89	93	
21.	Diagnosis Code 4	5	A		94	98	
22.	Diagnosis Code 5	5	A		99	103	
23.	Diagnosis Code 6	5	A		104	108	
24.	Diagnosis Code 7	5	A		109	113	
25.	Diagnosis Code 8	5	A		114	118	
26.	Diagnosis Code 9	5	A		119	123	

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Start	End	Threshold
27.	Diagnosis Code 10	5	A		124	128	
28.	Service From Date (CCYYMMDD)	8	N		129	136	100%
29.	Service Thru Date (CCYYMMDD)	8	N		137	144	100%*
30.	Place of Service	2	N		145	146	99%
31.	Service Location Zip Code	5	A		147	151	95%
32.	Service Unit Indicator	1	N		152	152	95%
33.	Units of Service	3	N	1 implied**	153	155	95%
34.	Procedure Code	6	A		156	161	95%
35.	Modifier I (This field must be mapped – see pg. 50)	2	A		162	163	
36.	Modifier II (specific to Modifier I)	2	A		164	165	
37.	Servicing Practitioner ID	11	A		166	176	100%
38.	Billed Charge (line item amounts required – see pg. 33)	9	N		177	185	
39.	Allowed Amount (line item amounts required – see pg. 33)	9	N		186	194	
40.	Reimbursement Amount (line item amounts required – see pg. 33)	9	N		195	203	
41.	Date of Enrollment	8	N		204	211	99%
42.	Date of Disenrollment	8	N		212	219	99%
43.	Patient Deductible (line item amounts required – see pg. 33)	9	N		220	228	
44.	Patient Coinsurance or Patient Co-payment (line item amounts required– see pg. 33)	9	N		229	237	
45.	Other Patient Obligations (line item amounts required– see pg. 33)	9	N		238	246	
46.	Plan Liability	1	N		247	247	95%
47.	Servicing Practitioner Individual National Provider Identifier (NPI) number	10	A		248	257	95%
48.	Practitioner National Provider Identifier (NPI) number used for Billing	10	A		258	267	95%

** If the Service Thru Date is not reported, then assume that the Service From Date (data element #28) 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.*

DATA WITHOUT PROPER DOCUMENTATION WILL BE RETURNED!

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

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

MHCC will return files that do not link.

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 MODIFIED!

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Occurs	Start	End	Threshold
1.	Record Identifier	1	N			1	1	100%
2.	Patient Identifier (encrypted)	12	A			2	13	100%
3.	Patient Year and Month of Birth (CCYYMM00)	8	N			14	21	99%/99%/ 100%('00')
4.	Patient Sex	1	N			22	22	99%
5.	Consumer Directed Health Plan (CDHP) alone or w/ HSA or HRA Indicator	1	N			23	23	95%
6.	Patient Zip Code	5	N			24	28	99%
7.	Patient Covered by Other Insurance Indicator	1	N			29	29	95%
8.	Coverage Type (This field must be mapped – see pg. 14)	1	A			30	30	99%
9.	Delivery System Type (This field must be mapped – see pg. 16)	1	N			31	31	99%
10.	Claim Related Condition	1	N			32	32	
11.	Practitioner Federal Tax ID	9	A			33	41	100%
12.	Participating Provider Flag	1	N			42	42	95%
13.	Record Status (renamed from Type of Bill (This field must be mapped – see pg. 24)	1	A			43	43	95%
14.	Claim Control Number (This is the key to summarizing service detail to claim level & must be included on each record.)	23	A			44	66	
15.	Claim Paid Date (CCYYMMDD)	8	N			67	74	95%
16.	Date of Enrollment	8	N			75	82	99%
17.	Date of Disenrollment	8	N			83	90	99%
18.	Number of Line Items (see pg. 48 for clarification)	2	N			91	92	
▸	**Items 19-39 represent line items only. Repeat format 19-39 for each additional line item.**	130			26	93		
19.	Number of Diagnosis Codes	2	N					
20.	Diagnosis Field will hold up to 10 diagnosis codes. (Leave fields blank if not available.) **Remove imbedded decimal points**	5	A		10			99%
21.	Service From Date (CCYYMMDD)	8	N					100%
22.	Service Thru Date (CCYYMMDD)	8	N					100%*
23.	Place of Service	2	N					99%
24.	Service Location Zip Code	5	A					95%

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Occurs	Start	End	Threshold
25.	Service Unit Indicator	1	N					95%
26.	Units of Service	3	N	1 implied**				95%
27.	Procedure Code	6	A					95%
28.	Modifier I (This field must be mapped – see pg. 50)	2	A					
29.	Modifier II (specific to Modifier I)	2	A					
30.	Servicing Practitioner ID	11	A					100%
31.	Billed Charge (line item amounts required – see pg. 33)	9	N					
32.	Allowed Amount (line item amounts required – see pg. 33)	9	N					
33.	Reimbursement Amount (line item amounts required – see pg. 33)	9	N					
34.	Patient Deductible (line item amounts required – see pg. 33)	9	N					
35.	Patient Coinsurance or Co-payment (line item amounts required – see pg. 33)	9	N					
36.	Other Patient Obligations (line item amounts required– see pg. 33)	9	N					
37.	Plan Liability	1	N					95%
38.	Servicing Practitioner Individual National Provider Identifier (NPI) number	10	A					95%
39.	Practitioner National Provider Identifier (NPI) number used for Billing	10	A					95%

** If the Service Thru Date is not reported, then assume that the Service From Date (data element #21) 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.*

DATA WITHOUT PROPER DOCUMENTATION WILL BE RETURNED!

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

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

MHCC will return files that do not link.

PHARMACY DATA REPORT SUBMISSION – File Layout

This report details all prescription drug encounters for your enrollees **filled from January 1, 2009 through April 30, 2010.** Please provide information on all pharmacy services provided to Maryland residents 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.)*

MODIFIED! File Layout for the Pharmacy Data Report is a 174 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 (encrypted)	12	A		2	13	100%
3.	Patient Sex	1	N		14	14	
4.	Patient Zip Code	5	N		15	19	99%
5.	Patient Year and Month of Birth (CCYYMM00)	8	N		20	27	99%/99%/ 100%('00')
6.	Pharmacy NCPDP Number **(left justified)**	7	N		28	34	100%
7.	Pharmacy Zip Code (location where prescription was filled and dispensed)	5	N		35	39	95%
8.	Practitioner DEA # (left justified; for many payers the last 2 positions on the right will be blank)*	11	A		40	50	99%
9.	Fill Number	2	N		51	52	
10.	NDC Number	11	N		53	63	100%
11.	Drug Compound	1	N		64	64	
12.	Drug Quantity	5	N		65	69	99%
13.	Drug Supply	3	N		70	72	99%
14.	Date Filled (CCYYMMDD)	8	N		73	80	100%/95%/ 95%
15.	Date Prescription Written (CCYYMMDD)	8	N		81	88	
16.	Billed Charge (line item amounts required – see pg. 33)	9	N	2	89	97	
17.	Reimbursement Amount (line item amounts required – see pg. 33)	9	N	2	98	106	
18.	Prescription Claim Number	15	N		107	121	
19.	Prescribing Practitioner Individual National Provider Identifier (NPI)#	10	A		122	131	95%
20.	Patient Deductible (line item amounts required – see pg. 33)	9	N	2	132	140	
21.	Patient Coinsurance or Patient Co-payment (line item amounts – see pg. 33)	9	N	2	141	149	
22.	Other Patient Obligations (line item amounts required – see pg. 33)	9	N	2	150	158	
23.	Date of Enrollment	8	N		159	166	95%
24.	Date of Disenrollment	8	N		167	174	95%

** 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 and Institutional Services data by Encrypted Patient Identifier.
Encryption of Patient ID must be consistent with encryption of Patient ID in Professional Services and Institutional Services files.

PROVIDER DIRECTORY REPORT SUBMISSION – File Layout

This report details all health care Practitioners *(including other health care professionals, dental/vision services covered under a health benefit plan, and office facilities)* and Suppliers that provided services to your enrollees from **January 1, 2009 through April 30, 2010**. Please provide information for all in-State Maryland practitioners/suppliers and all out-of-State practitioners/suppliers serving Maryland residents.

MODIFIED! File Layout for the Provider Directory Report is a 122 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	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	3	A		82	84	100%
10.	Practitioner/Supplier Specialty – 2	3	A		85	87	
11.	Practitioner/Supplier Specialty – 3	3	A		88	90	
12.	Practitioner DEA #	11	A		91	101	99%
13.	Indicator for Multi-Practitioner Health Care Organization	1	A		102	102	99%
14.	Practitioner Individual National Provider Identifier (NPI) number	10	A		103	112	95%
15.	Practitioner Organizational National Provider Identifier (NPI) number	10	A		113	122	95%

REMINDERS !!!

- Use specific (separate) fields for practitioner First Name and Last Name.
- Confirm **Practitioner/Supplier ID #** matches **Servicing Practitioner ID #** in the Professional Services File Layout.
- 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.

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 from **January 1, 2009 through April 30, 2010**. Please provide information on all institutional services provided to Maryland residents 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 (encrypted)	12	A		2	13	100%
3.	Patient Year and Month of Birth (CCYYMM00)	8	N		14	221	99% /99%/ 100%('00')
4.	Patient Sex	1	N		22	22	99%
5.	Patient Zip Code of Residence	5	N		23	27	99%
6.	Date of Enrollment	8	N		28	35	99%
7.	Date of Disenrollment	8	N		36	43	99%
8.	Hospital/Facility Federal Tax ID	10	A		44	52	100%
9.	Hospital/Facility National Provider Identifier (NPI) Number	10	A		53	62	95%
10.	Hospital/Facility Medicare Provider Number	6	A		63	68	100%
11.	Hospital/Facility Participating Provider Flag	1	N		69	69	95%
12.	Claim Control Number	23	A		70	92	
13.	Record Type	2	N		93	93	99%
14.	Type of Admission	1	N		94	94	95%
15.	Source of Admission	1	N		95	95	95%
16.	Patient Discharge Status	2	N		96	97	
17.	Date of Admission or Start of Service	8	N		98	105	99%
18.	Date of Discharge or End of Service	8	N		106	113	99%*
19.	Diagnosis Code Indicator	1	N		114	114	
20.	Primary Diagnosis – **Remove embedded decimal points**	5	A		115	119	99%
21.	Primary Diagnosis present on Admission	1	A		120	120	
22.	Other Diagnosis Code 1	5	A		121	125	
23.	Other Diagnosis Code 1 present on Admission 1	1	A		126	126	
24.	Other Diagnosis Code 2	5	A		127	131	
25.	Other Diagnosis Code 2 present on Admission 2	1	A		132	132	
26.	Other Diagnosis Code 3	5	A		133	137	

	Field Name	Length	Type A= alphanumeric N=numeric	Dec	Start	End	Threshold
27.	Other Diagnosis Code 3 present on Admission 3	1	A		138	138	
28.	Other Diagnosis Code 4	5	A		139	143	
29.	Other Diagnosis Code 4 present on Admission 4	1	A		144	144	
30.	Other Diagnosis Code 5	5	A		145	149	
31.	Other Diagnosis Code 5 present on Admission 5	1	A		150	150	
32.	Other Diagnosis Code 6	5	A		151	155	
33.	Other Diagnosis Code 6 present on Admission 6	1	A		156	156	
34.	Other Diagnosis Code 7	5	A		157	161	
35.	Other Diagnosis Code 7 present on Admission 7	1	A		162	162	
36.	Other Diagnosis Code 8	5	A		163	167	
37.	Other Diagnosis Code 8 present on Admission 8	1	A		168	168	
38.	Other Diagnosis Code 9	5	A		169	173	
39.	Other Diagnosis Code 9 present on Admission 9	1	A		174	174	
40.	Other Diagnosis Code 10	5	A		175	179	
41.	Other Diagnosis Code 10 present on Admission 10	1	A		180	180	
42.	Other Diagnosis Code 11	5	A		181	185	
43.	Other Diagnosis Code 11 present on Admission 11	1	A		186	186	
44.	Other Diagnosis Code 12	5	A		187	191	
45.	Other Diagnosis Code 12 present on Admission 12	1	A		192	192	
46.	Other Diagnosis Code 13	5	A		193	197	
47.	Other Diagnosis Code 13 present on Admission 13	1	A		198	198	
48.	Other Diagnosis Code 14	5	A		199	203	
49.	Other Diagnosis Code 14 present on Admission 14	1	A		204	204	
50.	Other Diagnosis Code 15	5	A		205	209	
51.	Other Diagnosis Code 15 present on Admission 15	1	A		210	210	
52.	Other Diagnosis Code 16	5	A		211	215	
53.	Other Diagnosis Code 16 present on Admission 16	1	A		216	216	
54.	Other Diagnosis Code 17	5	A		217	221	
55.	Other Diagnosis Code 17 present on Admission 17	1	A		222	222	
56.	Other Diagnosis Code 18	5	A		223	227	

	Field Name	Length	Type A= alphanumeric N=numeric	Dec	Start	End	Threshold
57.	Other Diagnosis Code 18 present on Admission 18	1	A		228	228	
58.	Other Diagnosis Code 19	5	A		229	233	
59.	Other Diagnosis Code 19 present on Admission 19	1	A		234	234	
60.	Other Diagnosis Code 20	5	A		235	239	
61.	Other Diagnosis Code 20 present on Admission 20	1	A		240	240	
62.	Other Diagnosis Code 21	5	A		241	245	
63.	Other Diagnosis Code 21 present on Admission 21	1	A		246	246	
64.	Other Diagnosis Code 22	5	A		247	251	
65.	Other Diagnosis Code 22 present on Admission 22	1	A		252	252	
66.	Other Diagnosis Code 23	5	A		253	257	
67.	Other Diagnosis Code 23 present on Admission 23	1	A		258	258	
68.	Other Diagnosis Code 24	5	A		259	263	
69.	Other Diagnosis Code 24 present on Admission 24	1	A		264	264	
70.	Other Diagnosis Code 25	5	A		265	269	
71.	Other Diagnosis Code 25 present on Admission 25	1	A		270	270	
72.	Other Diagnosis Code 26	5	A		271	275	
73.	Other Diagnosis Code 26 present on Admission 26	1	A		276	276	
74.	Other Diagnosis Code 27	5	A		277	281	
75.	Other Diagnosis Code 27 present on Admission 27	1	A		282	282	
76.	Other Diagnosis Code 28	5	A		283	287	
77.	Other Diagnosis Code 28 present on Admission 28	1	A		288	288	
78.	Other Diagnosis Code 29	5	A		289	293	
79.	Other Diagnosis Code 29 present on Admission 29	1	A		294	294	
80.	Attending Practitioner Individual National Provider Identifier (NPI) number	10	A		295	304	95%
81.	Operating Practitioner Individual National Provider Identifier (NPI) number	10	A		305	314	95%
82.	Procedure Code Indicator	1	N		315	315	
83.	Principal Procedure Code 1	6	A		316	321	
84.	Procedure Code 1 Modifier I	2	A		322	323	
85.	Procedure Code 1 Modifier II	2	A		324	325	

	Field Name	Length	Type A= alphanumeric N=numeric	Dec	Start	End	Threshold
86.	Other Procedure Code 2	6	A		326	331	
87.	Procedure Code 2 Modifier I	2	A		332	333	
88.	Procedure Code 2 Modifier II	2	A		334	335	
89.	Other Procedure Code 3	6	A		336	341	
90.	Procedure Code 3 Modifier I	2	A		342	343	
91.	Procedure Code 3 Modifier II	2	A		344	345	
92.	Other Procedure Code 4	6	A		346	351	
93.	Procedure Code 4 Modifier I	2	A		352	353	
94.	Procedure Code 4 Modifier II	2	A		354	355	
95.	Other Procedure Code 5	6	A		356	361	
96.	Procedure Code 5 Modifier I	2	A		362	363	
97.	Procedure Code 5 Modifier II	2	A		364	365	
98.	Other Procedure Code 6	6	A		366	371	
99.	Procedure Code 6 Modifier I	2	A		372	373	
100.	Procedure Code 6 Modifier II	2	A		374	375	
101.	Other Procedure Code 7	6	A		376	381	
102.	Procedure Code 7 Modifier I	2	A		382	383	
103.	Procedure Code 7 Modifier II	2	A		384	385	
104.	Other Procedure Code 8	6	A		386	391	
105.	Procedure Code 8 Modifier I	2	A		392	393	
106.	Procedure Code 8 Modifier II	2	A		394	395	
107.	Other Procedure Code 9	6	A		396	401	
108.	Procedure Code 9 Modifier I	2	A		402	403	
109.	Procedure Code 9 Modifier II	2	A		404	405	
110.	Other Procedure Code 10	6	A		406	411	
111.	Procedure Code 10 Modifier I	2	A		412	413	
112.	Procedure Code 10 Modifier II	2	A		414	415	
113.	Other Procedure Code 11	6	A		416	421	
114.	Procedure Code 11 Modifier I	2	A		422	423	
115.	Procedure Code 11 Modifier II	2	A		424	425	
116.	Other Procedure Code 12	6	A		426	431	
117.	Procedure Code 12 Modifier I	2	A		432	433	
118.	Procedure Code 12 Modifier II	2	A		434	435	
119.	Other Procedure Code 13	6	A		436	441	
120.	Procedure Code 13 Modifier I	2	A		442	443	
121.	Procedure Code 13 Modifier II	2	A		444	445	
122.	Other Procedure Code 14	6	A		446	451	
123.	Procedure Code 14 Modifier I	2	A		452	453	
124.	Procedure Code 14 Modifier II	2	A		454	455	
125.	Other Procedure Code 15	6	A		456	461	
126.	Procedure Code 15 Modifier I	2	A		462	463	
127.	Procedure Code 15 Modifier II	2	A		464	465	

	Field Name	Length	Type A= alphanumeric N=numeric	Dec	Start	End	Threshold
128.	Diagnosis Related Groups (DRGs) Number	3	A		466	468	
129.	DRG Grouper Name	1	N		469	469	
130.	DRG Grouper Version	2	N		470	471	
131.	Billed Charge	9	N		472	480	
132.	Allowed Amount	9	N		481	489	
133.	Reimbursement Amount	9	N		490	498	
134.	Total Patient Deductible	9	N		499	507	
135.	Total Patient Coinsurance or Patient Co-payment	9	N		508	516	
136.	Total Other Patient Obligations	9	N		517	525	
137.	Coordination of Benefit Savings or Other Payer Payments	9	N		526	534	
138.	Type of Bill	3	N		535	537	
139.	Patient Covered by Other Insurance Indicator	1	N		538	538	

** If the Date of Discharge or End of Service (data element #18) is not reported, then assume that the Date of Admission or Start of Service (data element #17) and the Date of Discharge or End of Service are the same.*

DATA WITHOUT PROPER DOCUMENTATION WILL BE RETURNED!

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

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

MHCC will return files that do not link.

MARYLAND HEALTH CARE COMMISSION

APPENDIX F

DATA DICTIONARY

- PROFESSIONAL SERVICES DATA REPORT MODIFIED!
- PHARMACY DATA REPORT MODIFIED!
- PROVIDER DIRECTORY REPORT MODIFIED!
- INSTITUTIONAL SERVICES DATA REPORT **NEW!**

FORMATTED FOR THE 2009 MARYLAND MEDICAL CARE DATA BASE (MCDB) SUBMISSION

Data Dictionary – PROFESSIONAL SERVICES

Field Name	COMAR	Description	Field Contents
Record Identifier	10.25.06.06 D.(1)	The value is 1	**1 Professional Services**
Patient Identifier (encrypted)	10.25.06.06 D.(2)	Patient's unique identification number assigned by payer and encrypted. ** The new encryption algorithm will be provided for the 2010 MCDB submission (due June 30, 2011).*	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 Year and Month of Birth	10.25.06.06 D.(3)	Date of patient's birth using 00 instead of day.	CCYYMM00
Patient Sex	10.25.06.06 D.(4)	Sex of the patient.	1 Male 2 Female 3 Unknown
Consumer Directed Health Plan (CDHP) alone or w/ HSA or HRA Indicator	10.25.06.06 D.(5)	Consumer Directed Health Plan (CDHP) alone or with Health Savings Account (HSA) or Health Resources Account (HRA)	0 No 1 Yes
Patient Zip Code	10.25.06.06 D.(6)	Zip code of patient's residence.	5-digit US Postal Service code
Patient Covered by Other Insurance Indicator	10.25.06.06 D.(7)	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	10.25.06.06 D.(8)	Patient's type of insurance coverage.	1 Medicare Supplemental (i.e., Individual, Group, WRAP) 2 Medicare Advantage Plan 3 Individual Market (not MHIP) 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 [a self employed individual or small businesses (public or private employers) with 2-50 eligible employees] 9 Health Insurance Partnership (HIP) Z Unknown
Delivery System Type	10.25.06.06 D.(9)	Type of delivery system rendering service.	1 Policies or Contracts sold by a **Health Maintenance Organization** (including HMO, PPO, EPO) Policies or Contracts sold by a **Life & Health Insurance Co.**: 2 PPO, POS, EPO 3 Indemnity Care 4 Other 9 Unknown – Not Coded

Field Name	COMAR	Description	Field Contents
Claim Related Condition	10.25.06.06 D.(10)	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	10.25.06.06 D.(11)	Employer Tax ID of the practitioner, practice or office facility receiving payment for services.	
Participating Provider Flag	10.25.06.06 D.(12)	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
Record Status *(renamed from Type of Bill)*	10.25.06.06 D.(13)	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 Services
Claim Control Number	10.25.06.06 D.(14)	Internal payer claim number used for tracking.	
Claim Paid Date	10.25.06.06 D.(15)	The date a claim was authorized for payment.	CCYYMMDD
Number of Diagnosis Codes	10.25.06.06.D.(16)	The number of diagnosis codes, up to ten.	1 through 10. Maximum is 10.
Number of Line Items	10.25.06.06.D.(17)	If using **Variable Format**, the # of line items completed in the variable portion (data elements 19-39) 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.	
Diagnosis Codes	10.25.06.06.D.(18)-D.(27)	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	10.25.06.06.D.(28)	First date of service for a procedure in this line item.	CCYYMMDD
Service Thru Date	10.25.06.06.D.(29)	Last date of service for this line item.	CCYYMMDD

Field Name	COMAR	Description	Field Contents
Place of Service	10.25.06.06.D.(30)	Two-digit numeric code that describes where a service was rendered.	**CMS: (definitions listed on pages 18 - 19)** 11 Provider's Office 12 Patient's Home 13 Assisted Living Facility 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	10.25.06.06.D.(31)	Zip code for location where service described was provided.	5-digit US Postal Service code
Service Unit Indicator	10.25.06.06.D.(32)	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)

Field Name	COMAR	Description	Field Contents
Units of Service	10.25.06.06.D.(33)	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	10.25.06.06.D.(34)	Describes the health care service provided (i.e., CPT-4, HCPCS, ICD-9-CM, ICD-10-CM).	
Modifier I	10.25.06.06.D.(35)	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	10.25.06.06.D.(36)	Specific to Modifier I.	
Servicing Practitioner ID	10.25.06.06.D.(37)	Payer-specific identifier for the practitioner rendering health care service(s).	
Billed Charge	10.25.06.06.D.(38)	A practitioner's billed charges rounded to whole dollars. **DO NOT USE DECIMALS**	
Allowed Amount	10.25.06.06.D.(39)	Total patient and payer liability. **DO NOT USE DECIMALS**	
Reimbursement Amount	10.25.06.06.D.(40)	Amount paid to Employer Tax ID # of rendering physician as listed on claim. **DO NOT USE DECIMALS**	
Date of Enrollment	10.25.06.06.D.(41)	The start date of enrollment for the patient in this delivery system (in this data submission time period). (See Delivery System Type on page 47)	CCYYMMDD Date is 20090101 if patient is enrolled at start of 2009. Enter other date if patient **not enrolled** at start of year, enrolled during 2009.
Date of Disenrollment	10.25.06.06.D.(42)	The end date of enrollment for the patient in this delivery system (in this data submission time period). (See Delivery System Type on page 47)	CCYYMMDD **Leave blank** if patient is still enrolled on 20091231. If patient disenrolled before end of year enter date disenrolled.

Field Name	COMAR	Description	Field Contents
Patient Deductible	10.25.06.06.D.(43)	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	10.25.06.06.D.(44)	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	10.25.06.06.D.(45)	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**	
*Note: Total Patient Liability **should equal the sum** of Patient Deductible (43), Patient Coinsurance/Co-payment (44), and Other Patient Obligations (45).*			
Plan Liability	10.25.06.06.D.(46)	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 2 ASO (employer self-insured)
Servicing Practitioner Individual National Provider Identifier (NPI) number	10.25.06.06.D.(47)	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.	10.25.06.06.D.(48)	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

Data Dictionary – PHARMACY

Field Name	COMAR	Description	Field Contents
Record Identifier	10.25.06.07.C.(1)	The value is 2	**2 Pharmacy Services**
Patient Identifier (encrypted)	10.25.06.07.C.(2)	Patient's unique identification number assigned by payer and encrypted. ** The new encryption algorithm will be provided for the 2010 MCDB submission (due June 30, 2011).*	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 Sex	10.25.06.07.C.(3)	Sex of Patient.	1 Male 2 Female 3 Unknown
Patient Zip Code	10.25.06.07.C.(4)	Zip code of patient's residence.	5-digit US Postal Service code
Patient Year and Month of Birth	10.25.06.07.C.(5)	Date of patient's birth using 00 instead of day.	CCYYMM00
Pharmacy NCPDP Number	10.25.06.07.C.(6)	Unique 7 digit number assigned by the National Council for Prescription Drug Program (NCPDP).	
Pharmacy Zip Code	10.25.06.07.C.(7)	Zip code of pharmacy where prescription was filled and dispensed.	5-digit US Postal Service code
Practitioner DEA #	10.25.06.07.C.(8)	Drug Enforcement Agency number assigned to an individual registered under the Controlled Substance Act.	Same as DEA # in Provider File.
Fill Number	10.25.06.07.C.(9)	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	10.25.06.07.C.(10)	National Drug Code 11 digit number.	
Drug Compound	10.25.06.07.C.(11)	Indicates a mix of drugs to form a compound medication.	1 Non-compound 2 Compound
Drug Quantity	10.25.06.07.C.(12)	Number of units of medication dispensed.	
Drug Supply	10.25.06.07.C.(13)	Estimated number of days of dispensed supply.	
Date Filled	10.25.06.07.C.(14)	Date prescription was filled.	CCYYMMDD
Date Prescription Written	10.25.06.07.C.(15)	Date prescription was written.	CCYYMMDD

Field Name	COMAR	Description	Field Contents
Billed Charge	10.25.06.07.C.(16)	Retail amount for drug including dispensing fees and administrative costs. **MUST INCLUDE 2 IMPLIED DECIMAL PLACES.**	
Reimbursement Amount	10.25.06.07.C.(17)	Amount paid to the pharmacy by payer. Do not include patient copayment or sales tax. **MUST INCLUDE 2 IMPLIED DECIMAL PLACES.**	
Prescription Claim Number	10.25.06.07.C.(18)	Internal payer claim number used for tracking.	A credit should have the same claim number as the original debit record.
Prescribing Practitioner Individual National Provider Identifier (NPI) number	10.25.06.07.C.(19)	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	10.25.06.07.C.(20)	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	10.25.06.07.C.(21)	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	10.25.06.07.C.(22)	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.**	

*Note: Total Patient Liability **should equal the sum** of Patient Deductible (20), Patient Coinsurance/Co-payment (21), and Other Patient Obligations (22).*

Date of Enrollment	10.25.06.07.C.(23)	The start date of enrollment for the patient in this delivery system (in this data submission time period). (Delivery System Type on page 47)	CCYYMMDD Date is 20090101 if patient is enrolled at start of 2009. Enter other date if patient **not enrolled** at start of year, enrolled during 2009.
Date of Disenrollment	10.25.06.07.C.(24)	The end date of enrollment for the patient in this delivery system (in this data submission time period). (Delivery System Type on page 47)	CCYYMMDD **Leave blank** if patient is still enrolled on 20091231. If patient disenrolled before end of year enter date disenrolled.

Data Dictionary – PROVIDER

Field Name	COMAR	Description	Field Contents
Record Identifier	10.25.06.06 D.(1)	The value is 3	**3 Provider Services**
Practitioner/Supplier ID	10.25.06.08.D.(2)	Payer-specific identifier for a practitioner, practice, or office facility rendering health care service(s).	
Practitioner/Supplier Federal Tax ID (without embedded dashes)	10.25.06.08.D.(3)	Employer Tax ID # of the practitioner, practice or office facility receiving payment for services.	Same as Federal Tax ID # in Professional Services File.
Practitioner/Supplier Last Name or Multi-practitioner Health Care Organization	10.25.06.08.D.(4)	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	10.25.06.08.D.(5)	Practitioner's first name.	Individual provider's first name.
Practitioner Middle Initial	10.25.06.08.D.(6)		First letter of individual provider's middle name.
Practitioner Name Suffix	10.25.06.08.D.(7)		Individual provider's name suffix, such as Jr., Sr., II, III, IV, or V.
Practitioner Credential	10.25.06.08.D.(8)		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	10.25.06.08.D.(9) 10.25.06.08.D.(10) 10.25.06.08.D.(11)	The health care field in which a physician, licensed health care professional, dental practitioner, or office facility has been certified. Up to 3 codes may be listed.	**<u>Physicians:</u>** 001 General Practice 002 General Surgery 003 Allergy & Immunology 004 Anesthesiology 005 Cardiology 006 Dermatology 007 Emergency Medicine 008 Endocrinology Medicine 009 Family Practice 010 Gastroenterology 011 Geriatrics 012 Hand Surgery 013 Hematology

Field Name	COMAR	Description	Field Contents
Practitioner/Supplier Specialty (con't.)			014 Internal Medicine 015 Infectious Disease 101 Multi-Specialty Medical Practice 016 Nephrology 100 Neonatology 017 Neurology 018 Nuclear Medicine 039 Obstetrics/Gynecology 019 Oncology 020 Ophthalmology 021 Orthopedic Surgery 022 Osteopathy (includes manipulations) 023 Otology, Laryngology, Rhinology, Otolaryngology 024 Pathology 025 Pediatrics 026 Peripheral Vascular Disease or Surgery 027 Plastic Surgery 028 Physical Medicine and Rehabilitation 029 Proctology 030 Psychiatry 031 Pulmonary Disease 032 Radiology 033 Rheumatology 034 Surgical Specialty Not Listed Here 035 Thoracic Surgery 036 Urology 037 Other Spec Not Listed (public health,industrial medicine) 038 Phys w/o Spec Identified & Spec Not Listed 039 Obstetrics/Gynecology **Other Health Care Professionals:** 040 Acupuncturist 041 Alcohol/Drug Detox Services 042 Ambulance Services 043 Audiologist/Speech Pathologist 044 Chiropractor 045 Freestanding Clinic – Not a Government Agency 046 Day Care Facility: Medical, Mental Health 047 Dietitian/Licensed Nutritionist 048 Home Health Provider 102 Mental Health Clinic 049 Advanced Practice Nurse: Anesthetist 050 Advanced Practice Nurse: Midwife 051 Advanced Practice Nurse: Nurse Practitioner 052 Advanced Practice Nurse: Psychotherapist 053 Nurse – Other Than Advanced Practice

Field Name	COMAR	Description	Field Contents
Practitioner/Supplier Specialty (con't.)			054 Occupational Therapist 055 Optometrist 056 Podiatrist 057 Physical Therapist 058 Psychologist 059 Clinical Social Worker 060 Public Health or Welfare Agency (federal, state, and local government) 061 Voluntary Health Agency 062 Other Specialty Not Listed Above 063 Respiratory Therapist **Dental:** 070 General Dentist 071 Endodontist 072 Orthodontist 073 Oral Surgeon 074 Pedodontist 075 Periodontist 076 Prosthodontist **Office Facilities:** 080 Freestanding Pharmacy (includes grocery) 081 Mail Order Pharmacy 082 Independent Laboratory 083 Independent Medical Supply Company 084 Optician/Optometrist (for lenses & eye glasses) 085 All Other Supplies 090 Freestanding Medical Facility 091 Freestanding Surgical Facility 092 Freestanding Imaging Center 093 Other facility
Practitioner DEA #	10.25.06.08.D.(12)	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	10.25.06.08.D.(13)		0 Solo Practitioner 1 Multiple Practitioners
Practitioner Individual National Provider Identifier (NPI) number	10.25.06.08.D.(14)	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	10.25.06.08.D.(15)	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

Data Dictionary – INSTITUTIONAL SERVICES

Field Name	COMAR	Description	Field Contents
Record Identifier	10.25.06.09 C.(1)	The value is 4	**4 Institutional Services**
Patient Identifier (encrypted)	10.25.06.09 C.(2)	Patient's unique identification number assigned by payer and encrypted. ** The new encryption algorithm will be provided for the 2010 MCDB submission (due June 30, 2011).*	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 Year and Month of Birth	10.25.06.09 C.(3)	Date of patient's birth using 00 instead of day.	CCYYMM00
Patient Sex	10.25.06.09 C.(4)	Sex of the patient.	1 Male 2 Female 3 Unknown
Patient Zip Code of Residence	10.25.06.09 C.(5)	Zip code of patient's residence.	5-digit US Postal Service zip code
Date of Enrollment	10.25.06.07.C.(6)	The start date of enrollment for the patient in this delivery system (in this data submission time period). (See Delivery System Type on page 47)	CCYYMMDD Date is 20090101 if patient is enrolled at start of 2009. Enter other date if patient **not enrolled** at start of year, enrolled during 2009.
Date of Disenrollment	10.25.06.07.C.(7)	The end date of enrollment for the patient in this delivery system (in this data submission time period). (See Delivery System Type on page 47)	CCYYMMDD **Leave blank** if patient is still enrolled on 20091231. If patient disenrolled before end of year enter date disenrolled.
Hospital/Facility Federal Tax ID	10.25.06.09 C.(8)	Federal Employer Tax ID of the facility receiving payment for care.	
Hospital/Facility National Provider Identifier (NPI) Number	10.25.06.09 C.(9)	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	10.25.06.09 C.(10)	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	10.25.06.09 C.(11)	Indicates if the service was provided at a hospital/facility that participates in the payer's network.	1 Participating 2 Non-Participating 3 Unknown/Not Coded
Claim Control Number	10.25.06.09 C.(12)	Internal payer claim number used for tracking.	

Field Name	COMAR	Description	Field Contents
Record Type	10.25.06.09 C.(13)	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	10.25.06.09 C.(14)	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
Source of Admission	10.25.06.09 C.(15)	Applies **only** to hospital inpatient records. All other record types code "0".	0 Not a hospital inpatient record For Newborns (Type of Admission = 4) 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Extramural birth 9 Information not available Admissions other than Newborn 1 Physician referral 2 Clinic referral 3 HMO referral 4 Transfer from a hospital 5 Transfer from a skilled nursing facility 6 Transfer from another health care facility 7 Emergency Room 8 Court/Law enforcement 9 Information not available

Field Name	COMAR	Description	Field Contents
Patient Discharge Status	10.25.06.09 C.(16)	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)	10.25.06.09 C.(17)	First date of service for a procedure in this line item.	CCYYMMDD
Service thru date/End of Service (if Inpatient, Date of Discharge)	10.25.06.09 C.(18)	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	10.25.06.09 C.(19)	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)	10.25.06.09 C.(20)	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	10.25.06.09 C.(21)	ICD-9-CM/ICD-10-CM Diagnosis Code 1 Remove embedded decimal pt.	
Other Diagnosis Code 1 Present on Admission 1 (POA)	10.25.06.09 C.(22)	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*
Other Diagnosis Code 2	10.25.06.09 C.(23)	ICD-9-CM/ICD-10-CM Diagnosis Code 2 Remove embedded decimal pt.	
Other Diagnosis Code 2 Present on Admission 2 (POA)	10.25.06.09 C.(24)	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*

Field Name	COMAR	Description	Field Contents
Other Diagnosis Code 3	10.25.06.09 C.(25)	ICD-9-CM/ICD-10-CM Diagnosis Code 3 Remove embedded decimal pt.	
Other Diagnosis Code 3 Present on Admission 3 (POA)	10.25.06.09 C.(26)	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	10.25.06.09 C.(27)	ICD-9-CM/ICD-10-CM Diagnosis Code 4 Remove embedded decimal pt.	
Other Diagnosis Code 4 Present on Admission 4 (POA)	10.25.06.09 C.(28)	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	10.25.06.09 C.(29)	ICD-9-CM/ICD-10-CM Diagnosis Code 5 Remove embedded decimal pt.	
Other Diagnosis Code 5 Present on Admission 5 (POA)	10.25.06.09 C.(30)	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	10.25.06.09 C.(31)	ICD-9-CM/ICD-10-CM Diagnosis Code 6 Remove embedded decimal pt.	
Other Diagnosis Code 6 Present on Admission 6 (POA)	10.25.06.09 C.(32)	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	10.25.06.09 C.(33)	ICD-9-CM/ICD-10-CM Diagnosis Code 7 Remove embedded decimal pt.	
Other Diagnosis Code 7 Present on Admission 7 (POA)	10.25.06.09 C.(34)	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*
Other Diagnosis Code 8	10.25.06.09 C.(35)	ICD-9-CM/ICD-10-CM Diagnosis Code 8 Remove embedded decimal pt.	
Other Diagnosis Code 8 Present on Admission 8 (POA)	10.25.06.09 C.(36)	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*

Field Name	COMAR	Description	Field Contents
Other Diagnosis Code 9	10.25.06.09 C.(37)	ICD-9-CM/ICD-10-CM Diagnosis Code 9 Remove embedded decimal pt.	
Other Diagnosis Code 9 Present on Admission 9 (POA)	10.25.06.09 C.(38)	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	10.25.06.09 C.(39)	ICD-9-CM/ICD-10-CM Diagnosis Code 10 Remove embedded decimal pt.	
Other Diagnosis Code 10 Present on Admission 10 (POA)	10.25.06.09 C.(40)	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	10.25.06.09 C.(41)	ICD-9-CM/ICD-10-CM Diagnosis Code 11 Remove embedded decimal pt.	
Other Diagnosis Code 11 Present on Admission 11 (POA)	10.25.06.09 C.(42)	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	10.25.06.09 C.(43)	ICD-9-CM/ICD-10-CM Diagnosis Code 12 Remove embedded decimal pt.	
Other Diagnosis Code 12 Present on Admission 12 (POA)	10.25.06.09 C.(44)	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	10.25.06.09 C.(45)	ICD-9-CM/ICD-10-CM Diagnosis Code 13 Remove embedded decimal pt.	
Other Diagnosis Code 13 Present on Admission 13 (POA)	10.25.06.09 C.(46)	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	COMAR	Description	Field Contents
Other Diagnosis Code 14	10.25.06.09 C.(47)	ICD-9-CM/ICD-10-CM Diagnosis Code 14 Remove embedded decimal pt.	
Other Diagnosis Code 14 Present on Admission 14 (POA)	10.25.06.09 C.(48)	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	10.25.06.09 C.(49)	ICD-9-CM/ICD-10-CM Diagnosis Code 15 Remove embedded decimal pt.	
Other Diagnosis Code 15 Present on Admission 15 (POA)	10.25.06.09 C.(50)	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	10.25.06.09 C.(51)	ICD-9-CM/ICD-10-CM Diagnosis Code 16 Remove embedded decimal pt.	
Other Diagnosis Code 16 Present on Admission 16 (POA)	10.25.06.09 C.(52)	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	10.25.06.09 C.(53)	ICD-9-CM/ICD-10-CM Diagnosis Code 17 Remove embedded decimal pt.	
Other Diagnosis Code 17 Present on Admission 17 (POA)	10.25.06.09 C.(54)	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	10.25.06.09 C.(55)	ICD-9-CM/ICD-10-CM Diagnosis Code 18 Remove embedded decimal pt.	
Other Diagnosis Code 18 Present on Admission 18 (POA)	10.25.06.09 C.(56)	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	10.25.06.09 C.(57)	ICD-9-CM/ICD-10-CM Diagnosis Code 19 Remove embedded decimal pt.	
Other Diagnosis Code 19 Present on Admission 19 (POA)	10.25.06.09 C.(58)	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	COMAR	Description	Field Contents
Other Diagnosis Code 20	10.25.06.09 C.(59)	ICD-9-CM/ICD-10-CM Diagnosis Code 20 Remove embedded decimal pt.	
Other Diagnosis Code 20 Present on Admission 20 (POA)	10.25.06.09 C.(60)	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	10.25.06.09 C.(61)	ICD-9-CM/ICD-10-CM Diagnosis Code 21 Remove embedded decimal pt.	
Other Diagnosis Code 21 Present on Admission 21 (POA)	10.25.06.09 C.(62)	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	10.25.06.09 C.(63)	ICD-9-CM/ICD-10-CM Diagnosis Code 22 Remove embedded decimal pt.	
Other Diagnosis Code 22 Present on Admission 22 (POA)	10.25.06.09 C.(64)	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	10.25.06.09 C.(65)	ICD-9-CM/ICD-10-CM Diagnosis Code 23 Remove embedded decimal pt.	
Other Diagnosis Code 23 Present on Admission 23 (POA)	10.25.06.09 C.(66)	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	10.25.06.09 C.(67)	ICD-9-CM/ICD-10-CM Diagnosis Code 24 Remove embedded decimal pt.	
Other Diagnosis Code 24 Present on Admission 24 (POA)	10.25.06.09 C.(68)	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	10.25.06.09 C.(69)	ICD-9-CM/ICD-10-CM Diagnosis Code 25 Remove embedded decimal pt.	
Other Diagnosis Code 25 Present on Admission 25 (POA)	10.25.06.09 C.(70)	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	COMAR	Description	Field Contents
Other Diagnosis Code 26	10.25.06.09 C.(71)	ICD-9-CM/ICD-10-CM Diagnosis Code 26 Remove embedded decimal pt.	
Other Diagnosis Code 26 Present on Admission 26 (POA)	10.25.06.09 C.(72)	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	10.25.06.09 C.(73)	ICD-9-CM/ICD-10-CM Diagnosis Code 27 Remove embedded decimal pt.	
Other Diagnosis Code 27 Present on Admission 27 (POA)	10.25.06.09 C.(74)	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	10.25.06.09 C.(75)	ICD-9-CM/ICD-10-CM Diagnosis Code 28 Remove embedded decimal pt.	
Other Diagnosis Code 28 Present on Admission 28 (POA)	10.25.06.09 C.(76)	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	10.25.06.09 C.(77)	ICD-9-CM/ICD-10-CM Diagnosis Code 29 Remove embedded decimal pt.	
Other Diagnosis Code 29 Present on Admission 29 (POA)	10.25.06.09 C.(78)	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	10.25.06.09 C.(79)	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	10.25.06.09 C.(80)	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	COMAR	Description	Field Contents
Billed Charge	10.25.06.09 C.(81)	A provider's billed charges rounded to whole dollars. **DO NOT USE DECIMALS**	
Allowed Amount	10.25.06.09 C.(82)	Total patient and payer liability. **DO NOT USE DECIMALS**	
Reimbursement Amount	10.25.06.09 C.(83)	Amount paid by carrier to Tax ID # of provider as listed on claim. **DO NOT USE DECIMALS**	
Total Patient Deductible	10.25.06.09 C.(84)	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	10.25.06.09 C.(85)	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	10.25.06.09 C.(86)	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 payer reimbursement), non-covered services, or penalties. **DO NOT USE DECIMALS**	

*Note: Note: Total Patient Liability **should equal the sum** of Patient Deductible (84), Patient Coinsurance/Co-payment (85), and Other Patient Obligations (86).*

Coordination of Benefit Savings or Other Payer Payments	10.25.06.09 C.(87)	If you are not the primary insurer, report the amount paid by the primary payer.	

Field Name	COMAR	Description	Field Contents
Type of Bill	10.25.06.09 C.(88)	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 7 Replacement of Prior Claim 8 Void/Cancel of Prior Claim 9 Final Claim for a Home Health PPS Episode

Field Name	COMAR	Description	Field Contents
Patient Covered by Other Insurance Indicator	10.25.06.09 C.(89)	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	10.25.06.09 C.(90)	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	10.25.06.09 C.(91)	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	10.25.06.09 C.(92)	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	10.25.06.09 C.(93)	Specific to Modifier I.	
Other Procedure Code 2	10.25.06.09 C.(94)	Remove embedded decimal pt.	
Procedure Code2 Modifier I	10.25.06.09 C.(95)		Modifier applies only to CPT Codes.
Procedure Code2 Modifier II	10.25.06.09 C.(96)		
Other Procedure Code 3	10.25.06.09 C.(97)	Remove embedded decimal pt.	
Procedure Code3 Modifier I	10.25.06.09 C.(98)		Modifier applies only to CPT Codes.
Procedure Code3 Modifier II	10.25.06.09 C.(99)		
Other Procedure Code 4	10.25.06.09 C.(100)	Remove embedded decimal pt.	
Procedure Code4 Modifier I	10.25.06.09 C.(101)		Modifier applies only to CPT Codes.
Procedure Code4 Modifier II	10.25.06.09 C.(102)		
Other Procedure Code 5	10.25.06.09 C.(103)	Remove embedded decimal pt.	
Procedure Code5 Modifier I	10.25.06.09 C.(104)		Modifier applies only to CPT Codes.
Procedure Code5 Modifier II	10.25.06.09 C.(105)		
Other Procedure Code 6	10.25.06.09 C.(106)	Remove embedded decimal pt.	
Procedure Code6 Modifier I	10.25.06.09 C.(107)		Modifier applies only to CPT Codes.
Procedure Code6 Modifier II	10.25.06.09 C.(108)		

Field Name	COMAR	Description	Field Contents
Other Procedure Code 7	10.25.06.09 C.(109)	Remove embedded decimal pt.	
Procedure Code7 Modifier I	10.25.06.09 C.(110)		Modifier applies only to CPT Codes.
Procedure Code7 Modifier II	10.25.06.09 C.(111)		
Other Procedure Code 8	10.25.06.09 C.(112)	Remove embedded decimal pt.	
Procedure Code8 Modifier I	10.25.06.09 C.(113)		Modifier applies only to CPT Codes.
Procedure Code8 Modifier II	10.25.06.09 C.(114)		
Other Procedure Code 9	10.25.06.09 C.(115)	Remove embedded decimal pt.	
Procedure Code9 Modifier I	10.25.06.09 C.(116)		Modifier applies only to CPT Codes.
Procedure Code9 Modifier II	10.25.06.09 C.(117)		
Other Procedure Code 10	10.25.06.09 C.(118)	Remove embedded decimal pt.	
Procedure Code10 Modifier I	10.25.06.09 C.(119)		Modifier applies only to CPT Codes.
Procedure Code10 Modifier II	10.25.06.09 C.(120)		
Other Procedure Code 11	10.25.06.09 C.(121)	Remove embedded decimal pt.	
Procedure Code11 Modifier I	10.25.06.09 C.(122)		Modifier applies only to CPT Codes.
Procedure Code11 Modifier II	10.25.06.09 C.(123)		
Other Procedure Code 12	10.25.06.09 C.(124)	Remove embedded decimal pt.	
Procedure Code12 Modifier I	10.25.06.09 C.(125)		Modifier applies only to CPT Codes.
Procedure Code12 Modifier II	10.25.06.09 C.(126)		
Other Procedure Code 13	10.25.06.09 C.(127)	Remove embedded decimal pt.	
Procedure Code13 Modifier I	10.25.06.09 C.(128)		Modifier applies only to CPT Codes.
Procedure Code13 Modifier II	10.25.06.09 C.(129)		
Other Procedure Code 14	10.25.06.09 C.(130)	Remove embedded decimal pt.	
Procedure Code14 Modifier I	10.25.06.09 C.(131)		Modifier applies only to CPT Codes.
Procedure Code14 Modifier II	10.25.06.09 C.(132)		
Other Procedure Code 15	10.25.06.09 C.(133)	Remove embedded decimal pt.	
Procedure Code15 Modifier I	10.25.06.09 C.(134)		Modifier applies only to CPT Codes.
Procedure Code15 Modifier II	10.25.06.09 C.(135)		

Field Name	COMAR	Description	Field Contents
Diagnosis Related Groups (DRGs) Number	10.25.06.09 C.(136)	The inpatient classifications based on diagnosis, procedure, age, gender and discharge disposition.	
DRG Grouper Name	10.25.06.09 C.(137)	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	10.25.06.09 C.(138)	Version of DRG Grouper used.	

Data Dictionary – MEDICAL and PHARMACY ELIGIBILITY

Field Name	COMAR	Description	Field Contents

INFORMATION TO BE ADDED FOR THE 2010 MCDB SUBMISSION

MARYLAND HEALTH CARE COMMISSION

APPENDIX G

MCDB Data Expansion Timeline

2010 MCDB Data Submission (*due June 30, 2011*):

☐ **Mandatory Submission**: Institutional Services Claims File – COMAR 10.25.06.09

- 2nd year of the 3-year transition to mandatory submission of most required data elements
- Under *COMAR 10.25.06.13 – Waiver or Exception Requests*, payers may request a temporary exemption for a particular data element that they do not collect, but can demonstrate intention to collect in the future.

☐ **Mandatory Submission**: Medical Eligibility File & Pharmacy Eligibility File – COMAR 10.25.06.10

- 1st year of a 3-year transition to mandatory submission of most required data elements
- Race, Ethnicity, and Spoken Language are data elements in these files with a lower acceptance threshold. The requirement to populate the race/ethnicity/spoken language variables with responses other than "unknown" may be phased in over a longer time period. The waiver process will allow a payer to align the MCDB requirements with their own collection of race, ethnicity, and spoken language information.
- Under *COMAR 10.25.06.13 – Waiver or Exception Requests*, payers may request a temporary exemption for a particular data element that they do not collect, but can demonstrate intention to collect in the future.

2011 MCDB Data Submission (*due June 30, 2012*):

☐ **Mandatory Submission**: Institutional Services Claims File – COMAR 10.25.06.09

- Last year of the 3-year transition to mandatory submission of most required data elements
- Under *COMAR 10.25.06.13 – Waiver or Exception Requests*, payers may request a temporary exemption for a particular data element that they do not collect, but can demonstrate intention to collect in the future.

☐ **Mandatory Submission**: Medical Eligibility File & Pharmacy Eligibility File – COMAR 10.25.06.10

- 2nd year of a 3-year transition to mandatory submission of most required data elements
- The requirement to populate the race/ethnicity/spoken language variables with responses other than "unknown" may be phased in over a longer time period. The waiver process will allow a payer to align the MCDB requirements with their own collection of race, ethnicity, and spoken language information.
- Under *COMAR 10.25.06.13 – Waiver or Exception Requests*, payers may request a temporary exemption for a particular data element that they do not collect, but can demonstrate intention to collect in the future.

2012 MCDB Data Submission (*due June 30, 2013*):

☐ **Full Compliance Required**: Institutional Services Claims File – COMAR 10.25.06.09

☐ **Mandatory Submission**: Medical Eligibility File & Pharmacy Eligibility File – COMAR 10.25.06.10

- Last year of the 3-year transition to mandatory submission of most required data elements
- The requirement to populate the race/ethnicity/spoken language variables with responses other than "unknown" may be phased in over a longer time period. The waiver process will allow a payer to align the MCDB requirements with their own collection of race, ethnicity, and spoken language information.
- Under *COMAR 10.25.06.13 – Waiver or Exception Requests*, payers may request a temporary exemption for a particular data element that they do not collect, but can demonstrate intention to collect in the future.

MCDB Data Expansion Timeline

MEDICAL CARE DATA BASE (MCDB)	**2010 MCDB** (June 30, 2011)	**2011 MCDB** (June 30, 2012)	**2012 MCDB** (June 30, 2013)	**2013 MCDB** (June 30, 2014)
Professional Services Claims *(COMAR 10.25.06.06)*	mandatory	mandatory	mandatory	mandatory
Pharmacy Claims *(COMAR 10.25.06.07)*	mandatory	mandatory	mandatory	mandatory
Provider Directory *(COMAR 10.25.06.08)*	mandatory	mandatory	mandatory	mandatory
Institutional Claims *(COMAR 10.25.06.09)*	mandatory	mandatory	mandatory	mandatory
Eligibility/Enrollment Files *(COMAR 10.25.06.10)*	mandatory	mandatory	mandatory	mandatory
Race & Ethnicity *(COMAR 10.25.06.10.C.(7) - (11))*	Lower acceptance threshold (40%)	Lower acceptance threshold (60%)	mandatory	mandatory
Spoken Language *(COMAR 10.25.06.10.C.(12))*		Lower acceptance threshold (40%)	Lower acceptance threshold (60%)	mandatory

(Note: If you cannot meet the minimum thresholds, you must request an exemption prior to submission.)

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