



MARYLAND MULTI-PAYER PCMH PROGRAM

SUBMISSION GUIDE

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Formatted for the INITIAL SUBMISSION

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MMPP DATA SUBMISSION GUIDE

PURPOSE: The [Maryland Multi-Payer PCMH Program](#) was enacted by the Maryland General Assembly and signed by Governor O'Malley in April 2010. Data Submission Manual is designed to provide payers with guidelines of technical specifications, layouts, and definitions necessary for filing the Professional Services Data and the Medical Eligibility Data reports required to attribute patients to a participating practice. This manual is available in electronic form on the Commission's website at <http://mhcc.maryland.gov/pcmh/>

PAYER ID #: Please see Appendix A (pg. 29) for a list of MMPP participants 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:

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For information on the MCDB SFTP submission process contact:

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DATA SET GLOSSARY

MEDICAL ELIGIBILITY FILE: This is the most essential data file. It details information on the characteristics of Qualified Individuals that may participate under Maryland law or a self-insured contract with an employer who has sent you a letter stating they wish to participate in the MMPP. Carriers should include in their eligibility files all Maryland residents that are covered as well as all non-residents that are insured under a Maryland contract by an insurance or Maryland insurance contract. Residents or non-residents of Maryland covered by an out-of-state HMO under an insurance contract written in another state are NOT qualifying individuals.

Table 1 provides a cross-reference between the “Qualified Individual” definition and categories of insurance coverage. Any cell that is labeled “submit eligibility” should be included in the Eligibility file.

Table 1— Cross Walk of Insurance Coverage and the Qualifying Individual Definition

	Type of Coverage	Resident of Maryland	Non-resident
Insurance	Covered under an Insurance Contract issued in Maryland	Qualified Individual, Submit Eligibility Info	Qualified Individual, Submit Eligibility Info
	Covered under an Insurance Contract Issued in Another State	Qualified Individual, Submit Eligibility Info	Voluntary only, not required
In-State HMO	Covered under an HMO contract issued in Maryland	Qualified Individual, Submit Eligibility Info	Qualified Individual, Submit Eligibility Info
	Covered under an Insurance Contract Issued in Another State	Qualified Individual, Submit Eligibility Info	Voluntary only, not required
Out-of-State HMO (not licensed in MD)	Covered under an Insurance Contract Issued in Another State	Unlikely to occur except when patient has relocated	Voluntary only, not required.
Self Insured	Employer sponsor could be in or out of Maryland	Only after authorization by plan sponsor	Only after authorization by plan sponsor

Please provide an entry for each enrollee whether or not a single claim was processed in 2009-2010. NOTE THAT ONLY NON-SHADED ENTRIES IN THE RECORD LAYOUT ARE REQUIRED.

Reporting Period: For the initial submission provide an enrollment record for all enrolled individuals meeting the criteria on March 1, 2011. A carrier will provide a complete refresh of the Medical Eligibility File every 6 months during the MMPP.

File Format: Format is at the person-level, one record per enrolled individual as of the date specified by MHCC for the first implementation, report eligible as of March 1, 2011.

II. RETROSPECTIVE PROFESSIONAL SERVICES FILE: Contains a subset of Evaluation and Management (E&M) Fee-for-service encounters and capitated encounters defined by MHCC and provided by selected primary care health care practitioners. Include all E&M services in the

specified range for Maryland residents covered by your company regardless of where the contract is written and all E&M services delivered by a primary care provider with a primary practice location in Maryland, a service ZIP code, or Billing zip code in Maryland. For example, if your company covers Maryland residents under a contract written in California, the services should be included in your submission.

Reporting Period: For the initial submission, provide E&M services delivered from January 1, 2009 through December 31, 2010. A carrier will provide additional E&M services every 6 months during the MMPP.

File Format: File is at the line-item or service level, one service (CPT) per record.

III. ATTRIBUTED PATIENT ELIGIBILITY FILE Delivered to the Carrier: Contains information on patients attributed to PCMH practices in the MMPP by MHCC. Each record will contain patient data sufficient for the carrier to identify the patient and the MMPP practice identifier for the practice response for the attributed patient.

Reporting Period: MHCC will deliver a file to each participating carrier approximately 15 days after the Medical Eligibility Files and the Retrospective Files have been delivered to MHCC. MHCC will provide an updated Attributed Patient Eligibility File at 6-month intervals throughout the MMPP.

IV. ALTERNATIVE UUID FILE: A file provided by the Carrier to the MHCC Database contractor Social & Scientific Systems, Inc. (SSS), which will enable SSS to assign the common encrypted identifier. This file is only needed if the carrier is unable to conduct the encryption in its own facility. MHCC must approve the submission of this file.

Reporting Period: This will be defined by MHCC

File Format: Format is at the person-level one record per enrolled individual in a CSV format

OVERVIEW OF KEY SPECIFICATIONS

- The Commission is providing to all payers the **Universally Unique Identifier (UUID)** algorithm to uniquely encrypt patient/enrollee identifiers, using a common one-way hashing method. As a result, a second patient/enrollee identifier field, **Patient/Enrollee IdentifierU**, has been inserted to enable the Commission to identify patients across payers over time.
- For the **Retrospective Professional Services File** provide E&M services falling into the following ranges: 99201 – 99205; 99211 – 99215, 99381 – 99387; 99391 – 99397, 99241 – 99245
- E&M services provided by the following specialties must be provided in **Retrospective Professional Services File**: General Medicine, Family Medicine, Internal Medicine, and Pediatrics. In addition, please provide services billed by a nurse practitioner and physician assistant.
- Carriers are required to continue to use their current encrypted identifier, **Patient/Enrollee IdentifierP**, coincident with the new identifier. Using two identifiers will: 1) provide the means to perform trend analysis by cross referencing the two identifiers, and 2) increase the efficacy of the identifiers in the event encryption of one of the algorithms is compromised.
- The **Record Identifier** field is used to identify the data report file: 1 – Professional Services; 5 – Medical Eligibility.
- **Patient Date of FIRST Enrollment** in plan (CCYYMMDD) – Enter the date that the patient was initially enrolled with your organization. If patient is initially enrolled at the start of 2011 enter 2011011. If patient is enrolled since January 2009 enter 20090101. If patient was enrolled continuously prior to January 2009, it is acceptable to enter 20090101.

FORMATTING NOTES –

- **POPULATE** any NUMERIC field—except the financial fields for capitated/global contract services—for which you have no data to report with **ZEROS**.
- Leave **BLANK** the positions in NUMERIC fields for which the entry is less than the allowed field length.
- **DO NOT** add leading zeroes to amount/financial fields.
- **LEFT** justify all ALPHANUMERIC fields.
- Leave **BLANK** any ALPHANUMERIC fields for which you have no data to report.

MEDIA FORMAT/TRANSMISSION INFORMATION

(Please label all media & documentation with your Payer ID # listed on page 29)

Secure SFTP Server

Payers have the ability to upload MCDB data files directly to the MHCC Secure SFTP site. If you would like to use this submission option, please contact Mr. Lee Nelson at (410) 764-3486 or via e-mail at lnelson@mhcc.state.md.us.

This is the only allowed method of submission and delivery for all files.

SECTION I ^{Updated}

DEADLINES AND MILESTONES

- By May 1st – Carriers submit the Retrospective Professional Services File and Medical Eligibility File with the Encrypted Identifier
 - ❖ Retrospective Professional Services File: claim data for E&M services provided to all enrolled individuals during the previous 2 years, January 1, 2009 - December 31, 2011. This includes claims for patients insured during all or part of those years.
 - ❖ Medical Eligibility File: an eligibility file for all eligible individuals and for self-insured for whom the plan sponsor agrees to participate.
- May 20th – MHCC returns the Attributed Patient Eligibility File with enrollees flagged who are eligible to participate in a PCMH practice. Eligible patient means:
 - ❖ Attributed to the practice
 - ❖ On a carrier's medical eligibility file
- June 7th – Each carrier informs the PCMH practices of the patients insured by that carrier that are eligible to participate. This would consist of a file containing the names of currently enrolled individuals.
- Practices would have 30 days to notify patients of their opportunity to participate and offer the opportunity to decline.
- August 1st – Practices return list of decliners to the carrier.
- July 1st – Carriers deliver payments to practices based on the list of attributed eligible patients identified by MHCC with decliners, flagged by practice, not included.
- October 1st – Carrier submits the Retrospective Professional Services and Medical Eligibility Files with the encrypted identifier. The Services File contains claim data for January 1, 2011 to June 30, 2011. The Eligibility File reflects enrollment as of September 1, 2011 and the process repeats.
- October 15th – MHCC returns the Attributed Patient Eligibility File with enrollees flagged who are eligible to participate in a PCMH practice. Eligible patient means:
 - ❖ Attributed to the practice
 - ❖ On a carrier's medical eligibility file

- October 20th – Each carrier informs PCMH practices of the patients insured by that carrier that are eligible to participate. This would consist of a file containing the names of currently enrolled individuals.
- November 20th – Practices return list of decliners to the carrier.
- January 1, 2012 – Carriers deliver payments to practices based on the list of attributed eligible patients identified by MHCC with opt-outs removed using claims from July 1, 2009 through June 30, 2011.

Retrospective Professional Services and Medical Eligibility Files ^{UPDATED}

- Retrospective Professional Services File for July 1 through December 31, 2011 and Medical Eligibility as of March 1, 2012, due by March 31, 2012
- Retrospective Professional Services File for January 1 through June 30, 2012 and Medical Eligibility as of September 1, 2012, due by October 1, 2012
- Retrospective Professional Services File for July 1, 2012 through December 31, 2012, and Medical Eligibility as of March 1, 2013, due by March 31, 2013
- Retrospective Professional Services File for January 1 through June 30, 2013 and Medical Eligibility as of September 1, 2013, due by October 1, 2013
- Retrospective Professional Services File for July 1 through December 31, 2013, and eligibility as of March 1, 2014, due by March 31, 2014

SECTION II Processing Overview

PROCESS FLOW PATIENT ATTRIBUTION

The attribution approach is designed to attribute as many patients in a practice as possible. A carrier will not be responsible for all patients that are attributed using that carrier's claim data, but rather the patients attributed from any carrier's claim files for which the carrier is the responsible payer. The Medical Eligibility File containing all eligible individuals as defined in Maryland law and covered lives from employers committed to participate will determine a plan's obligations for fixed payments.

Data Requirements from Carriers by May 1st (See Figure 1)

- I. Submit Retrospective Professional Services – initial selection of services for attribution that conform to the following specifications:
 1. The service is one of the following codes (# 35) : 99201 – 99205; 99211 – 99215), (99381 – 99387; 99391 – 99397, Office Consult (99241 – 99245)
 2. Restrict services as follows:
 - a. By Location:
 - i. The patient has a residence with a Maryland ZIP code (#7), or
 - ii. The rendering or billing provider has a Maryland provider service ZIP code #32) or Maryland billing Zip code, or
 - iii. The primary practice location on the carrier's health care professional directory is in Maryland.
 - b. By the Date of Service – between January 1, 2009 and December 31, 2010.¹
 - c. By the Specialty of the rendering specialists (*pg. 14, pg. 23*).
 - i. General Practice,
 - ii. Family Medicine,
 - iii. Internal Medicine,
 - iv. Pediatrics,
 - v. CRNP practicing in a primary care practice, or
 - vi. Physician Assistant practicing in a primary care practice.
- II. The Medical Eligibility File as of a specific date – A snapshot of all covered individuals eligible to participate in the MMPP:
 1. For fully-insured – include all individuals who hold health care coverage that is issued or renewed under the Maryland Insurance Article or
 2. For self-insured – include all individuals who hold health care coverage through a plan sponsor that has agreed to participate in the MMPP program

¹ At six month intervals thereafter provide a claim file and an eligibility snapshot of all individuals eligible to participate in the MMPP.

MHCC tasks (see Figure 2)

- I. Prior to attribution – Build a PCMH Practice ID – MHCC requires that all MMPP Practice Sites provide individual NPIs for the physicians, physician assistants, and CRNPs that practice at that practice site. If the practice site is part of a larger practice organization, the individual-level NPIs will be used to define the site. In a multi-site practice, the providers (NPIs) identified by the practice that participate in the MMPP and the services they have provided define if a patient can be attributed. These practices will be identified by the Federal Tax ID + the MMPP application ID. If the practice is a single site practice, MHCC will use the Federal Tax ID and the Organizational NPI to identify the practice and attribute patients.

1. Logic for attributing participating patients to practices using a 2-step, 24-month look-back:

- a. First attribute for the most recent 12 months:
 - i. Count the number of visits (all same day services count as 1) for the E & M codes for patient at each practice or practice site.
 - ii. Select the practice with the highest number of visits in the year as the attributed practice.
 - iii. If there is a tie attribute to the practice with the most recent visit.
- b. If no services were provided in the most recent year, look back a second year using the same process as described above in 2.a.
- c. Other information: MMPP applicants will be counted as practices using the Federal Taxid (if solo site) or the Federal Tax ID + the MMPP ID (if multi-site). Other professional practices will be counted by Federal TaxID only.
- d. For example, if a certain primary care practice has 4 sites, one of which is selected, then it would be identified based on the NPIs flagged as practicing and labeled as 521221121 1000.

1. Assume we generated the following counts of visits for Patient Z

Practice	# of Visits
521221121 1000	5
521221121	3
201124311	2

The MMPP practice site would be assigned the patient because it accounted for the most visits.

2. Logic for assigning an attributed patient to a Carrier – The attributed patients from the attribution program are the output from Step 2. Patients treated by the practice are now identified and MHCC determines if a responsible carrier exists.

- a. Merge attributed patients to the Medical Eligibility Data File for each carrier by the Encrypted Patient ID (UUID).
- b. A carrier is assigned an attributed patient if that patient is on the carrier's eligibility file and the carrier is listed as the primary payer, even though the carrier may not have been responsible for any services.
- c. Each carrier will be provided an Attributed Patient Eligibility File. The file will list all of the patients insured by that carrier that have been assigned to the carrier.

- d. The carrier will have one final opportunity to flag patients that are not covered when the Attributed Patient Eligibility File (APEF) is delivered.
3. Fixed Transformation Payment calculation (*see Figure 3*)
 - a. A carrier will total the patients attributed to each practice. The payment level will be determined by the size of the practice site and the level of attribution.
 - b. The FTP may be delivered via a claim or a transfer via a carrier's banking entity.
 - c. The payment process for the initial period should begin by July 1, 2011.
 - d. Carriers are given some flexibility in delivering the rewards, but are encouraged to use a method that will enable the carrier to count the FTP toward the medical loss ratio calculations required by HHS under ACA.
 4. The attribution process is repeated every 6 months. Each Carrier submits an additional set of claims for the most recent 6 months using the selection criteria defined in steps 1 – 4 above. The new subset is combined with the claims for the recent 18 months and the attribution process is repeated.

Practice Responsibilities – Opt-out (*responsibilities are flagged in Figure 3*) Practices will have additional time to obtain opt-out due to submission delay granted to carriers for first submission

- I. Informing Patients:
 1. MMPP practices are given 1 month to notify a carrier that a patient has declined participation.
 2. Practices may use telephonic, face-to-face, the mail, or electronic methods to achieve compliance.
 3. Practices must return the APEF to each carrier with the names of opt-outs identified.

Figure 1 Processing Flow at The Carrier

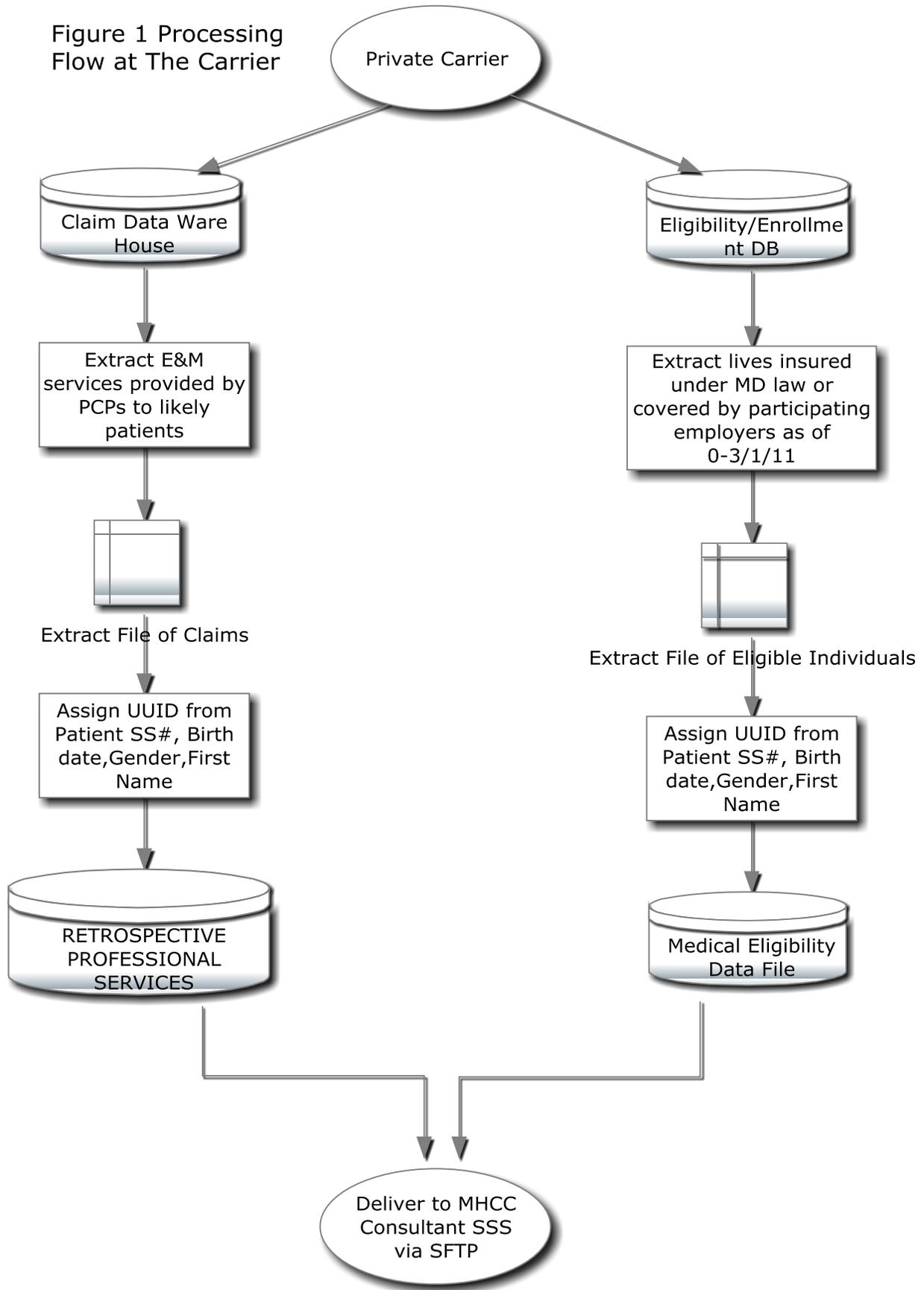
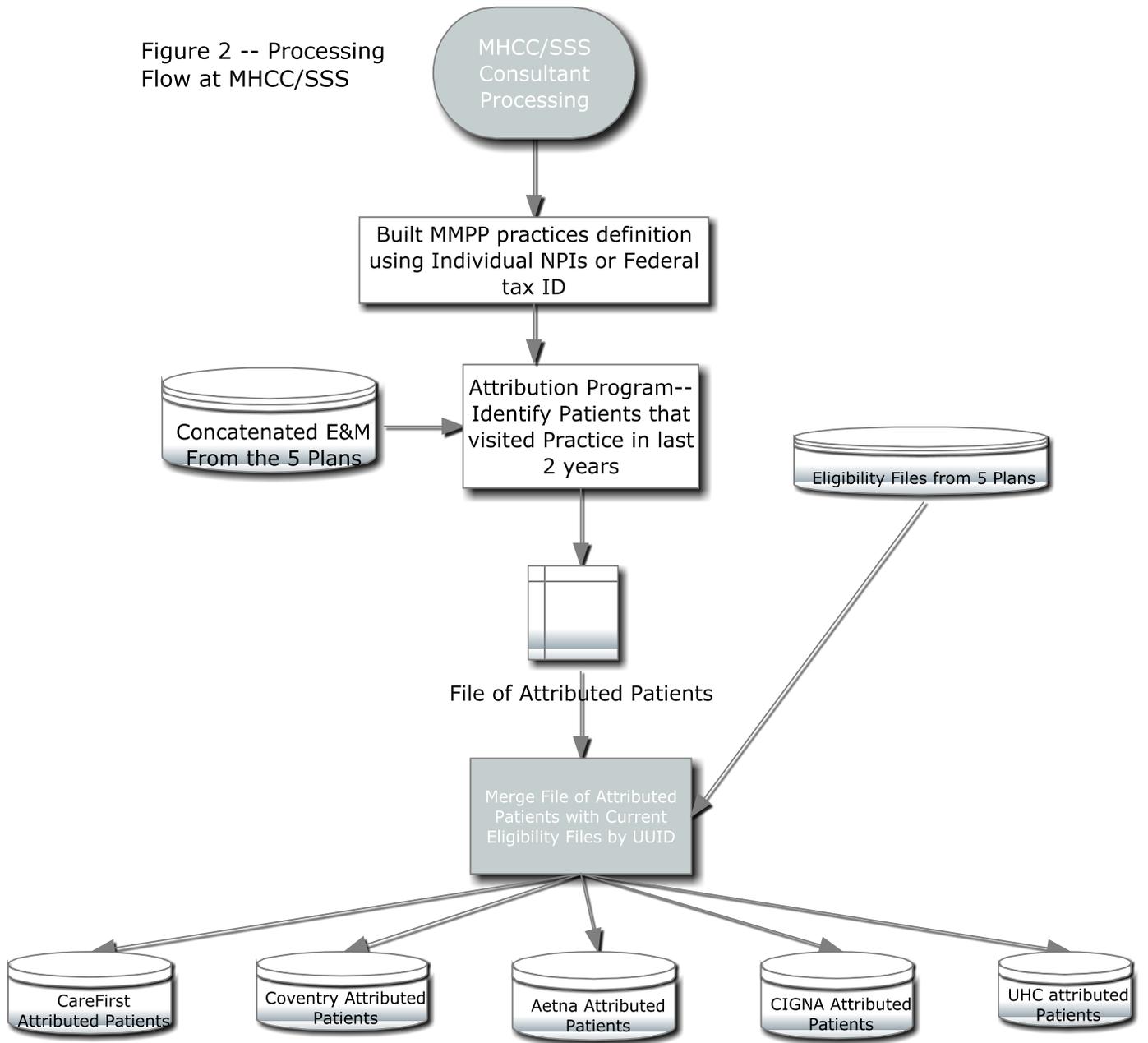


Figure 2 -- Processing Flow at MHCC/SSS



Explanation of UNIVERSALLY UNIQUE IDENTIFIER (UUID)

Cross Payer Encryption Algorithm

MHCC shall provide each payer an encryption algorithm, **Universally Unique Identifier (UUID)**, using one-way hashing consistent with the Advanced Encryption Standard (AES) recognized by the National Institute of Standards and Technology. Each payer shall maintain the security and preserve the confidentiality of the UUID encryption algorithms provided by MHCC.

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

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

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

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

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

Questions regarding the Universally Unique Identifier (UUID) Cross Payer Encryption Algorithm should be directed to Mr. Larry Monroe at 410-764-3390.

Please Document How You Define Practitioner Specialty

Practitioner Specialty: The health care field in which a physician or a licensed health care professional has been certified. For the MMPP program only four (4) specialties and two (2) other provider categories are allowed. If you need to remap specialties to identify these specialties please provide that information below and submit it with your data.

Practitioner Specialty	Value	Description (payer specialty descriptions mapped to COMAR defined specialties)
General Practice	001	
Family Practice	009	
Internal Medicine	014	
Pediatrics	025	
Advanced Practice Nurse: Nurse Practitioner	051	
Physician Assistant	064	

SECTION III

FILE LAYOUTS

- **RETROSPECTIVE PROFESSIONAL SERVICES FILE**
- **MEDICAL ELIGIBILITY FILE**

RETROSPECTIVE PROFESSIONAL SERVICES FILE – File Layout

File format is at the line-item or service level, one service (CPT) per record. Every six months update the service submission by providing six (6) months of additional service information using the same query specification.

*	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Start	End
1.	Record Identifier	1	N		1	1
2.	Patient Identifier P (payer encrypted)	12	A		2	13
3.	Patient Identifier U (UUID encrypted)	12	A		14	25
4.	Patient Year and Month of Birth (CCYYMMDD)	8	N		26	33
5.	Patient Sex	1	N		34	34
7.	Patient Zip Code	5	N		35	39
12.	Practitioner Federal Tax ID	9	A		40	48
29.	Service From Date (CCYYMMDD)	8	N		49	56
30.	Service Thru Date (CCYYMMDD)	8	N		57	64
31.	Place of Service	2	N		65	66
32.	Service Location Zip Code	5	A		67	71
33.	Service Unit Indicator	1	N		72	72
34.	Units of Service	3	N	1 implied**	73	75
35.	Procedure Code	6	A		76	81
36.	Modifier I (This field must be mapped – see pg. 22)	2	A		82	83
37.	Modifier II (specific to Modifier I)	2	A		84	85
38.	Servicing Practitioner ID	11	A		86	96
48.	Servicing Practitioner Individual National Provider Identifier (NPI) number	10	A		97	106
	Practitioner Specialty	3	A		107	109

* The field numbers cross-reference with the field numbers on the Professional Services file on the Medical Care Data Base (MCDB).

MEDICAL ELIGIBILITY DATA REPORT – File Layout

Please provide information on the characteristics of eligible individuals as defined under Maryland law or by an employer who wishes to participate. A record entry must be provided for each patient regardless of whether or not the patient has received any covered services rendered by the program in the previous year. This layout conforms with the eligibility file used in the MHCC's all payer claim data base (MCDB), for the MMPP a shaded field is NOT required.

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Start	End	Required by the MMPP
1.	Record Identifier	1	N		1	1	X
2.	Encrypted Enrollee's Identifier ^P (payer encrypted)	12	A		2	13	X
3.	Encrypted Enrollee's Identifier ^{U*} (UUID encrypted)	12	A		14	25	X
4.	Enrollee Year and Month of Birth (CCYYMMYY)	8	N		26	33	X
5.	Enrollee Sex	1	N		34	34	X
6.	Enrollee Zip Code of Residence	5	N		35	39	X
7.	Enrollee County of Residence	2	N		40	41	
8.	Source of Enrollee Race/Ethnicity Information	1	N		43	43	
9.	Enrollee OMB Race 1	1	N		44	44	
10.	Enrollee OMB Race 2	1	N		45	45	
11.	Enrollee OMB Race 3 <i>(for future use)</i>	1	N		46	46	
12.	Enrollee OMB Hispanic Ethnicity 1	1	N		47	47	
13.	Enrollee Other Ethnicity 2 <i>(for future use)</i>	1	N		48	48	
14.	Enrollee Preferred Spoken Language <i>(for future use)</i>	2	N		49	50	
15.	Coverage Type	1	A		51	51	
16.	Source Company <i>(retained from Delivery System Type)</i>	1	A		52	52	
17.	Product Type	1	N		53	53	
18.	Policy Type	1	N		54	54	
19.	Encrypted Contract or Group Number (payer encrypted)	20	A		55	74	X
20.	Encrypted Employer Federal Tax ID Number (payer encrypted)	9	A		75	83	X

21.	Medical Services Indicator (for future use)	1	N		84	84	
22.	Pharmacy Services Indicator	1	N		85	85	
23.	Behavioral Health Services Indicator	1	N		86	86	
24.	Dental Services Indicator	1	N		87	87	
25.	Plan Liability	1	N		88	88	X
26.	Consumer Directed Health Plan (CDHP) with HSA or HRA Indicator	1	N		89	89	
27.	Start Date of Coverage (in the month CCYYMMDD)	8	N		90	97	X
28.	End Date of Coverage (in the month CCYYMMDD)	8	N		98	105	X
29.	Date of First Enrollment In CCYYMMDD	8	N		106	113	X
30.	Date of Disenrollment	8	N		114	121	
31.	Relationship to Policyholder	1	N		122	122	X
	Patient Covered by Other Insurance	1	N		123	123	X

* Note: The Commission expects the algorithm to be applied to every eligibility record.

ALTERNATIVE UUID FILE

If the carrier submits directly to SSS with no UUID and SSS generates the UUID , the file must link with a Carrier's Retrospective Professional Claims And Medical Eligibility Files via the Internal Encrypted ID.

Comma Delimited File Required if SSS conducts the attribution		
	Label	Length
1	Patient Encrypted Internal ID data record identifier: Alphanumeric. No maximum length.	
2	Patient first name: Alphanumeric. No maximum length.	
3	Patient SSN: Must contain exactly 9 numerical digits. Other characters ignored	9
4	Patient gender: Alphanumeric. The value 1 represents male gender, and a value of 2 represents a female gender. Acceptable values are 1 and 2.	1
5	Patient birth year: Integer. Acceptable values are from 1850 to 2100 inclusive.	4
6	Patient birth month: Integer. Acceptable values are from 1 to 12 inclusive.	2
7	Patient birth day: Integer. Acceptable values are from 1 to 31 inclusive	2
8	Policy holder first name. Alphanumeric. No maximum length.	
9	Policy holder SSN: Alphanumeric. Must contain exactly 9 numerical digits. Other characters ignored	9
10	Policy holder gender: Alphanumeric. The value 1 represents male gender, and a value of 2 represents a female gender. Acceptable values are 1 and 2.	1
11	Policy holder birth year: Integer. Acceptable values are from 1850 to 2100 inclusive.	4
12	Policy holder birth month: Integer. Acceptable values are from 1 to 12 inclusive.	2
13	Policy holder birth day: Integer. Acceptable values are from 1 to 31 inclusive	2

FILE DELIVERED TO A CARRIER

ATTRIBUTED PATIENT ELIGIBILITY FILE FOR CARRIER

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Start	End
1.	Record Identifier	1	N		1	1
2.	Encrypted Enrollee's Identifier P (payer encrypted)	12	A		2	13
3.	Encrypted Enrollee's Identifier U (UUID encrypted)	12	A		14	25
4.	NPI of the Attributed Practice	10	A		26	35
5.	MMPP Identifier	4	A		36	39
6.	Federal Tax ID of Attributed Practice	9	A		40	48
7.	Encrypted Contract or Group Number (payer encrypted)	20	A		49	68
8.	Encrypted Employer Federal Tax ID Number (payer encrypted)	9	A		69	77
9.	Relationship to Policyholder	1	N		78	78
10.	FTP Payment for this practice for six month period	6	N	2	79	84

SECTION IV

DATA DICTIONARY

- RETROSPECTIVE PROFESSIONAL SERVICES FILE
- MEDICAL ELIGIBILITY FILE

FORMATTED FOR THE MMPP SUBMISSION

Data Dictionary – RETROSPECTIVE 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 P (payer encrypted)	10.25.06.06 D.(2)	Patient's unique identification number assigned by payer and encrypted.	The unique ID for each person on this file should correspond to the same unique Patient ID used for all other files (Pharmacy Claims and Institutional Services)
Patient Identifier U (UUID encrypted)	10.25.06.06 D.(2)	Patient's universally unique identification (UUID) number generated using an encryption algorithm provided by MHCC.	Refer to the UUID summary description sheet on page 13. A full description is available in the UUID Users' Manual on the MHCC website.
Patient Year and Month of Birth	10.25.06.06 D.(3)	Date of patient's birth using 00 instead of day.	CCYMM00
Patient Sex	10.25.06.06 D.(4)	Sex of the patient.	1 Male 2 Female 3 Unknown
Patient Zip Code	10.25.06.06 D.(6)	Zip code of patient's residence.	5-digit US Postal Service code
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
Service From Date	10.25.06.06.D.(28)	First date of service for a procedure in this line item.	CCYMMDD
Service Thru Date	10.25.06.06.D.(29)	Last date of service for this line item.	CCYMMDD
Place of Service	10.25.06.06.D.(30)	Two-digit numeric code that describes where a service was rendered.	CMS: 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

Field Name	COMAR	Description	Field Contents
			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
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: <ul style="list-style-type: none"> • 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).	

Field Name	COMAR	Description	Field Contents
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 Specialty		The health care field in which a physician or licensed health care professional has been certified.	001 General Practice 009 Family Practice 014 Internal Medicine 025 Pediatrics 051 Advanced Practice Nurse: Nurse Practitioner 064 Physician Assistant

Data Dictionary – MEDICAL ELIGIBILITY *(please submit required elements only)*

Field Name	COMAR	Description	Field Contents
Record Identifier	10.25.06.10 C.(1)	The value is 5	5 Medical Eligibility
Encrypted Enrollee Identifier P (payer encrypted)	10.25.06.10 C.(2)	Enrollee’s unique identification number assigned by payer and encrypted.	The unique ID for each person on this file would correspond to the same unique Patient/Enrollee ID used for all other files (Professional Services, Pharmacy Claims, and Institutional Services Files).
Encrypted Enrollee Identifier U (UUID encrypted)		Enrollee’s universally unique identification (UUID) number generated using an encryption algorithm provided by MHCC.	Refer to the UUID summary description sheet on page 13. A full description is available in the UUID Users’ Manual on the MHCC website.
Enrollee Year and Month of Birth	10.25.06.10 C.(3)	Date of enrollee’s birth using 00 instead of day.	CCYYMM00
Enrollee Sex	10.25.06.10 C.(4)	Sex of the enrollee.	1 Male 2 Female 3 Unknown
Enrollee Zip Code of Residence	10.25.06.10 C.(5)	Zip code of enrollee’s residence.	5-digit US Postal Service code

Field Name	COMAR	Description	Field Contents
Enrollee County of Residence	10.25.06.10 C.(6)	County of enrollee's residence. If known, please provide. If not known, MHCC will arbitrarily assign using Zip code of residence.	001 Allegany 003 Anne Arundel 005 Baltimore County 009 Calvert 011 Caroline 013 Carroll 015 Cecil 017 Charles 019 Dorchester 021 Frederick 023 Garrett 025 Harford 027 Howard 029 Kent 031 Montgomery 033 Prince George's 035 Queen Anne's 037 St. Mary's 039 Somerset 041 Talbot 043 Washington 045 Wicomico 047 Worcester 510 Baltimore City 999 Unknown <i>County codes based on the U.S. Census Bureau's Federal Information Processing Standards (FIPS).</i>
Source of Enrollee Race/Ethnicity Information	10.25.06.10 C.(7)	Race/ethnicity of enrollee gathered from enrollee or other source.	0 Enrollee not asked 1 Enrollee asked and reported 2 Enrollee asked but refused 3 Obtained from other source
Enrollee OMB Race 1	10.25.06.10 C.(8)	Race of enrollee.	1 American Indian or Alaska Native 2 Asian 3 Black or African American 4 Native Hawaiian or Other Pacific Islander 5 White/Caucasian 6 Some Other Race 9 Missing/Unknown/Not specified

Field Name	COMAR	Description	Field Contents
Enrollee OMB Race 2	10.25.06.10 C.(9)	Race of enrollee.	<ul style="list-style-type: none"> 1 American Indian or Alaska Native 2 Asian 3 Black or African American 4 Native Hawaiian or Other Pacific Islander 5 White/Caucasian 6 Some Other Race 9 Missing/Unknown/Not specified
Enrollee OMB Race 3 <i>(for future use)</i>			For Future Use
Enrollee OMB Hispanic Ethnicity 1 (Hispanic Indicator)	10.25.06.10 C.(10)	Ethnicity of enrollee.	<ul style="list-style-type: none"> 1 Hispanic or Latino or Spanish origin 2 Not Hispanic or Latino or Not of Spanish origin 9 Missing/Unknown/Not specified
Enrollee Other Ethnicity 2 <i>(for future use)</i>	10.25.06.10 C.(11)		For Future Use
Enrollee Preferred Spoken Language <i>(for future use)</i>	10.25.06.10 C.(12)	A locally relevant list of languages will be developed by the Commission in consort with the Racial, Ethnic and Language Disparities Work Group.	For Future Use
Coverage Type	10.25.06.10 C.(13)	Enrollee's type of insurance coverage.	<ul style="list-style-type: none"> 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) A Student Health Plan Z Unknown

Field Name	COMAR	Description	Field Contents
Source Company <i>(renamed from Delivery System Type this file only)</i>		Defines the payer company that holds the beneficiary's contract; for use in characterizing contract requirements under Maryland law.	<ul style="list-style-type: none"> 1 Health Maintenance Organization 2 Life & Health Insurance Company or Not-for-Profit Health Benefit Plan 3 Third-Party Administrator (TPA) Unit
Product Type ^{New!}	10.25.06.10 C.(14)	Classifies the benefit plan by key product characteristics (scope of coverage, size of network, coverage for out-of-network benefits).	<ul style="list-style-type: none"> 1 Exclusive Provider Organization (for self-insured risks only) 2 Health Maintenance Organization (fully-insured EPOs sold by licensed HMOs go here) 3 Indemnity 4 Point of Service (POS) 5 Preferred Provider Organization (PPO) (fully-insured EPOs sold by a licensed life & health insurance company or not-for-profit health benefit plan go here) 6 Limited Benefit Plan (Mini-Meds) 7 Student Health Plan 8 Catastrophic
Policy Type	10.25.06.10 C.(15)	Type of policy.	<ul style="list-style-type: none"> 1 Individual 2 Any combination of two or more persons
Encrypted Contract or Group Number <i>(payer encrypted)</i>	10.25.06.10 C.(17)	Payer assigned contract or group number for the plan sponsor using an <u>encryption algorithm generated by the payer</u> .	This number should be the same for all family members on the same plan.
Encrypted Employer Federal Tax ID Number <i>(payer encrypted)</i>	10.25.06.10 C.(18)	Employer Federal Tax ID number using an <u>encryption algorithm generated by the payer</u> in such a way that the same employer has the same encrypted number from year to year.	
Medical Services Indicator <i>(for future use)</i>	10.25.06.10 C.(19)		For Future Use
Pharmacy Services Indicator	10.25.06.10 C.(20)	Prescription Drug Coverage	<ul style="list-style-type: none"> 0 No 1 Yes
Behavioral Health Services Indicator	10.25.06.10 C.(21)	Behavioral Health Services Coverage	<ul style="list-style-type: none"> 0 No 1 Yes
Dental Services Indicator	10.25.06.10 C.(22)	Dental Coverage	<ul style="list-style-type: none"> 0 No 1 Yes

Field Name	COMAR	Description	Field Contents
Plan Liability ^{Modified!}	10.25.06.10 C.(23)	Indicates if insurer is at risk for the patient's service use or the insurer is simply paying claims as an ASO.	1 Risk (under Maryland contract) 2 Risk (under non-Maryland contract) 3 ASO (employer self-insured)
Consumer Directed Health Plan (CDHP) with HSA or HRA Indicator	10.25.06.10 C.(24)	Consumer Directed Health Plan (CDHP) with Health Savings Account (HSA) or Health Resources Account (HRA).	0 No 1 Yes
Start Date of Coverage ^{New!} (in the month)		The start date for benefits in the month (for example, if the enrollee was insured at the start of the month of January in 2010, the start date is 20100101)	CCYYMMDD
End Date of Coverage ^{New!} (in the month)		The end date for benefits in the month (for example, if the enrollee was insured for the entire month of January in 2010, the end date is 20100131)	CCYYMMDD
Date of Enrollment	10.25.06.10 C.(25)	The start date of enrollment for the patient in this delivery system (in this data submission time period).	CCYYMMDD Date is 20100101 if patient is enrolled at start of 2010. Enter other date if patient not enrolled at start of year, enrolled during 2010.
Date of Disenrollment	10.25.06.10 C.(26)	The end date of enrollment for the patient in this delivery system (in this data submission time period).	CCYYMMDD Leave blank if patient is still enrolled on 20101231. If patient disenrolled before end of year enter date disenrolled.
Relationship to Policyholder	10.25.06.10 C.(27)	Member's relationship to subscriber/insured.	1 Self/employee 2 Spouse 3 Child 4 Other Dependent 5 Other Adult 9 Unknown
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

APPENDIX A

MMPP PAYERS & PAYER ID NUMBERS

ORGANIZATION	Payer ID #	ORGANIZATION	Payer ID #
Aetna U.S. Healthcare	P030	Golden Rule Insurance Co.	P320
Aetna Life & Health Insurance Co.	P020	Coventry Healthcare of Delaware, Inc. (Coventry Life & Health, Inc.)	P680
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	Optimum Choice, Inc.	P620
Connecticut General Life Ins. Co.	P180	United Healthcare Insurance Co.	P820
Great-West Life & Annuity Ins. Co.	P330	United Healthcare of the Mid-Atlantic, Inc.	P870



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