[](http://mhdo.maine.gov/imhdo/)

April 2018 APCD Data Release Notes

# Opening Statement

This release contains the following data:

* 2017 Q4 Commercial data
* 2017 Q4 MaineCare (Medicaid) data

## **New Medical Claim Consolidation Table**

Based on feedback from MHDO data users we have developed and are releasing "Claim Consolidation" information for medical claims for the first time with this release. This involves providing information on which claim lines should be included to form "the final version" of the claim. Delivering this level of information will allow data users to more quickly exclude claim lines that have been reversed or reissued.

MaineCare and commercial payers occasionally issue adjustments or reversals to previously paid medical claims. Past analysis has shown that adjustments happen with **less than 3%** of the commercial claims and the claims that get reversed are more likely to get reversed multiple times. According to MHDO Rule Chapter 243 and the ASC X12 837 standard each version of the claim should be fully reversed before new claim lines are issued. However, of the top five commercial payers which represent approximately 80% of the commercial claims data, the MHDO is aware of one that is not able to do this. Aetna has provided the MHDO with their custom versioning logic which allows the MHDO to determine the final version of the claim in these cases. When there is payer-specific logic, MHDO will use it instead of the standard versioning method. By default, however, the version of the claim with the latest paid date will be considered the final version of the claim.

In some cases, the most recent version of a claim will be the reversal—the reissue of the new claim lines may have been issued under a new claim number, for instance. In these cases, the original claim will include both the most recent set of reversals and the previous set of non-reversals, essentially "zeroing out" the claim.

*Claim Consolidation Table Example*

| MC907\_MHDO\_Claim | MC902\_IDN |
| --- | --- |
| 15434324 | 9854741 |
| 15434324 | 9854742 |
| 15434324 | 9854743 |
| 15434325 | 56849847 |
| 15434325 | 56849848 |
| 15434325 | 56849849 |

In the above example, claim detail lines associated with two claims are shown: 15434324 and 15434325. Each of these claims has three claim detail lines associated with it. Performing an inner join of this table to the medical claims detail table on the MC902\_IDN field will restrict the detail to only detail lines that in the final version of the claim.

As the MHDO receives new data, the set of "final claim lines" may change for a claim. The MHDO will distribute a full refresh of the Claim Consolidation table with every data release.

## Reminders

**Note: The next three issues were included in the February 2018 APCD Data Release Notes. We are also including them here due to their critical importance.**

**Substance Abuse and Mental Health Services Administration (SAMHSA)-Confidentiality of Substance Use Disorder (SUD) Patient Records, 42 CFR Part 2**

The Department of Health and Human Services (HHS) issued the final rule to update and modernize the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2. The regulations became effective as of March 21, 2017. In general, the 42 CFR Part 2 rule limits data shared about a substance use disorder (SUD) service by a Part 2 Provider, as well as other lawful holders of data related to services rendered by Part 2 providers.

The original proposal the MHDO made to the payers (who are considered lawful holders of the data and are the entities that are required to comply with the provisions in 42 CFR Part 2) submitting data to the MHDO was to establish a uniform approach regarding the redaction of substance abuse claims that complies with the requirements in 42 CFR Part 2. CMS/ResDAC has created a filter that flags and suppresses claim lines containing SUD-related codes prior to releasing Medicare claims files to the MHDO. A description of the policy and a listing of the codes used for redaction are found here: <https://www.resdac.org/resconnect/articles/203>

Unfortunately, due to the lack of clarity in the Rule -- and to date no endorsement from SAMSHA on the use of the CMS/RasDAC filter -- payers are applying their own set of codes/filters to their data before submitting claims data to the MHDO. In some cases, payers are suppressing data that is not protected under this Rule. **Impact of SAMHSA** **42 CFR Part 2 on MHDO Historical Claims Data**

The MHDO has applied the CMS/ResDAC filter to our historical claims data, which means we have removed any claim lines that have a code that is included on the redaction list. We leave any portion of a claim that doesn’t include one of these codes.

The MHDO is working with the National Association of Health Data Organizations and other states across the country to raise issues and concerns specific to this rule with SAMSHA in hope of clarification on how best to proceed.

**Identification of Non-Continuing Self-Funded Groups or Employers**

MHDO data users raised the question about how best to do a trend analysis post Gobeille. While the mix of commercial claims for self-funded ERISA plans and fully insured plans included in the APCD varies over time (see the MHDO Payer Index) the Gobeille decision caused many self-funded ERISA plans to stop submitting claims data to the MHDO as of December 2016.

MHDO produced a file in September 2017 of MHDO Member IDs of individuals who were part of a self-funded ERISA employer group in the 2015/16 MHDO APCD that discontinued submitting claims data to the MHDO after the Gobeille decision. There are 271,002 distinct member IDs included in this file. You can flag these distinct member IDs in your 2015 and 2016 MHDO claims data if you are looking to create a 2015 data set (pre-Gobeille) that looks like 2016 (post Gobeille) data. Please note: The MHDO continues to reach out to self-funded ERISA employer groups to ask that they voluntarily submit their claims data to the MHDO. As of January 2018, two of the largest self-funded ERISA plans in Maine have directed their TPA’s to submit their claims data to the MHDO. Both these groups are working with their TPA’s to go back to when they stopped submitting data which was the end of 2016. MHDO will provide an update as soon as data is submitted. We are asking that if an employer agrees to voluntarily submit claims data to the MHDO that it go back to the date its TPA stopped submitting data to the MHDO (in many cases December 31, 2015 was the last submission). As we discussed at the last data user group meeting, the list of member IDs may be a fluid list, since self-funded employers decide to voluntarily submit data to the MHDO.

If you would like to obtain this list, please contact the MHDO at [Webcontact.MHDO@maine.gov](mailto:Webcontact.MHDO@maine.gov).

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# Documentation Included with This Release

The documentation included in this release:

1. MHDO’s Release Notes (this document)
2. MHDO’s 2017 Q4 Release Report
3. MHDO’s 2017 Q4 Payer Index
4. MHDO’s 2017 Q4 Validation Report
5. MHDO’s APCD FAQ
6. MHMC’s Methodology for Removing Duplicate Rx Claims

# Member Match to Eligibility

Overall, the match rate (which represents the percentage of claims that have a matching eligibility record for the member) is high for all claims. Information on these match rates can be found in MHDO’s 2017 Q4 Release Report.

**Medical Claims File**

The overall match rate for the medical claims file is 99.4%.

**Dental Claims File**

The overall match rate for the dental claims file is 98.4%.

**Pharmacy Claims File**

The overall match rate for the pharmacy claims file is 99.6%.

# Payer Specific Notes

**G0001 – MaineCare**

MaineCare and their data vendor have identified an issue in their reporting causing a gap in their submissions. They will submit the missing data for the time period January 2013 through May 2017. We expect to be able to include these data in the Q1 2018 release. MHDO will distribute the newly received records to those who would like to request them. The table below summarizes the missing data.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| DATE | 1500 | UB04 | PC | DC | TOTAL | Claims $$$ |
| 4/30/2013 | 616 | 5066 | 358 | 8 | 6048 | $95,271.27 |
| 7/31/2013 | 262782 | 167388 | 120756 | 11331 | 562257 | $34,432,406.73 |
| 12/31/2013 | 123827 | 133638 | 87205 | 5519 | 350189 | $25,278,290.46 |
| 4/30/2014 | 229131 | 229057 | 96597 | 10530 | 565315 | $37,503,923.20 |
| 7/31/2014 | 10652 | 1059 | 0 | 3 | 11714 | $32,352.66 |
| 12/31/2014 | 21143 | 2204 | 0 | 5 | 23352 | $4,895.60 |
| 3/31/2015 | 13 | 77 |  |  | 90 | -$83,903.93 |
| 6/30/2015 | 17 | 8 |  |  | 25 | -$1,498.67 |
| 9/30/2015 | 214943 | 187213 | 83567 | 9851 | 495574 | $40,092,305.97 |
| 6/30/2016 | 477 | 1287 |  |  | 1764 | $83,500.25 |
| 8/31/2016 | 210508 | 155307 | 78903 | 11147 | 455865 | $35,575,711.72 |
| 11/30/2016 | 233626 | 153701 | 79102 | 7654 | 474083 | $37,264,348.06 |
| 5/31/2017 | 362807 | 166377 | 83003 | 8530 | 620717 | $33,085,768.86 |

**C0065 – Anthem**

Anthem recently brought to our attention that there are issues with the Medicare supplemental data they submitted for the time-period January 2015-July 2017 (see details below). Anthem has resubmitted supplemental files to fill the reporting gaps and provided logic to recode Medicare Supplemental and Medicare Advantage members in historical files. These issues have been addressed as part of the Q4 2017 release.

1. Medicare Part C and Medicare Part D data not populated accurately beginning in 2015. Medicare Part D is missing from eligibility files, and Part D claim data decreases over the first 11 months of 2015 before dropping off completely in December 2015.
2. ‘SP’ Medicare Supplemental eligibility record volumes ceased as of January 2016, and SP claims volumes ceased as of July 2015.
3. Indemnity, ‘IN’, eligibility volumes increased significantly beginning in January 2016.
4. Medicare Advantage products mapped to product type codes HM or PR.

**C0010 & C0011 – Aetna**

Aetna is reporting ICD codes to the MHDO but not as they appear on the incoming claims. Aetna is working on a new data store which will allow them to capture the ICD codes and submit to the MHDO as they appear on the incoming claims. This should be completed in late 2018. The information below details how Aetna is reporting ICD-10 codes in the interim.

| **Data Element** | **Notes** |
| --- | --- |
| MC200 | Will be populated with any ICD-10 code. |
| MC202 | Will be populated with any ICD-10 code for inpatient facility claims only.  If there is only one ICD-10 code billed by the provider the code can be populated in both the MC200 and the MC202. Unable to distinguish the admitting versus principal diagnosis in our claims system. |
| MC203 - MC205 (Reason Codes) | It would be reasonable if Aetna leaves these three fields null in the data. |
| MC206 | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200. |
| MC208 | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200, or MC206. |
| MC210 | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200, MC206 or MC208. |
| MC212 | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200, MC206, MC208, or MC210. |
| MC214 | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200, MC206, MC208, MC210, or MC212. |
| MC216 | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200, MC206, MC208, MC210, MC212, or MC214. |
| MC218 | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200, MC206, MC208, MC210, MC212, MC214, or MC216. |
| MC220 | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200, MC206, MC208, MC210, MC212, MC214, MC216, or MC218. |
| MC222 | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200, MC206, MC208, MC210, MC212, MC214, MC216, MC218, or MC220. |
| MC224 | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200, MC206, MC208, MC210, MC212, MC214, MC216, MC218, MC220, or MC222. |
| MC226 | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200, MC206, MC208, MC210, MC212, MC214, MC216, MC218, MC220, MC222, or MC224. |
| MC228 | Will be populated when the first byte of the ICD-10 diagnosis code is equal to ‘V’, ‘W’, ‘X’, or ‘Y’ and is not equal to the value in MC200, MC206, MC208, MC210, MC212, MC214, MC216, MC218, MC220, MC222, MC224, or MC226. |
| MC230 - MC252 | Not available in our data as it does not downstream to our adjudication system. |
| MC254 – MC274 | Other diagnosis fields will be populated with any ICD-10 code that has not already been populated in fields MC200, MC202 or MC206 through MC228. |

# Missing Data and Other Data Observations

Refer to the MHDO Payer Index for more information about payer submitter deactivations and data end dates. As a reminder of our data release policy, we typically don’t release claims data if the supporting eligibility file was not submitted for a particular reporting period.

## Medical Claims File

**Voluntary Submitters:**

Geisinger Indemnity Insurance Company (T0552) has not submitted Q4 2016 – Q4 2017 Medical Claims data. We are working with them to submit self-funded ERISA client data on a voluntary basis. This payer has approximately 17,000 medical members per month, which represents less than 3% of commercial medical volume.

**Mandated Submitters:**

Maine Community Health Options (C0726) is missing July, November, and December 2017 data in this release. This payer has approximately 39,000 medical members per month which represents approximately 5% of commercial medical volume. All missing data are expected to be part of the Q1 2018 release which is scheduled for the week of July 23, 2018.

## Dental Claims File

Securian Life Insurance Company (C0532) missing December 2017 Dental Claims data. This payer has approximately 5,000 dental members per month which represents less than 1% of commercial dental volume.

## Pharmacy Claims File

**Voluntary Submitters:**

Geisinger Indemnity Insurance Company (T0552) has not submitted Q4 2016 – Q4 2017 Pharmacy Claims data. We are working with them to determine if they will continue to submit data to the MHDO on a voluntary basis. This payer has approximately 15,000 pharmacy members per month, which represents less than 2% of commercial pharmacy volume.

**Mandated Submitters:**

Cigna HealthSpring (C0025F) is missing February – December 2017 Part D Medicare data. All missing data are expected to be part of the Q1 2018 release which is scheduled for the week of July 23, 2018. This payer has approximately 1,800 pharmacy members per month, which represents less than 1% of commercial pharmacy volume.

# Other Release Reports

1. Release Report

This report provides a summary by payer and file type of all the data included in this release (Release Summary Pivot worksheet). It also contains worksheets by claim type (DC, PC, and MC) on the match rate to the eligibility file. This report is produced with each quarterly release.

1. Payer Index

This release includes a new Payer Index. With each previous release, we included a Payer Activation/Deactivation Report that contained select information from our portal registration system but only included payers with recent activity. The Payer Index now contains additional information for all payers.

1. Validation Report

This report lists all validations that incoming data are checked against, and indicates accuracy by payer (payer codes as defined in the APCD Payer table). This report is produced with each quarterly release.

1. MHMC’s methodology for removing duplicate Rx Claims

This document details one user’s methodology for removing duplicate pharmacy claims.

1. Frequently Asked Questions

This resource on the MHDO website is available to answer questions about the APCD: [https://mhdo.maine.gov/faqs\_data.html#apcd data](https://mhdo.maine.gov/faqs_data.html%23apcd%20data)

1. MHDO APCD Data Dictionary

The MHDO APCD data dictionary is an interactive tool to assist data users with understanding the content, format and structure of the MHDO All Payer Claims (APCD) data sets. The data dictionary is available at <https://mhdo.maine.gov/mhdo-data-dictionary/>