90-590 Maine Health Data Organization

Final Rule Summary of Changes and Basis Statement
Chapter 243: Uniform Reporting System for Health Care Claims Data Sets

*(Routine Technical Rule)*

The Maine Health Data Organization is authorized by statute to collect health care data. The purpose of this Chapter is to explain the provisions for filing health care claims data sets from all third-party payers, third-party administrators, Medicare health plan sponsors and pharmacy benefits managers.

The MHDO Board met on May 23, 2019 and authorized the MHDO to initiate rulemaking to Chapter 243. The proposed rule was publicly noticed on August 14, 2019 and a public hearing was held on September 5, 2019 in Augusta. No public comments were received at the public hearing or by the 10-day comment period of September 16, 2019. The Board adopted the routine technical rule on November 21, 2019.

The following represent the proposed changes to the rule and the rationale for these changes:

1. **General submission requirements**

Non-substantive changes:

* Section 1, pages 1-3
* Section 2, page 4
* Section 6, page 9
* Section 8, page 9
1. **Appendices**
	1. Plan Begin Date (Member Effective Date-ME114) and Plan End Date (Member Cancellation Date-ME115) fields have been added. (Appendix C-1, page 24; Appendix C-2, page 26)

***Note:*** *MHDO has added the commonly used terms for Plan Begin Date and Plan End Date to clarify this addition to the rule.*

There are two situations where the data MHDO currently collects from payers to calculate member months can fall short:

1. Payer submissions exhibit slight fluctuations above and below the reporting thresholds over several years. In this scenario, a payer may submit data for several years, stop, and begin submitting again. With the existing data layout and member month calculations it may appear a member's coverage has been discontinued rather than not reported to the MHDO.
2. A submitting entity/payer has an issue with their internal processes to prepare data for submission resulting in some members not being reported for a given time. With the existing data layout and member month calculations it may appear a member's coverage has been discontinued rather than not reported to the MHDO.

The addition of the Plan Begin Date (Member Effective Date) and Plan End Date (Member Cancellation Date) fields will allow MHDO to perform necessary data quality checks to ensure the accuracy of the various analyses involving member month calculations.

* 1. Type of Bill (MC036) field length increased. (Appendix D-1; page 30)

Type of bill codes are three-digit codes (not counting lead zero) located on the UB-04 claim form that describes the type of bill a provider is submitting to a payer. Currently MHDO collects most of the data specific to type of bill. This change will allow space in the field for the payer to submit the remaining information associated with type of bill codes, namely bill frequency. This is important information for many users of the MHDO claims data as it will provide information like the following:

0 - Nonpayment or Zero Claims
1 - Admit Through Discharge Claim
2 - Interim (First Claim)
3 - Interim (Continuing Claims)
4 - Interim (Last Claim)
5 - Late Charge Only
7 - Replacement of Prior Claim or Corrected Claim
8 - Void or Cancel of a Prior Claim
9 - Final Claim for a Home Health PPS Episode

* 1. Date of Service – From (MC059) and Date of Service – Thru (MC060) are remapped to the ASC X12N 837. (Appendix D-2; page 54)

Based on the recommendations of the National Uniform Billing Committee (NUBC) and the National Uniform Claim Committee (NUCC), the population of these fields should follow the mapping of the ASC X12N 837. Currently the mapping in the rule is based on the ASC X12N 835. We anticipate this remapping may improve the population of these fields, which should enhance the value of the data.

* 1. Code decimal point for Quantity (MC061) and Quantity Dispensed (PC033) fields. (Appendix D-1 page 33; Appendix E-1, page 65)

Clarifies the specifications for quantity fields. If there is a decimal it must be reported.

* 1. Two decimal places implied for Charge Amount (MC062, PC035, DC037); Paid Amount (MC063, PC036; DC038); Ingredient Cost/List Price (PC037); Postage Amount Claimed (PC038); Dispensing Fee (PC039); Prepaid Amount (MC064); Co-Pay Amount (MC065, PC040; DC039); Coinsurance Amount (MC066, PC041, DC040); Deductible Amount (MC067, PC042, DC041); and Patient Pay Amount (PC043) fields. (Appendix D-1, pages 33, 34; Appendix E-1, page 66; Appendix E-1, page 73)

Clarifies the specifications for currency fields, which will ensure that only two implied decimal places are used rather than three or four. In other words, we are asking for the rounded values for the cents.

**Statutory Authority:** 22 M.R.S.A., §§8703(1), 8704(4), 8708(6-A) and 8712(2)

**Effective Date**: This rule change will be effective 5 days from the date the Secretary of State accepts the filing.