Frequently Asked Questions

December 17, 2019

# Overview

This document contains a summary of recent data user questions and answers recently received by MHDO. These questions will be added to the MHDO [Frequently Asked Questions](https://mhdo.maine.gov/faqs_data.html) page of the website in January 2020.

# APCD

Q. Is it possible for two different payers to submit claims using the same FILEID?

A. Each file only contains claims from a single submitter

Q. I use MC907\_MHDO\_CLAIM to identify a single claim which must come from a single payer (please correct me if I’m wrong about that). However, some claims have multiple FILEIDs. I would assume that those FILEIDs are from the same payer, but I could imagine a scenario where I merge in payer\_type using FILEID and end up with claims that are part Medicare and part Commercial. Perhaps when you create the crosswalk file you can just check that each value of MC907\_MHDO\_CLAIM is mapped to only one payer\_type.

A. Claims that are resubmitted will appear associated with multiple files, but they will always be from the same payer.

Q. If there is any information on how billing facility information can be linked to facility name that would be really helpful for future analyses using record level data from the APCD.

 A. We use the MC077\_NPI (billing NPI) value as the primary means for attributing rows to a facility. If we aren’t able to find a facility using this, we then look at MC078\_PRVLNAME (billing provider name).

Q. How do I identify the final claim? I would expect that after joining the MC table with the claim consolidation table I would get final claim. I would expect that a final claim would have one row per claim line where a claim line is identified by a unique combination of MC907\_MHDO\_CLAIM and MC005\_LINE. However, I can see that after joining the MC table to the claim consolidation table I have multiple rows with the same values of MC907\_MHDO\_CLAIM and MC005\_LINE. Can you help me understand this?

A. We ran a similar analysis and found about 0.8% of claim/claim line combos had more than one row per claims line. There can be a number of reasons why a given claim might have more than one row with the same line number. While it certainly is true that under ideal circumstances where a payer fully reverses the previous claim and then reissues a new one with the same line numbers, things should be as Adam expects them. But we know that there are circumstances where payers are not issuing fully reversals as we would expect. We have custom logic to handle this situation for Aetna, but there may be other payers who are reissuing claims without any reversal rows.

We have looked at some sample claims and we see in some cases, the reason there is more than one claim line with the same line number is because that is what the payer submitted. That is, the payer has given us a revised claim with no reversals at all. Since the claim was revised, it isn’t flagged as a duplicate by the system. The system thus passes along both versions of the claim line to the end user. With the exception of Aetna, for which we have custom logic, we have no process for versioning claims when there is no reversal issued.

Another potentially confounding factor could be claims that only have partial reversals. We have seen in the past situations where a payer only issues a reversal for some of the lines in a claim and then issues a new version only with the revised lines. The numbering on partial reversals may overlap that of the original claim. This is one reason why our versioning logic disregards claim line number entirely and uses the CPT, revenue codes, and other information to detect sets of lines that go together. Just because a claim line has a given number in one version doesn’t mean it will have the same line number in future versions.

The bottom line is that our versioning logic does a good job determining the final set of claim lines. However, we know that payer data anomalies do prevent us from being able to version claims when the payer has not given us enough information to do so.

Q. I am running into some issues with the Medical claims data for a large employer group. It looks like the total paid amount by month is in the $25 million to $30 million range for all of the first 8 months of 2016. Starting in September of 2016 and continuing through 2018, the monthly total is about half that, in the $11 million to $13 million range.

The weird thing is that the unique count of members with claims stays the same for all 12 months of 2016. That means that the average paid amount per member with a claim goes from $2,500 in March, April and May down to about $1,200 in October, November and December. Even the $1,200 is rich compared to the MEABT average of around $800, but the $2,500 is well out of the reasonable range.

In 2017, another weird thing happens. The average paid amount per member with a claim drops to $800 in April and May, and $530 in June. The rest of the months of 2017 are in the $1,000 - $1,200 range, which is very rich, but consistent with the last 3 months of 2016 and with all the months in 2018.

A. It looks like what is going on is that some of these claims were submitted in late 2016 and again in early 2017 with slightly different provider information. These records aren’t flagged as duplicates because of the minor differences in provider information, even though the paid dates and other information are the same. Looking into this further, it appears that the root cause is some of the data submitters resubmitting claims data that had already been released back in early 2017.

When a data submitter submits a new version of a file, the older version is marked as deleted in the portal. The table below is a scan of all of the currently released claims data that is associated with a file that has been deleted in the portal with a 2016-2018 service date. We believe these are duplicates.

Given this finding, we think that it would make sense to either update the claim consolidation table to automatically exclude the row IDNs associated with these files going forward or produce an “excluded files” report to include in future release notes to inform data users if previously released data should be excluded.

Q. I have a question about the quantity field on the APCD. Each claim line has an amount associated with it. If I want to know what a payment is for, I need to look at either the CPT code or the revenue code. Sometimes we have both, sometimes only one, and occasionally an amount is paid without a CPT or revenue code. The quantity field may or may not be populated in any of these cases. In addition to a positive integer, sometimes the quantity field is 0, missing/null, or a negative value.

Here is how I’m currently understanding what a payment on a claim line was for:

Revenue code only – associate payment with the revenue code and quantity if it is populated

CPT code only – associate payment with the CPT code and the quantity if populated. Assume quantity is 1 if not populated.

Revenue and CPT code – associate payment with the CPT code and the quantity (?)

Some questions:

Does my interpretation above seem correct?

Does it make sense to fill a missing quantity value in with 1 when either the CPT code or revenue code are populated?

How should I interpret a quantity value of zero?

Does the interpretation of a zero quantity change when there is a positive payment amount?

I’m assuming negative quantity amounts are reversals and should be removed from any analysis based on final claims.

Do you have any idea what to attribute payments to when no CPT or revenue code is populated on the claim line? Perhaps these are DRGs or ICD procedures?

A. To discuss

# Hospital

No questions since last data request meeting.