

July 2018 APCD Data Release Notes

# Opening Statement

This release contains the following data:

* 2018 Q1 Commercial data
* 2018 Q1 MaineCare (Medicaid) data
* 2017 Q1-Q3 Medicare data

## **NEW Metadata Documentation: Business Rules and Entity Relationship Diagrams (ERDs)**

This new documentation has been developed in collaboration with our data users to support the MHDO’s metadata strategy. The Business Rules describe the current methodology used to derive the value-added components of the MHDO APCD. The Entity Relationship Diagrams (ERDs) show the relationships between data tables. This documentation will evolve over time as we continue to enhance the MHDO Data Warehouse and APCD capabilities. This will include the development of analysis ready datasets and the inclusion of more value adds (groupers).

## Reminders

**New Medical Claim Consolidation Table**

This is the second MHDO APCD data release that includes claim consolidation information for medical claims. 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. The logic takes into account claim line-level information such as member, service date, and procedure codes to attempt to detect reversals that are issued under different claim numbers.

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

So, for instance, claim 15434324 may have had an initial bill (IDNs 8841231-8841233), a reversal (IDNs 9268232-9268234), and a newly issued bill (IDNs 9854741-9854743). In this case, only the claim lines from the newly issued bill should be used.

### 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. This table should cover the full date range of your data request, including IDNs for both newly distributed data and data that have been previously sent. Users making use of this table will need to perform an inner join with the with the medical claims detail table with each data release since reversal activity can continue long after the initial payment of the claim, especially for high-dollar claims. As MHDO becomes aware of payer-specific issues that prevent the standard logic from operating correct, the MHDO will work with payers to implement custom consolidation logic.

**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 which 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.  SAMHSA concurrently issued a supplemental notice of proposed rulemaking that proposed additional clarifications to the part 2 regulations as amended by the final rule.  Questions were raised by commenters on the proposed rule that highlighted varying interpretations of the 1987 rule's restrictions on lawful holders and their contractors and subcontractors' use and disclosure of part 2-covered data for purposes of carrying out payment, health care operations, and other health care related activities.

**Impact to MHDO:**  The impact of the clarifications made to the rule to the MHDO is that CMS/ResDAC is no longer suppressing claim lines containing SUD-related codes prior to releasing Medicare claims file to the MHDO effective for files shipped or extracted after 5/22/17.  MHDO is looking into the process and expense associated with requesting the missing records, in the form of “gap” files for those files where the ResDac filter was applied before the files were sent to MHDO.

**Impact to MHDO Data Users and Release Files:**  MHDO is applying the CMS/ResDAC filter to both Medicare and MaineCare data to suppress claim lines containing SUD-related codes prior to releasing MHDO APCD data to authorized MHDO data users. This data is then stored in its own protected database and may be available to authorized MHDO data users under the terms and conditions of payment, health care operations and other health care related activities. Please contact MHDO for more information for additional information.

**Notes:**

* Commercial payers use their own filters to suppress SUD-related claim lines before submitting the data 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>

**Impact of SAMHSA** **42 CFR Part 2 on MHDO Historical and Future Claims Data**

The MHDO has applied the CMS/ResDAC filter to our historical claims data and all new data as they are released, 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. Note: based on the clarifications made to 42 CFR Part 2, SUD-related data for the public payers may be available to authorized MHDO users with an approved IRB. For further information contact MHDO.

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

MHDO produced a file in September 2017 of MHDO Member IDs of individuals who were part of a self-funded ERISA employer group for which submissions to the MHDO discontinued in 2015/16 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 TPAs to submit their claims data to the MHDO. Both groups are working with their TPAs 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, if an employer agrees to voluntarily submit claims data to the MHDO, that it go back to the date its TPA discontinued submissions to the MHDO (usually December 31, 2015). 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.

**Table of Contents**

[Opening Statement 1](#_Toc494379456)

[Documentation Included with This Release 5](#_Toc494379457)

[Member Match to Eligibility 5](#_Toc494379458)

[Payer Specific Notes 5](#_Toc494379459)

[Missing Data and Other Data Observations 7](#_Toc494379460)

[Other Release Reports 8](#_Toc494379461)

# Documentation Included with This Release

The documentation included in this release:

1. MHDO’s Release Notes (this document)
2. MHDO’s 2018 Q1 Release Report
3. MHDO’s 2018 Q1 Payer Index
4. MHDO’s 2018 Q1 Validation Report
5. MHDO’s APCD FAQ
6. MHMC’s Methodology for Removing Duplicate Rx Claims
7. Business Rules and Entity Relationship Diagrams (ERDs)

# 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 2018 Q1 Release Report.

**Medical Claims File**

The overall match rate for the medical claims file is 99.1%.

**Dental Claims File**

The overall match rate for the dental claims file is 99.0%.

**Pharmacy Claims File**

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

# Payer Specific Notes

**G0001 – MaineCare**

MaineCare and their data vendor recently identified an issue in their internal reporting which caused a gap in their claims submissions to MHDO. We expect to include these data in the Q2 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 |

**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 that reporting period.

## Medical Claims File

**Voluntary Submitters:**

Geisinger Indemnity Insurance Company (T0552) has not submitted Q4 2016 – Q1 2018 Medical Claims data. Their self-funded ERISA client data has been transitioned to a new payer, with which the MHDO is working to obtain submission on a voluntary basis of both historical and current data. This payer had approximately 17,000 medical members per month, which represented less than 3% of commercial medical volume.

EBPA Benefits, LLC (T0423) missing March 2018 Medical Claims data. This payer has approximately 5,800 medical members per month which represents less than 1% of commercial medical volume.

North American Administrators (T0508) missing Q1 2018 Medical Claims data. This payer has approximately 1,300 medical members per month which represents less than 1% of commercial medical volume.

The self-funded ERISA data for State of Maine employees previously submitted by Aetna Life Insurance Company (C0010) transitioned to Anthem Health Plans of Maine (C0065) as of July 1, 2017 and completed a six-month claims run-out on December 31, 2017. This accounts for approximately 33,000 medical members per month and represents less than 6% of commercial medical volume.

## Dental Claims File

**Mandated Submitters:**

Securian Life Insurance Company (C0532) missing December 2017 – Q1 2018 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 – Q1 2018 Pharmacy Claims data. Their self-funded ERISA client data has been transitioned to a new payer which the MHDO is working with to submit historical and future data on a voluntary basis. This payer has approximately 15,000 pharmacy members per month, which represents less than 2% of commercial pharmacy volume.

Goold Health Systems (T0420) is missing Q1 2018 Pharmacy Claims data. This payer has approximately 400 pharmacy members per month, which represents less than 1% of commercial pharmacy volume.

EBPA Benefits, LLC (T0423) missing March 2018 Pharmacy Claims data. We expect these data to be included in the Q2 2018 release. This payer has approximately 5,800 medical members per month which represents less than 1% of commercial pharmacy volume.

**Mandated Submitters:**

Cigna HealthSpring (C0025F) is missing 2015 – Q1 2018 Part D Medicare data. All missing data are expected to be part of the Q2 2018 release which is scheduled for the week of October 1, 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 Data Dictionary

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

1. Business Rules and Entity Relationship Diagrams (ERDs)

The Business Rules describe the current methodology used to derive the value-added components of the MHDO APCD. The entity relationship diagrams (ERDs) show the relationships between data tables.