**Maine Health Data Organization (MHDO)**

**Refresh Release**

**July 1, 2014**

**Release Notes:**

**Opening Statement**

In an effort toward our goal of continuous  quality improvement the  Maine Health Data Organization (MHDO) recently contracted with the Maine Health Management Coalition (MHMC) for an external review of our APCD data. Given the size of this release (over a billion records) the MHMC reviewed a sample of the commercial data over a two year period; 2012 and 2013.  The issues that the MHMC identified in the sample fall into two categories:

1. Immediate issues that we have addressed in this release (documented in our release notes)
2. Longer term issues that we either need to work with specific  payers on addressing or we need to consider a validation and or rule change in order to address the systemic issue (documented in our release notes and user guide)

Note that some of the issues that we have addressed in this release are based on our current structure.  As we work towards building our master indices (provider, individual and payer) we are confident that greater improvements will be realized.

Lastly,  we continue to work on improving our documentation.  We are providing the users with three documents as part of this release:

1. MHDO’s Release Notes (this document)
2. MHMC’s Review Notes
3. MHMC’s methodology for removing duplicate Rx Claims

**Update on Previously Reported Issues**

1. Member ID Integer Replacement Issue

In the previous refresh release, an issue with the Member ID integer replacement was introduced, which resulted in cases where the integer replacements were not being attributed correctly-for example some individual members ended up being assigned multiple integer identifiers. That issue has now been resolved.

**Replacement Data**

1. HPHC Healthcare Inc – MedImpact (C0511B)

It has been brought to our attention that C0511B sent in duplicate files for December 2013 Pharmacy Claims and Eligibility. This issue was identified too late in the current extract process to suppress the duplicate records. End users will need to remove from the refresh, which can be done using the newly released File ID fields. The Files IDs that should be removed are 146334 and 146335, which are the duplicate claims and corresponding eligibility file for C0511B for December 2013. Removing all PC records where the PC905\_FILEID value equals 146334 and all PE records where the PE904\_FILEID value equals 146335 will resolve the duplication introduced by this issue.

**Missing Data**

1. Anthem Run Out Data

Anthem recently reported that for the time period April 2013 forward, “run out” claims for members that were terminated prior to the claim being paid has not been submitted. Anthem is working on identifying this missing data and submitting to the MHDO. Once submitted, the missing data will be included in a future release.

1. Missing Anthem data (C0065 & C0541)

There are several months of data which were recently resubmitted by Anthem Insurance Companies, Inc. The replacement data was received in April and recently passed through our validation process.. To prevent any further delay in this release, we will include the missing Anthem data in our quarterly release which is scheduled for the end of July 2014. The missing data falls into the following years, months and data types impacted:

**Year 2010 (C0541):**

* January-May Medical file
* June –Rx file
* July-August-Medical file
* September –Medical and Rx files
* October-Medical and Rx files
* November-Medical Files

**Year 2012 (C0541):**

* March, August and September- Medical Files

**Year 2013 (C0065):**

* July-December - Medical Files
* July-December - Rx Files
* July-December - Eligibility Files

1. Caremark (Payer codeT0005)

Pharmacy Claims – Missing November 2013. We have been working with the payer to get these data into Q1 2014 release scheduled to come out at the end of July.

**Duplicate Data**

1. Optum Rx/UMR duplicate claims (T0172/T0216)

It has been brought to our attention that Optum Rx (T0172) and UMR (T0216) were sending duplicate pharmacy claims from January, 2012 through March, 2014. They are now isolating the duplicates and will provide a list of the claim control numbers (PC004 and PC005) that were submitted in duplicate. We will share this with data users once it becomes available.

1. De-duplicating Pharmacy Claims

The Maine Health Management Coalition identified that record level duplication is occurring in the Pharmacy Claims data and has provided a document that describes a process they have developed to identify and remove those duplicate records.

**Other Notes and Information**

1. Provider Identification

The MHDO worked in collaboration with the Maine Health Management Coalition (MHMC) to review the MC\_Provider table, and determine the accuracy of matching providers using NPI versus DPCID. The recommendation is that NPI be used instead of the DPCID to identify individual servicing providers for professional claims when it is available, only relying on the DPCID in cases where no NPI is available. Doing so yielded an overall match rate of 98% of claims (95% from NPI and 3% from DPCID). Facility claims should continue to rely on the DPCID for identification; the current match rate for these claims is 96.4%.

1. Clarification on fields ME913\_DUP and PE913\_DUP

Concerns were raised about the values reported in the fields ME913\_DUP and PE913\_DUP. To be clear, these fields do not indicate that a given record has been identified as being duplicated in the eligibility data. This field indicates that a given individual has more than one type of eligibility in a given month. Although this could indicate that a single payer has sent in duplicate data for a given member, the majority of the time that it is populated it is due to a single member having coverage by more than one payer in a given month. These fields are not sufficient to remove all duplication of records at the member ID level.

1. Addition Field - File ID

Effective with this release, an additional field is being included in each claim and eligibility table. These File ID fields link records back to a particular submission of data received from any given payer. Over time, payers sometimes resubmit entire files of data due to issues identified after the original submission. In cases where this happens after the original data has been released to end users, it will be necessary to identify the original records to prevent duplication. The File ID values will be used to identify which records should be considered obsolete due to file level replacement of data. To prevent duplication on an ongoing basis, it is crucial that these values be retained at the record level when loading claims and eligibility data.

1. Primary Keys

Each claims and eligibility table contains an xx902\_IDN field. These fields serve as the primary key for each table. Like the File ID above, it is crucial that this value be retained at a record level. In addition to the complete file replacement scenario described above, there may be instances going forward where record level duplication occurs, and it will be necessary to identify individual records by their primary key value rather than the File ID.

1. Repurposed Payer Field and Addition of Submitter Field

Until now, each claim and eligibility table has contained a single field containing a Payer code (xx001\_PAYER, where xx is specific to each table – for example, MC001\_PAYER on the medical claims table). There are situations where the entity submitting data is not actually the payer, but is submitting data on behalf of the actual payer. In order to add clarity to these cases, and following a Rule change that was implemented in late 2012, an additional field is now being included in each table and the xx001\_PAYER fields have been renamed. Each table now contains an xx001\_SUBMITTER field, which contains the State-specified identifier of payer submitting claims data, and a new xx002\_PAYER field, which contains the State-specified code of the insurer/underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Unfortunately, there are some invalid values that were captured in the files being created for the Refresh Release. The xx002 fields had originally been intended to capture the National Plan ID of payers, but that code set was never actually implemented. The field was repurposed and has been used to capture the on-behalf codes since the rule change, but there were some garbage values that were not suppressed in the current extract. Rather than reset the entire release process, the decision was made to let the values remain in the current release, and advise users that only values which are defined on the PAYER table that accompanies this release should be considered as valid. All other values in the xx002 field are artifacts that will be suppressed going forward.