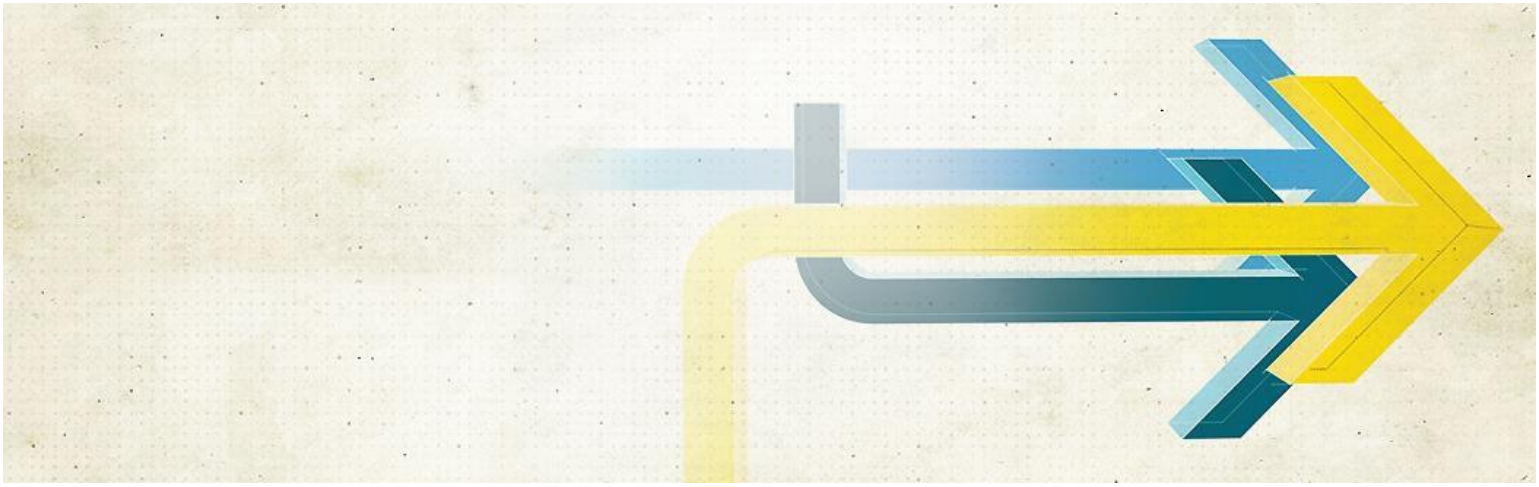

New Mexico APCD – MedInsight Data Submission Manual

Milliman Solutions LLC

MedInsight All-Payer Claims and Community Coalitions Database

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Table of Contents

Summary

The New Mexico All-Payer Claims Database (APCD) Data Submission Manual is to be used as a guide for entities submitting data to Milliman Solutions LLC. It contains the following information:

- Description of a registration process for healthcare claims processors
- General data submission requirements and specific requirements for each file type
- File submission methods
- Submission timelines
- File format and structure
- Data quality requirements
- File layouts for all data types

Also included are code lists, references, and data element mapping to national standards.

APCD Overview

All-Payer Claims Databases (APCDs) are large-scale databases that systematically collect healthcare claim data from the existing transaction systems created to pay healthcare claims. They are typically created by a state mandate, that generally includes data derived from medical claims, pharmacy claims, eligibility files, provider (physician and facility) files, and dental claims from private and public payers. APCDs can exist as a statewide, comprehensive database managed by an agency of state government or its designee. APCDs can also be created at a regional or sub-state level, usually by nonprofit organizations such as healthcare-related employer business groups or community coalition organizations.

APCDs collect claims data for each patient encounter that is used to better understand health care payments, quality, and utilization.

The New Mexico APCD will be utilized by state agencies, employers, providers, consumers, health plans and other researchers for many purposes, but not limited to:

- Examining healthcare costs, utilization, quality, and outcomes
- Promoting transparency of healthcare costs
- Evaluating value-based purchasing

- Designing wellness programs
- Trending and benchmarking
- Providing CMS-required quality measures

APCDs are designed with these use cases in mind. Most are structured to create a single de-identified person identifier across payers to describe services rendered and their associated costs, without duplication.

For additional information please refer to the HIS Act - https://nmonesource.com/nmos/nmsa/en/item/4384/index.do#!b/a14A and APCD Rule - https://nmonesource.com/nmos/nmac/en/item/18064/index.do#!b/t7c1p31

Milliman – Data Aggregator / Client Services Role

Milliman will provide assistance to data submitters as they submit data to the New Mexico APCD. Milliman will assign a Client Services Manager (CSM) who will be the single point of contact for each data submitter's data and submission issues (i.e., their help desk). The CSM is responsible for the following as it relates to the data submission process:

- Data file management notification processes and requirements, such as sending status reports on file submissions during submission cycles
- Acting as the client's point-of-contact for data reconciliation and quality audit issues and reviews via the MedInsight Ticketing System (NMAPCD.MedInsight@Milliman.com)
- Acting as the point-of-contact for submitters seeking data quality exceptions when files do not pass the standard MedInsight FFQCs via the MedInsight Ticketing System
- MI assistance to payers, data submissions, quality analysis, ticketing system, and automated file processing messages.

CDL Purpose

The purpose of the Common Data Layout (CDL) for All-Payer Claims Databases (APCD-CDL™) is to harmonize the claims collection effort across states and reduce the burden of data submission. The overall goals of this initiative are to improve efficiency, reduce administrative costs, and enhance the accuracy of claims data collection. The current version of the CDL to be followed by NM APCD submitters is Version 2.1. Data submitters will be notified of any accepted changes to this layout. The CDL can be requested at:

Common Data Layout | APCD Council. Please note as new CDL versions are released, New Mexico will determine whether to adopt them and will provide adequate notice to data suppliers.

Definitions

The following definitions are provided for terms referenced in this document.

Allowed Amount

The maximum amount a plan will pay for a covered health care service.

Capitated Services

Services rendered by a provider through a contract where payments are based upon a fixed dollar amount for each member on a monthly basis.

Carrier

An insurance company, such as a health maintenance organization, multiple employer welfare arrangement, preferred provider organization, fraternal benefit society, nonprofit hospital, medical service organization, or health plan that contracts with or offers to provide, deliver, arrange for, pay for, or reimburse any of the costs of health services.

Dental Claims File

A data file composed of service level remittance information including but not limited to member demographics, provider information, charge/payment information, and codes on dental procedures and nomenclature from all non-denied adjudicated claims for each billed service.

Healthcare Claims Processor

Processes claims for an insurance product from a third-party payer, third-party administrator, Medicare health sponsor, or pharmacy benefits manager.

Healthcare Practitioner

Physicians and all other professionals such as nurses, podiatrists, optometrists, pharmacists, chiropractors, physical therapists, dentists, psychologists, and physicians' assistants that are certified, registered, or licensed in the healing arts.

Medical Claims File

A data file composed of service level remittance information including but not limited to member demographics, provider information, charge/payment information, and clinical diagnosis/procedure codes from all non-denied adjudicated claims for each billed service.

Medicare Health Plan Sponsor

A health insurance carrier or other private company authorized by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) to administer Medicare Part C and Part D benefits under a health plan or prescription drug plan.

Member Eligibility File

A data file composed of demographic information for each individual member eligible for medical, pharmacy, or dental insurance benefits for one or more days of coverage at any time during the reporting month.

Payer

Pays providers for health services and manages the benefit adjudication and eligibility such as a health insurance company, third-party administrator (TPA), or pharmacy benefits manager (PBM).

Pharmacy Benefits Manager

An entity that performs pharmacy benefits management on behalf of a plan sponsor or under a contract to a carrier.

Pharmacy Claims File

A data file composed of service-level remittance information including but not limited to member demographics, provider information, charge/payment information, and national drug codes from all non-denied adjudicated prescription drug claims.

Plan Sponsor

Persons other than an insurer who establish or maintain a plan covering their employees including, but not limited to, plans established or maintained by two or more employers, or jointly by one or more employers and one or more employee organizations; or the association, committee, joint board of trustees, or other similar group of representatives of the parties that establish or maintain the plan are included.

Provider File

A data file composed of information including but not limited to names, NPIs, specialty codes, and practice location(s) for all providers found in claims files.

Rendering Provider

The provider who directly performed or provided a healthcare service to a subscriber or member.

Third-Party Administrator

Any person/organization that receives or collects charges, contributions, premiums, adjusts or settles claims on behalf of a plan sponsor, health care service plan, nonprofit hospital, medical service organization, health maintenance organization, or insurer.

Third-Party Payer

A health insurer or a carrier including carriers that provide only administrative services for plan sponsors, nonprofit hospital, medical services organization, or a managed care organization.

Registration

Milliman will contact each of the data suppliers regarding their initial registration. Milliman will confirm contact information for staff involved in data submissions and provide required information for data submitters to begin submitting data to the New Mexico APCD including:

- Payer Abbreviation
- Payer ID
- SFTP username

On an ongoing basis Milliman facilitates communication, data submissions, and processing of the files. Each healthcare claims processor will provide by December 31st of each year with the following registration information:

- Company contacts information
- Relative information regarding carve out plans that may impact claims files submitted
- Special data considerations

It is the responsibility of the healthcare claims processor to resubmit or amend the registration information whenever modifications occur relative to the data files, type(s) of business conducted, or contact information.

Data Submission Requirements – General

Each healthcare claims processor must submit a completed healthcare claims data set for all members in accordance with the requirements described within this manual. The healthcare claims data set must include where applicable: a member eligibility file containing records associated with each of the claim files reported (medical claims file, pharmacy claims file, dental claims file, and a provider file).

Historical Data Submissions

Each healthcare claims processor must submit a historical submission of paid claims from January 1, 2020 – current. Data submitters may submit a single set of files with all historical data, or the files may be partitioned into smaller time. Milliman does not have size constraints relative to file size. Each file that is submitted will be required to pass file validations. Once historical data submissions have been approved, data submitters will be required to submit paid claims through the most recent available month. Thereafter the data submissions will be required monthly.

Filing Responsibility

All medical or pharmacy claims processed by a third-party administrator (TPA) or pharmacy benefits managers (PBM) under contract to a carrier for carved-out services are to be submitted by the carrier with unified member IDs in all files. If this is not possible due to contractual requirements, two fields are required for completion in both the Medical Claims (MC) and/or Pharmacy Claims (PC) files to link the individual claims to the specific carrier(s) and to associate the members with separate eligibility files. The fields which are Carrier Associated with Claim (MC207/PC203), Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number (MC208/PC204), are to be filled by the TPA or PBM submitting the files. If the carrier does provide unified member IDs in all files, MC207/PC203 and MC208/PC204 are not required. In instances where more than one healthcare claims processor is involved in the administration of a policy, the carrier will be responsible for submitting the claims data on policies that it has written, and the TPA will be responsible for submitting claims data on self-insured plans that it administers.

Claims Data Required

Claims data are required for submission for each month during which some action has been taken on that claim (e.g., payment, adjustment or other modification). Any claims that have been “soft” denied (denied for incompleteness, incorrectness, or other administrative reasons) which the data supplier expects to be resubmitted upon correction’ do not have to be submitted until corrections have been completed and the claim paid.

Capitated Services Claims (Encounters)

Claims for capitated services are to be reported with all medical, pharmacy, and dental claims file submissions. These encounter records should have billed and allowed amounts but should not have paid amounts.

Claims Records

Records for the medical, pharmacy, and dental claims file submissions are to be reported at the visit, service, or prescription level. The submission of the medical, pharmacy, and dental claims is based upon the paid dates and not upon the dates of service associated with the claims.

Codes/Code Sources

The data files where applicable should be populated using the most current nationally adopted code sets. Unless otherwise specified the code sources listed and described in the file layouts (Appendices A-F) and Appendices G and H are to be utilized in association with the member eligibility file and medical, pharmacy, and dental claims file submissions. If codes specified in this submission manual are updated by the code source, whether the update includes new codes or a modification of descriptions, the changes provided by the source preempt the definitions and descriptors provided within this manual.

Coordination of Benefits Claims

Claims where multiple parties have financial responsibility must be included with all medical, pharmacy, and dental claims file submissions.

Fully Processed Claim Lines

Only fully processed claim service lines that have gone through an accounts payable run and have been booked to the health plan ledger will be included on medical, pharmacy, and dental claims data submissions.

Behavioral or Mental Health Claims

All claims related to behavioral or mental health must be included in the medical claims file**.**

Denied Claims

Denied complete claims should be excluded from all medical, pharmacy, and dental claims file submissions. Healthcare claims processors may submit all versions of fully-processed paid and denied claims service lines, provided that lines and versions thereof are clearly indicated by a Claim Status Code = '04,' and the line version number is sequentially noted on any reversal and adjustment versions of those lines to clearly indicate the order in which all changes to these lines were processed, and the units, allowed, and paid amounts are $0.

Exclusions

Medical Claims File Exclusions

All claims related to stand alone healthcare policies issued for specific disease, accident, injury, hospital indemnity, disability, long-term care, student comprehensive health, or vision coverage of durable medical equipment are to be excluded from the medical claims file submission. These policies do not utilize the standard ANSI ASC X12 processes for claims and payments and may have incomplete data associated with the claims (e.g. - there is usually no eligibility information associated with student comprehensive health plans).

Medicare Advantage Exclusion

At this time, insurers will not be required to report Medicare Advantage data to the NM APCD. Though not required, insurers may include Medicare Advantage data in their submissions to the APCD.

Pharmacy Claims File Exclusions

Pharmacy services claims generated from non-retail pharmacies that do not contain national drug codes should be included in the following files:

- If the pharmacy claims are covered under the medical benefit and/or are submitted as standard UB92, NSF, or ANSI 835 formatted transactions without NDC codes, they should be included in the medical claims file and not the pharmacy claims file
- If the claims are covered under the prescription benefit, then the claim should be included in the pharmacy claims file.

Supplemental Health Insurance

Medicare supplemental claims should be included in the submissions to NM APCD.

Claims related to Tricare supplemental or other supplemental health insurance policies are to be excluded unless the policies are for healthcare services entirely excluded by the Tricare or other program.

Submitting Claim Runout

If a carrier has ceased operations, a six-month claim runout period is mandatory. During this time, submission of member eligibility files is not required.

File Retention Management

Carriers must retain and archive 12 months of historical files to facilitate resubmission when needed.

System Changes

Carriers must notify of system or platform changes at least six months before submitting from the updated systems, including any effects on data quality.

Technical Specifications

Data Submission Requirements

File Content

Individual data elements, data types, field lengths, field description/code assignments, and industry standards can be found in the file layout in Appendices A-H. The submission of the medical, pharmacy, and dental claim is based on the adjudication date within a given reporting period. The member eligibility file, medical claims file, pharmacy claims file, dental claims file, and provider file must be submitted as separate ASCII files with variable field lengths, and pipe delimiters. Variations from this format can cause data processing delays, errors, and additional resources to correct non-compliant submissions before they can be accepted into the APCD. Therefore, exceptions to these requirements should only be granted under exceptional circumstances where compliance by the data submitter is not a practical option. Any exception should only be granted for the shortest time possible.

Consistent Inter-file Identifier

The member eligibility file, claims files, and provider file are intended to be used as parts of a relational database. Therefore, it is critical to provide consistent person identifiers across all files for members, providers, and plans. A health care claims processor and any contracted entity acting on behalf of a carrier shall ensure that member and subscriber identifiers for the same individuals are unique and consistent across medical claims, pharmacy claims, dental claims, and member eligibility files.

Header and Trailer Records

Each member's eligibility file, medical claims, pharmacy claims, dental claims, and provider file submission must contain a header record and a trailer record. The header record is the first record of each separate file submission, and the trailer record is the last.

Member Eligibility File (ME)

A member eligibility file is a data file composed of demographic information for each individual member eligible for medical, pharmacy, and dental benefits for one or more days of coverage at any time during the reporting period. Dates of coverage are also included in the member eligibility file. Data suppliers must provide a data set containing information on every covered plan member, regardless of whether the member utilizes services during the reporting period.

One record, per member, per month, per plan, is required. For example, if a member is covered as both a subscriber and a dependent on two different policies during the same month, two records must be submitted. If a member has two contract numbers for two different coverage types, two member eligibility records must be submitted. References for the ASC X12 270/271 implementation guides are provided in the tables below.

Consideration for Specific Data Files

The following consideration potentially applies to all claim types:

Adjustment Records

Adjustment records are to be reported with the appropriate positive or negative fields in the medical, pharmacy, and dental claims file submissions. Negative values should include the negative sign before the value, while no sign should appear before a positive value. Subsequent incremental claims submissions must include all reversal and adjustment/restated versions of previously submitted claim service lines. They should also include all new, fully processed service lines associated with the claim, provided that they have paid dates within the reporting period. The claim status code should be used to indicate reversals of previously submitted claims. Data suppliers that assign a completely new Payer Claim Control Number for adjusted claims must submit the original claim number on each record. The data supplier will use the designated field in the standard layout for inclusion of the original Claim Control Number.

Financial Amounts

Financial amount data elements assume the following:

- The sum of all claim lines for a given claim will equal the total dollar amount of the following data elements: Charge Amount, Withhold Amount, Plan Paid Amount, Co-Pay Amount, Coinsurance Amount, Deductible Amount, Other Insurance Paid Amount, COB/TPL Amount, and Allowed Amount (elements may differ among the medical, pharmacy and dental claims files).

- The paid amount provided for each non-charge financial amount data element is mutually exclusive.

Medical Claims File (MC)

A medical claims file is a data file composed of service level remittance information, including, but not limited to, member demographics, provider information, charge/payment/allowed information, clinical diagnosis codes, and procedure codes from all non-denied adjudicated claims for each billed service. Data suppliers must report paid medical service claims and encounters data for all applicable or covered members. For the purposes of the descriptions in the tables below, the term “claims” refers to both “claims and encounters”. Many descriptions in the tables below refer to “inpatient” claims; please refer to the National Uniform Billing Committee for the definition of “inpatient”. References for the ASC X12 Post Adjudicated Claims Data Reporting Guides (Institutional and Professional) are provided in the tables below.

Pharmacy Claims File (PC)

A pharmacy claims file is a data file composed of service-level remittance information including, but not limited to, member demographics, provider information, charge/payment/allowed amounts information, and national drug codes from all non-denied adjudicated prescription drug claims. Data suppliers must provide data for all pharmacy claims for prescriptions that were dispensed and paid for the reporting period. References to the NCPDP Uniform Healthcare Payer Data Standard Implementation Guide Version 27 are provided in the tables below.

Dental Claims File (DC)

A dental claims file is a data file composed of service level remittance information including, but not limited to, member demographics, provider information, charge/payment/allowed information, clinical diagnosis codes, and procedure codes from all non-denied adjudicated claims for each billed service. Data suppliers must report dental service paid claims and encounters data for all applicable members. References to the ASC X12 Post Adjudicated Claims Data Reporting Guide (Dental) are provided in the tables below.

Provider File (PV)

A provider file is a data file composed of information including but not limited to provider IDs, provider names, National Provider Identifiers (NPI), specialty codes, and practice location(s) for all providers as indicated by the payer on the eligibility file and on the claim. Data suppliers must submit a data set that contains information for all providers listed by the payer in the eligibility file, as well as every provider associated with an adjudicated claim (Medical, Dental, and Pharmacy) during the targeted reporting period. Third party administrators (including pharmacy benefit managers, etc.) who may not contract directly with providers are still expected to include all providers appearing on the claims file for the corresponding reporting period.

File Submission Methods

Healthcare claims processors may submit APCD files using the following methods:

Connecting via SFTP Client

The recommended method for uploading data to or downloading data from the Milliman servers is via an SFTP client. SFTP clients are readily available (FileZilla is a free version).

Milliman recommends managing files via an SFTP application rather than a web browser to avoid complications caused by the additional settings and variables inherent in web browsers. The large variety of available web browsers can lead to inconsistencies and connection issues when attempting to upload or download files from remote servers. By using an SFTP application, there is a central point of management and configuration that, once set up, is unlikely to be affected by Windows updates or other system changes. Using an SFTP application is more reliable and easier to manage, especially for multiple users.

Recommended SFTP Application

FileZilla – A free SFTP solution that is easy to download, install, and configure. Download here: https://filezilla-project.org/

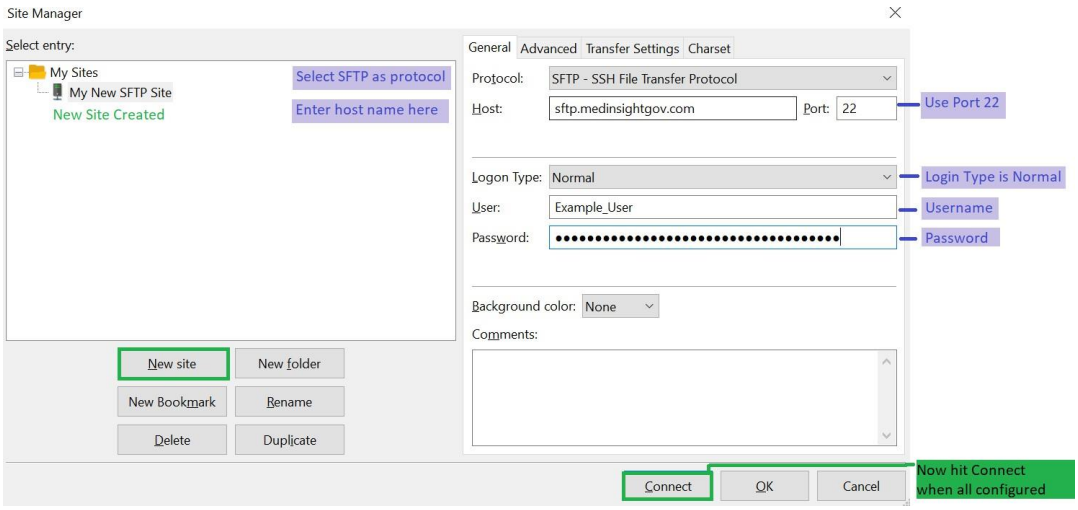
SFTP Connection Settings

- **Host:** sftp.medinsightgov.com
- **Port:** 22
- **Login:** MedInsight username/password will authenticate the session.

Configuring an SFTP Site Connection within FileZilla

Upon opening the FileZilla program, open the Site Manager by clicking File > Site Manager.

This prompt will open the window displayed below. Select “New Site” and name the new SFTP site.



- Upon selecting the new SFTP site created in the left-hand panel, a prompt will appear to enter the appropriate Host Name (sftp.medinsightgov.com), Protocol (SFTP – SSH File Transfer Protocol), Port (22), and Logon Type (Normal), as well as your Username, and Password. When these actions are taken, click Connect.

SFTP Support

While Milliman is available to assist with troubleshooting, clients should first consult with their internal information technology staff before submitting an issue ticket to Milliman support. The support team can verify whether Milliman systems are receiving a login request from the user and confirm that all systems are working properly. However, Milliman is not able to review web-browser settings or assist with firewall troubleshooting.

If issues cannot be solved internally, Milliman's information technology consultants are available to assist (normal billing rates may apply).

Milliman supports the following issues related to the SFTP process:

- Confirming that login requests are received by the server

- Confirming that Milliman SFTP servers are functioning properly

Milliman **does not** support:

- Reviewing web-browser settings
- Troubleshooting firewall settings

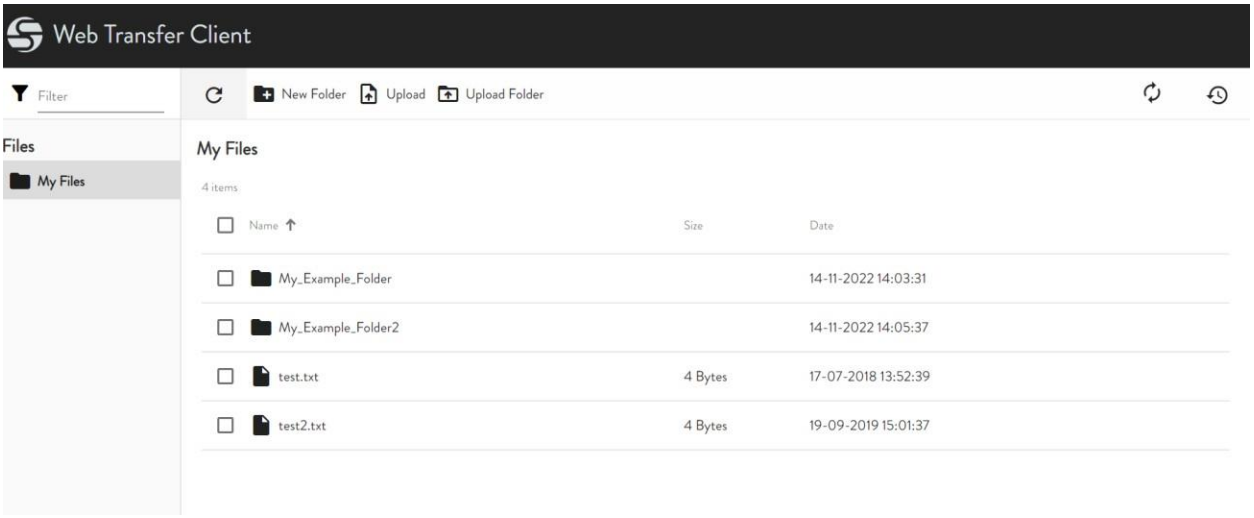
Connecting via Internet Browser

If an SFTP client, like the one mentioned in the previous section, is not available, you can use an internet browser (e.g., Edge, Firefox, Chrome, etc.). The SFTP service supports most commonly used business browsers. The following example uses Internet Explorer, which is our preferred browser While not required, enabling Java in your browser is recommended to take advantage of all system features.

Connecting to SFTP Site Using Edge

Go to https://sftp.medinsightgov.com and enter your MedInsight Username and Password.

This will take you to the site below where you can transfer files from your computer to the remote server.



Filing Periods

Due to the large volume of data contained in APCD files, it is requested that files be submitted on a monthly schedule. Files should be submitted by the end of the month following the month in which claims were paid, with an additional ten days allowed for resubmission of files that fail field level and quality audits.

- Examples:
  - February 2023 submissions must be approved by March 31st, 2023
  - March 2023 submissions must be approved by April 30th, 2023

Run-Out Period

Healthcare claims processors must submit medical, pharmacy, and/or dental claims files for a period of six months following the termination of a member's coverage.

File Naming Convention

All files submitted to the APCD must follow a standard naming convention. The naming convention is as follows:

NMAPCD_[TestorProd]_[FileType]_[PayerID]_ [FileCreateDateYYYYMMDD] _[CoveragePeriodYYYYMM].txt

- TestorProd – TEST for test files; PROD for production
- PayerID – Unique Payer ID assigned to each data submitter during the initial registration.
- FileType – ME, MC, PC, DC, PV
    - ME - Member Eligibility
    - MC – Medical Claims
    - PC – Pharmacy Claims
    - DC – Dental Claims
    - PV – Provider File
- FileCreateDateYYYYMMDD – Date file was created, format should be YYYYMMDD.
- CoveragePeriodYYYYMM – The month of data represented in the file.
    - MC, DC, PC: paid month for claims in file
    - PV: paid month of corresponding claims file that provider file is associated with
    - Eligibility files: month that eligibility corresponds to

Files that are compressed should use the following standards:

- Compressing individual files: Same naming convention can be used but replace .txt with compression file extension: .zip, .zipx, .pgp, etc.
    - Example: NMAPCD_[TestorProd]_[FileType]_[PayerID]_ [FileCreateDateYYYYMMDD] _[CoveragePeriodYYYYMM].zip

- Compressing all files into single file: Same naming convention can be used but replace .txt with compression file extension: .zip, .zipx, .pgp, etc.

- NMAPCD_[PayerID] [FileCreateDateYYYYMMDD]. [extension]

    - PayerID – Unique Payer ID assigned to each data submitter during the initial registration

    - FileCreateDateYYYYMMDD – Date file was created, format should be YYYYMMDD.

    - Extension – file extension associated with the type of compression, i.e. .zip, .zipx, .pgp, etc.

File Format

The member eligibility file, medical claims file, pharmacy claims file, dental claims file, and provider file should be submitted as separate ASCII files, with variable field lengths, pipe-delimited formatting, and must comply with the following standards:

- Each record must be terminated with a carriage return and line feed (ASCII 13, ASCII 10).

- All fields must be filled where applicable. Text fields (varchar, char, date) must be left blank when not applicable or if the data are not available. “Blank” means do not supply any value at all between field delimiters (pipes). Numeric fields (int, dec) without a value are to be filled with a zero.

- Positive values are assumed and do not need to be indicated. Negative values must be indicated with a minus sign, placed in the left-most position of all numeric fields.

- Submit one record per row. No single line item of data may contain carriage return or line feed characters.

- The first row of the files always contains the data element numbers of the data columns (commonly referred to as field names).

- Unless otherwise specified, numbers (ID numbers, account numbers, etc.) must not contain spaces, hyphens, or other punctuation marks (including commas).

- Text fields should never be padded with leading or trailing spaces or tabs.

- Numeric fields should never be padded with leading or trailing zeroes.

Test Data Submissions

Milliman will discuss test data file submissions directly with data suppliers during the onboarding process. Milliman will request one month of claims data, a complete enrollment history and a complete provider demographic file including production data. Once received, Milliman will complete File Field and Quality (FFQ) validations to review and remediate any file-level issues. After the file-level intake testing is complete, data suppliers will submit the full historical data set, upon which Milliman will conduct a comprehensive Data Quality Audit.

Data Quality Requirements

Validation and Auditing

A validation process will be employed to ensure that the format and content of the submitted files are valid and complete. The process consists of three primary groups of audits: field level audits, quality audits, and post data consolidation data quality audits.

Field Level Audits

Field level audits are used to evaluate field length and type, code values, and the percentage of fields that are properly populated. File and field level audits are performed by MedInsight's File, Field, and Quality Checks (FFQC) system.

File Level Quality Checks

Quality checks are employed to determine whether the submitted data meets a pre-determined level of reasonableness (e.g., percentage of institutional claims vs. percentage of professional claims). Default thresholds defined by either rates or ranges have been established for approximately 200 quality audits. These audits are also part of the FFQC system. Milliman recommends using the system in conjunction with the field level audits.

Data Quality Audits

Once the files are loaded into staging tables, additional audits are conducted on the consolidated data to identify global issues that may not be apparent during the FFQC process. The data quality audits verify whether the appropriate volume and accuracy of data have been received in relation to the corresponding membership volume. Examples of these audits include:

- Frequency of individual field values
- Volume reconciliation
- Cost/utilization reasonableness

Threshold Establishment and Alteration

Default thresholds (or rates) are applied to the field level audits for each element in the eligibility, claims, and provider files, as well as for each quality audit. The standard acceptable threshold for field length, field type, and data value audits is 100%. However, for some fields such as NDC or CPT values, which are subject to national level code revisions acceptable data value threshold may be set below 100%.

Individual field completeness thresholds are defined for each data element in the eligibility, medical, pharmacy, dental and provider files and will vary accordingly.

All predefined default thresholds can be individually adjusted in cases where extenuating circumstances affect data completeness or content. If a file is processed and rejected for failing to meet the field level and/or quality audit default thresholds, the healthcare claims processor may request an exemption through a standardized process. Exemptions or adjustments may be granted for data variances that cannot be corrected due to systematic issues.

Testing of Files

At least thirty days prior to the initial submission or whenever the data element in the files is subsequently altered, each healthcare claims processor may submit a data set for validation. This set will be evaluated using the same validation process applied to actual submissions. Iterative rounds of testing may be necessary until the files meet all submission requirements. A test file should contain data covering a period of one month.

Rejection of Files

Failure to meet any of the submission requirements will result in the rejection and return of the applicable data file(s). All rejected must be resubmitted in the appropriate, corrected form within 10 days. Alternatively, the healthcare claims processor may request an exemption to adjust the threshold for the failing field(s).

Due to the volume and complexity of the data processed, it is generally more efficient to resubmit an entire file rather than to correct data within the file.

Document Revision History

Date	Revision Description	Author	Organization
10/24/2022	Addition of information on CDL changes	Brent Dunn	Milliman
10/24/2022	Section added on Historical Data submissions	Brent Dunn	Milliman
10/24/2022	Additional information added on monthly file submission cadence	Brent Dunn	Milliman
11/10/2022	Updated sFTP information to comply with Govcloud host information	Brent Dunn	Milliman
11/30/2022	Updated information on Medicare Supplemental claims submissions	Brent Dunn	Milliman
05/09/2025	Added information for runout, archiving of data, and any system changes	Rose Hess	Milliman