

CENTER FOR HEALTH INFORMATION AND ANALYSIS

Data Specification Manual

957 CMR 2.00:
Payer Reporting of Total Medical Expenses

March 24, 2016

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Payer Reporting of Total Medical Expenses
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Summary of Changes

- Beginning with CY2014 Final and CY2015 Preliminary TME data, payers shall report physician group data for:
 1. Massachusetts members required to select a primary care provider (PCP) by plan design (as reported in all previous TME filings)
 2. Members not included in (1) who are attributed to a PCP pursuant to a contract between the payer and provider for financial or quality performance
 3. Members not attributed to a PCP (aggregate line)
- Clarification on reporting Massachusetts residents: Payers must calculate and report TME by the five-digit zip code for all members who are residents of Massachusetts, *including, to the extent possible, residents with policies issued (sitused) out-of-state*
- Clarification on reporting pediatric practices: The pediatric indicator should be used to separately report pediatric *practices*, not the subset of pediatric patients within a non-pediatric practice.

Introduction

M.G.L. c. 12C, § 10 requires the Center for Health Information and Analysis (CHIA) to collect from private and public health care payers “health status adjusted total medical expenses by registered provider organization, provider group and local practice group and zip code calculated according to the method established under section 51 of chapter 288 of the acts of 2010.”

Regulation 957 CMR 2.00 governs the methodology and filing requirements for health care payers to calculate and report this data to CHIA. The Data Specification Manual provides additional technical details to assist payers in reporting and filing this data.

Payers are required to submit two Total Medical Expense (TME) files to CHIA annually: one for the previous calendar year and one for the calendar year ending 16 months prior. Files can only contain data for one year. Files will contain different record types, including:

- Header, including summary data and payer comments
- Total Medical Expenses (TME) by physician group and local practice group
- TME by member zip code

File Submission Instructions and Schedule

CHIA has attached file layout details in Appendix B of this document. Further file submission instructions are available on CHIA’s website. Payers will submit flat files with total medical expense

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data via INET.¹ The fields are variable in length and relative to position; therefore, they need to be separated by an asterisk (*). Payers will submit this information on an annual basis. Payers will have an opportunity to review the final calculation before it is publicly reported by CHIA.

Payers will submit total medical expenses information in accordance with regulation 957 CMR 2.00 on the following schedule:

Total Medical Expenses Filing Schedule	
Date	Files Due
Monday, May 2, 2016	Zip-Code Level <ul style="list-style-type: none"> • CY 2014 Final TME • CY 2015 Preliminary TME (+ IBNR factors)
Monday, May 16, 2016	Physician Group Level <ul style="list-style-type: none"> • CY 2014 Final TME • CY 2015 Preliminary TME (+ IBNR factors)

Payers will be able to access a summary report of their data on INET within 24 hours of successful submission. After reviewing this report, a payer’s Chief Financial Officer or equivalent must sign and return the data verification statement on the final page of the summary report within ten days. A payer’s filing is not complete until the data verification statement has been received by CHIA.

Data Submission

Overview

In accordance with 957 CMR 2.04, payers must report TME at two levels: by physician group and by member zip code.

Reported TME should be based on allowed amounts, i.e. provider payment and any patient cost sharing amounts. Payers should include only information pertaining to members for which they are the primary payer, and exclude any paid claims for which it was the secondary or tertiary payer.

Physician Group Data

- Payers shall report TME by Physician Group, and Physician Local Practice Group for two groups of Massachusetts members:
 1. Members required to select a primary care provider (“PCP”) by plan design, and,

¹ For more information and instructions about how to use INET, see <http://www.chiamass.gov/information-for-data-submitters/#inetinfo>.

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2. Members not included in (1) who are attributed to a primary care provider pursuant to a contract between the payer and provider for financial or quality performance
 3. Members not attributed to a PCP (aggregate line)
- Payers must calculate and report TME by Physician Group and constituent Local Practice Group for any Local Practice Group for which the payer has 36,000 Massachusetts member months or more for the specified reporting period. The number of member months is determined by summing the total member months for a given product type for the Local Practice Group. Payers must report the CHIA numeric identifier, the “OrgID,” for all Physician Groups and Local Practice Groups that are listed on CHIA’s website. Refer to Appendix A, Uniform Provider List, for this identifier.
 - Data must be reported in aggregate for all practices in which the Local Practice Group’s member months are below 36,000 and the practice has no parent Physicians’ Group. This group is to be identified as “Groups below minimum threshold” with an OrgID of 999996.
 - For Local Practice Groups below the 36,000 member month threshold that are part of a larger Physicians’ Group, payers will report the data on a separate line within the parent group data section (“Other [name of physician group] Aggregate Data”) using an OrgID of 999997.

Zip Code Data

- Payers must calculate and report TME by the five-digit zip code for all members who are residents of Massachusetts, including, to the extent possible, residents with policies issued (situated) out-of-state. The zip code is determined based on the member’s residence of record on the last day of the relevant reporting period. Payers shall only report data for Massachusetts residents.
- Payers must report all allowed amounts for members regardless of whether services are provided by providers located in Massachusetts.

Field Definitions

Each category below represents a column in the Appendix B TME File Layout.

Header Record

- Payer Org ID. The CHIA-assigned organization ID for the payer or carrier submitting the file.

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- National Plan ID. National Plan Identification Number. This element is not required at this time, but may be required for future filings.
- Reporting Period. The period of time represented by the reported data, as indicated by period beginning and end dates.
- Provider Record Count: Number of provider level records reported in file.
- Zip code Record Count: Number of zip code level records reported in file.
- Health Status Adjustment tool. The health status adjustment tool, software or product used to calculate the Health Status Adjustment Score required in the TME file.
- Health Status Adjustment version. The version number of the health status adjustment tool used to calculate the Health Status Adjustment Score required in the TME file.
- Comments. Payers may use this field to provide any additional information or describe any data caveats for the Total Medical Expense submission.
- Submission Period Indicator: Indicates whether file contains data for preliminary or final APM reporting period.
- Submission Type: Indicates whether file is for testing purposes only (Test), or for submission (Production).

Physician Group Records

- Physician Group OrgID. The CHIA-assigned OrgID of the Physician Group. This may be the parent organization of one or more Local Practice Groups. For Local Practice Groups with no parent or larger affiliation, the Physician Group OrgID is the same as the Local Practice Group OrgID.
- Local Practice Group OrgID. The CHIA-assigned OrgID of the Local Practice Group. If the Local Practice Group is the complete Physician Group, report the Physician Group OrgID. For Local “Groups below minimum threshold” that are part of a larger physicians’ group, data should be reported using aggregate OrgID 999997.

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- Pediatric Indicator. Indicates if the Local Practice Group is a practice in which at least 75% of its patients are children up to the age of 18. The pediatric indicator should be used to separately report pediatric *practices*, not the subset of pediatric patients within a non-pediatric practice.

Pediatric Indicator	Definition
0	Not a pediatric practice
1	Pediatric practice

- Insurance Category Code. A number that indicates the insurance category that is being reported. Commercial claims should be separated into two categories, as shown below. Commercial self-insured or fully insured data for physicians’ groups or zip codes for which the payer is able to collect information on all direct medical claims and subcarrier claims should be reported in the “Full Claims” category. Commercial data that does not include all medical and subcarrier claims should be reported in the “Partial Claims” category. Payers shall report for all insurance categories for which they have business, even if those categories do not meet the member month threshold.

Insurance Category Code	Definition
1	Medicare & Medicare Advantage
2	Medicaid & Medicaid Managed Care (MCO)
3	Commercial – Full Claims
4	Commercial – Partial Claims
5	Commonwealth Care
6	Medicare and Medicaid Dual Eligibles, 65 and over
7	Medicare and Medicaid Dual Eligibles, 21 – 64
8	Other (MSP, SCO, PACE, Bridge)

- Member Months (annual). The number of members participating in a plan over the specified period of time expressed in months of membership.

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- Health Status Adjustment Score. A value that measures a patient’s illness burden and predicted resource use based on differences in patient characteristics or other risk factors. Payers must disclose the Health Status Adjustment tool and version number and calibration settings in the Header record. Please see section 4.c for calibration details.
- PCP Type Indicator. The method used to attribute members to a specific physician group.

PCP Type Indicator	Definition
1	Member-selected PCP
2	Member attributed to PCP pursuant to payer – provider contract
3	Members not attributed to a PCP

- Claims: Hospital Inpatient. All payments made by the payer to hospitals for inpatient services generated from claims. Includes all room and board and ancillary payments. Includes all hospital types. Includes payments for emergency room services when the member is admitted to the hospital, in accordance with the specific payer’s payment rules. Does not include payments made for observation services. Does not include payments made for physician services provided during an inpatient stay that have been billed directly by a physician group practice or an individual physician. Does not include inpatient services at non-hospital facilities.
- Claims: Hospital Outpatient. All payments to hospitals for outpatient services generated from claims. Includes all hospital types and includes payments made for hospital-licensed satellite clinics. Includes emergency room services not resulting in admittance. Includes observation services. Does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.
- Claims: Professional Physician. All payments to physicians or physician group practices generated from claims. Includes services provided by a doctor of medicine or osteopathy.
- Claims: Professional Other. All payments generated from claims to health care providers for services provided by a licensed practitioner other than a physician. This includes, but is not limited to, community health center services, freestanding ambulatory surgical center services, licensed podiatrists, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dietitians, dentists, and chiropractors.

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- Claims: Rx. All payments generated from claims to health care providers for prescription drugs, biological products, or vaccines as defined by the payer’s prescription drug benefit.
- Claims: Other. All payments generated from claims to health care providers for medical services not otherwise included in other categories. Includes, but is not limited to, skilled nursing facility services, home health services, durable medical equipment, freestanding diagnostic facility services, hearing aid services and optical services. Payments made to members for direct reimbursement of medical services may be reported in “Claims: other” if the payer is unable to classify the service. However, payments to members for non-medical services, such as fitness club reimbursements, are not allowable medical expenses and should not be reported in any category.
- Non-Claims: Incentive Programs. All payments made to providers for achievement in specific pre-defined goals for quality, cost reduction, or infrastructure development. Examples include, but are not limited to, pay-for-performance payments, performance bonuses, and EMR/HIT adoption incentive payments.
- Non-Claims: Capitation and Risk Settlements. All payments made to providers as a reconciliation of payments made (risk settlements) and payments made *not* on the basis of claims (capitated amount). Amounts reported as Capitation and Risk Settlement should not include any incentive or performance bonuses.
- Non-Claims: Care Management. All payments made to providers for providing care management, utilization review, discharge planning, and other care management programs.
- Non-Claims: Other. All other payments made pursuant to the payer’s contract with a provider that were not made on the basis of a claim for medical services and that cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants, or other surplus payments. Only payments made to providers are to be reported. Payments to government entities, such as the Health Safety Net Surcharge, may not be included in any category.

Zip Code Records

- Zip Code. The five-digit zip code, based on the member’s residence. Payers should report only Massachusetts zip codes.
- Product Type: The product type under the insurance category reported.

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Product Type Code	Definition
1	HMO and POS
2	PPO
3	Indemnity
4	Other (e.g. EPO)

- Insurance Category Code. A number that indicates the insurance category that is being reported. Commercial claims should be separated into two categories, as shown below. Commercial self-insured or fully insured data for physicians’ groups or zip codes for which the payer is able to collect information on all direct medical claims and subcarrier claims should be reported in the “Full Claims” category. Commercial data that does not include all medical and subcarrier claims should be reported in the “Partial Claims” category. Payers shall report for all insurance categories for which they have business, even if those categories do not meet the member month threshold.

Insurance Category Code	Definition
1	Medicare & Medicare Advantage
2	Medicaid & Medicaid Managed Care (MCO)
3	Commercial – Full Claims
4	Commercial – Partial Claims
5	Commonwealth Care
6	Medicare and Medicaid Dual Eligibles, 65 and over
7	Medicare and Medicaid Dual Eligibles, 21 – 64
8	Other (MSP, SCO, PACE, Bridge)

- Member Months (annual). The number of members participating in a plan over the specified period of time expressed in months of membership.
- Health Status Adjustment Score. A value that measures a patient’s illness burden and predicted resource use based on differences in patient characteristics or other risk factors.

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Payers must disclose the Health Status Adjustment tool and version number and calibration settings in the Header record. Please see section 4.c for calibration details.

- Normalized Health Status Adjustment Score. The Health Status Adjustment Score divided by the payer's weighted average health status adjustment score within each Insurance Category.
- Claims: Hospital Inpatient. Same definition as Provider Level Records above.
- Claims: Hospital Outpatient. Same definition as Provider Level Records above.
- Claims: Professional Physician. Same definition as Provider Level Records above.
- Claims: Professional Other. Same definition as Provider Level Records above.
- Claims: Rx. Same definition as Provider Level Records above.
- Claims: Other. Same definition as Provider Level Records above.
- Total Non-Claims Payments. The sum of all non-claims expense categories.

Health Status Adjustment Specifications

Payers are permitted to use a health status adjustment method and software of their own choosing, but must disclose the method (e.g. ACGs, DxCG, etc.) and version in the payer comment file. A payer's Health Status Adjustment tool and version must be the same for all files submitted in a given reporting year (CY2014 Final TME and CY2015 Preliminary TME files in 2016). Where possible, payers shall apply the following parameters in completing the health status adjustment:

- The health status adjustment tool used should correspond to the insurance category reported, e.g. Medicare, Medicaid, commercial. For the purposes of reporting, Commonwealth Care products should be adjusted using the Medicaid model.
- Payers must use **concurrent** modeling.
- The health status adjustment tool must be all-encounter diagnosis-based (no cost inputs) and output total medical and pharmacy costs **with no truncation**.

Claims Run-Out Period Specifications

For preliminary TME, payers shall allow for a claims run-out period of at least 60 days after December 31 of the prior Calendar Year. To request a variance on this specification, email tmerp@state.ma.us. Payers should apply incurred but not reported (IBNR) factors to preliminary

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TME data submitted through INET for each type of TME service category. These factors should be documented in a separate excel sheet and submitted to CHIA.

Appendix A: Physician Group OrgIDs

Please visit:<http://chiamass.gov/reference-materials>

Please note that CHIA's mapping of parent and local physician group relationships is meant to serve as a guide only. Payers should report physician group data based on their individual contracting structures with providers.

Appendix B: Data Submission Guidelines

Please see pages following this section.

Appendix C: Massachusetts Zip Codes for Use with Zip Code TME

Please see the database of Massachusetts Zip Codes posted on CHIA's website at <http://chiamass.gov/reference-materials>

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Appendix B: Data Submission Guidelines

Data Submission Guidelines

Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
HD-TME	1	HD001	Record Type	12/10/10	Text	HD	2	Yes	This must have HD reported here. Indicates the beginning of the Header Record
HD-TME	2	HD002	Payer	12/10/10	Integer	#####	8	Yes	This is the Carriers OrgID. This must match the Submitters OrgID
HD-TME	3	HD003	National Plan ID	12/10/10	Text		30	No	Unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans.
HD-TME	4	HD004	Type of File	12/10/10	Integer	####	4	Yes	This must have 117 reported here. This is an indicator that defines the type of file and the data contained within the file.
HD-TME	5	HD005	Period Beginning Date	12/10/10	Date Period	MMDDYY Y Or MM/DD/YY YY	10	Yes	This is the start date period of the reported period in the submission file.
HD-TME	6	HD006	Period Ending Date	12/10/10	Date Period	MMDDYY Y Or MM/DD/YY YY	10	Yes	This is the end date period of the reported period in the submission file; if the period reported is a single month of the same year then Period Begin Date and Period End Date will be the same date.
HD-TME	7	HD007	Provider Record Count	12/10/10	Integer	#	10	Yes	Record Count for TME by Provider
HD-TME	8	HD008	Zip code Record Count	12/10/10	Integer	#	10	Yes	Record Count for TME by Zip Code

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Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
HD-TME	9	HD009	Comments	12/10/10	Text	Free Text Comments	255	No	Provider TME Comments
HD-TME	10	HD010	Comments	12/10/10	Text	Free Text Comments	255	No	Zip Code TME Comments
HD-TME	11	HD011	Comments	02/20/11	Text	Free Text Comments	255	No	Other Comments to support the submission data
HD-TME	12	HD012	Health Status Adjustment Tool	12/10/10	Text	Text	80	Yes	The health status adjustment tool, software or product used to calculate the health status adjustment score required in the Total Medical Expense (TME) file
HD-TME	13	HD013	Health Status Adjustment Version	12/10/10	Text	Text	20	Yes	The version number of the health status adjustment tool used to calculate the health status adjustment score required in the Total Medical Expense (TME) file.
HD-TME	14	HD014	Submission Period Indicator	03/15/11	Text	Text	1		Identifies whether the submission is a Preliminary filing or Final filing for the time period P = Preliminary; F = Final
HD-TME	15	HD015	Submission Type	12/30/10	Text	Flag	1	Yes	Type of Submission file T= Test; P = Production
PR	1	PR001	TME Record Type ID	01/12/11	Text	Text	2	Yes	This must have PR reported here. Indicates the beginning of the Provider based TME record
PR	2	PR002	Physician Group Org ID	12/10/10	Integer	#####	6	Yes	OrgID (Owning entity – Same value of site if self-owned) For aggregation of all other sites that fall below the threshold and that do not belong to a larger parent organization, use OrgID 999996.

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Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
									Must be a CHIA-issued OrgID. Note: If PR002=999996, then PR003 must also equal 999996
PR	3	PR003	Local Practice Group Org ID	12/10/10	Integer	#####	6	Yes	Local Practice Group OrgID For aggregation of sites that fall below threshold, but that are part of a larger parent organization, use OrgID 999997 Must be a CHIA-issued OrgID. If PR002 = 999996, then PR003 = 999996
PR	4	PR004	Pediatric Indicator	12/10/10	Integer	#	1	Yes	Indicates pediatric care 0 = No; 1 = Yes Value must be either a '0' or '1'.
PR	5	PR005	Insurance Category Code	12/10/10	Integer	#	1	Yes	Indicates the insurance category that is being reported : 1 = Medicare & Medicare Advantage 2 = Medicaid & Medicaid MCOs 3 = Commercial: Full-Claim 4 = Commercial: Partial-Claim 5 = Commonwealth Care 6 = Medicare and Medicaid Dual-Eligibles, 65 and over 7 = Medicare and Medicaid Dual-Eligibles, 21-64 8 = Other Value must be an integer between '1' and '8'.

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Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
PR	6	PR006	Member Months	12/10/10	Integer	#####	9	Yes	The number of members participating in a plan over a specified period of time expressed in months of membership
PR	7	PR007	Health Status Adjustment Score	12/10/10	Number	##.##	6	Yes	A value that measures a patient's illness burden and predicted resource use based on differences in patient characteristics or other risk factors. No negative values. Number must be between '.2' and '10'.
PR	8	PR008	PCP Type Indicator	3/14/2016	Integer	#	1	Yes	Describe the physician group's member population: 1 = Members required to select a PCP by plan design 2 = Members attributed to PCP pursuant to contract between payer and provider group 3 = Members not attributed to a PCP (aggregate OrgID 999996) Value must be an integer between '1' and '3'.
PR	9	PR009	Claims: Hospital Inpatient	12/10/10	Money	#####.##	12	Yes	Total allowed claims for hospital inpatient medical expenses No negative values.
PR	10	PR010	Claims: Hospital Outpatient	12/10/10	Money	#####.##	12	Yes	Total allowed claims for hospital outpatient medical expenses No negative values.
PR	11	PR011	Claims: Professional Physician	12/10/10	Money	#####.##	12	Yes	Total allowed claims for professional physician medical expenses No negative values.

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PR	12	PR012	Claims: Professional Other	12/10/10	Money	#####.##	12	Yes	Total allowed claims for other professional services medical expenses No negative values.
PR	13	PR013	Claims: Rx	12/10/10	Money	#####.##	12	Yes	Total allowed claims for pharmacy medical expenses No negative values.
PR	14	PR014	Claims: Other	12/10/10	Money	#####.##	12	Yes	Total allowed claims for all other medical expenses No negative values.
PR	15	PR015	Non-Claims: Incentive Programs	12/10/10	Money	#####.##	12	Yes	
PR	16	PR016	Non-Claims: Risk Settlements	12/10/10	Money	#####.##	12	Yes	
PR	17	PR017	Non-Claims: Care Mgmt	12/10/10	Money	#####.##	12	Yes	
PR	18	PR018	Non-Claims: Other	12/10/10	Money	#####.##	12	Yes	
ZR	1	ZR001	TME Record Type ID	01/12/11	Text	ID	2	Yes	This must have ZR reported here. Indicates the beginning of the Zip Code based TME record
ZR	2	ZR002	Zip Code	12/10/10	Text	ID	10	Yes	Zip Code Must be a valid MA zip-code.

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ZR	3	ZR003	Product Type Code	12/10/10	Integer	#	1	Yes	<p>Indicates the product type that is being reported:</p> <p>1= HMO and POS 2= PPO 3= Indemnity 4= Other (e.g. EPO)</p> <p>Value must be an integer between '1' and '4'.</p>
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Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
ZR	4	ZR004	Insurance Category Code	12/10/10	Integer	ID	1	Yes	Indicates the insurance category that is being reported : 1 = Medicare & Medicare Advantage 2 = Medicaid & Medicaid MCOs 3 = Commercial: Full-Claim 4 = Commercial: Partial-Claim 5 = Commonwealth Care 6 = Medicare and Medicaid Dual-Eligibles, 65 and over 7 = Medicare and Medicaid Dual-Eligibles, 21-64 8 = Other Value must be an integer between '1' and '8'
ZR	5	ZR005	Member Months	12/10/10	Integer	#####	9	Yes	The number of members participating in a plan over a specified period of time expressed in months of membership
ZR	6	ZR006	Health Status Adjustment Score	12/10/10	Number	##.##	6	Yes	A value that measures a patient's illness burden and predicted resource use based on differences in patient characteristics or other risk factors. No negative values. Number must be between '.2' and '10'.
ZR	7	ZR007	Normalized Health Status Adjustment Score	12/10/10	Number	##.##	6	Yes	The health status adjustment score divided by the Payer's weighted average health status adjustment score within each insurance category No negative values. Number must be between '.2' and '10'.
ZR	8	ZR008	Claims: Hospital Inpatient	12/10/10	Money	#####.##	12	Yes	Total allowed claims for hospital inpatient medical expenses No negative values.

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Record Type	Col	Element	Data Element Name	Date Active (version)	Type	Format	Length	Required	Element Submission Guideline
ZR	9	ZR009	Claims: Hospital Outpatient	12/10/10	Money	#####.##	12	Yes	Total allowed claims for hospital outpatient medical expenses No negative values.
ZR	10	ZR010	Claims: Professional Physician	12/10/10	Money	#####.##	12	Yes	Total allowed claims for professional physician medical expenses No negative values.
ZR	11	ZR011	Claims: Professional Other	12/10/10	Money	#####.##	12	Yes	Total allowed claims for other professional services medical expenses No negative values.
ZR	12	ZR012	Claims: Rx	12/10/10	Money	#####.##	12	Yes	Total allowed claims for pharmacy medical expenses No negative values.
ZR	13	ZR013	Claims: Other	12/10/10	Money	#####.##	12	Yes	Total allowed claims for all other medical expenses No negative values.
ZR	14	ZR014	Non-Claims Total Expense	02/16/11	Money	#####.##	12	Yes	Total non-claims related payments

Note: Any Required Integer, Number or Money field must have at least a zero in its place.

File Record Legend

File Field	Description
HD-TME	TME header record
PR	Provider TME record
ZR	Zip Code TME Record

File Submission Naming Conventions

Chapter 288 data submissions should follow the following naming conventions:

SubmissionType_YYYY_Version.dat,

Where Submission Type is one of the following:

TME288 for Chapter 288 Total Medical Expenses data submissions

YYYY is the four digit year

Version is **optional**, and indicates the submission number.

The file extension must be .dat (or .DAT)

Below are examples of validly named files:

TME288_2015_01.dat or tme288_2015_1.dat or tme288_2015.dat