

Data Specification Manual

957 CMR 2.00:

Payer Reporting of Primary Care and Behavioral
Health Expenses

August 11, 2020

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Introduction

There is emerging interest in the Commonwealth to better measure expenditures on primary care and behavioral health services, as reflected in recent legislative proposals, findings, and recommendations from state agencies, as well as support from patient advocates. These spending categories comprise an array of vital services that can meaningfully shape patient outcomes and are often associated with lower costs and higher quality.

Consistent with CHIA’s mission to create and curate data assets that support evidence-based policy making and program oversight, the agency is collecting more detailed information about primary care and behavioral health spending in the Commonwealth. The data specifications outlined below will provide a foundational data set that can be leveraged and adapted to support future initiatives and policies related to primary care and behavioral health.

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 one Primary Care & Behavioral Health Expenditures (PCBH) file to CHIA annually: the file must include final data for the prior calendar year. In the 2020 collection year, payers are required to submit final data for calendar year 2018 and preliminary data for calendar year 2019. Files will contain different tabs, including:

- Front page, including data confirmation and payer comments
- Primary Care & Behavioral Health expenses by managing physician group
- Summary tab, which automatically calculates totals with inputted data from the data entry tab

File Submission Instructions and Schedule

Payers will submit data using the excel template provided using CHIA’s online submission platform at <https://chiasubmissions.chia.state.ma.us>. Data submitters with an existing username and password will login to the submission platform and upload the completed excel file. The file name will be automatically generated by the “Save and Submit” button on the Front Page tab. If this format is not used, the file will not be accepted for submission.

If data submitters require a new username and password, please complete a [User Agreement for Insurance Carriers](#) and email the completed form to CHIA-DL-Data-Submitter-HelpDesk@massmail.state.ma.us. For technical issues, please call 617-701-8217 or email CHIA-DL-Data-Submitter-HelpDesk@massmail.state.ma.us.

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

Date	Files Due
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December 2, 2020	<ul style="list-style-type: none"> • CY 2018 Final PCBH • CY 2019 Preliminary PCBH
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Data Validation and Verification

Within the template, Tab C automatically calculates totals with data entered in Tab B. It is the responsibility of the data submitter to review this summarized information for accuracy before submitting the data to CHIA. In addition, the total expenditures for a given physician group should equal the total expenditures for that same physician group as reported in the Total Medical Expenses/Alternative Payment Methods (TME-APM) submission.¹ CHIA will compare the totals reported in the PCBH data file and the TME-APM data file to confirm consistency.

[Data Submission Guidelines](#)

3a. Overview

In accordance with 957 CMR 2.00, payers must report expenditures, including claims and non-claims based payments, made to providers for their member populations. These expenditures will be reported by mutually-exclusive behavioral health, primary care, or other service categories using the detailed code sets provided by CHIA. Expenditures will be attributed to the member’s managing physician group, as applicable, regardless of whether that physician group delivered the services.

Expenses in the PCBH data submission should separately include incurred amount and member cost-sharing. For claims based spending, the sum of the total payer liability and member cost share columns should equal allowed claims. Payers should include only information pertaining to Massachusetts residents, members for which they are the primary payer, and exclude any paid claims for which it was the secondary or tertiary payer. Allowed claims should not be capped or truncated and should represent claims prior to the impact of any reinsurance.

When reporting non-claims payments by the behavioral health, primary care, or all other services categories, payers should make determinations based on their contracts to report non-claims payments into the appropriate service area and non-claims specific category. For payments that are unable to be separated out into behavioral health or primary care, the “all other services” category should be used. For payments that may combine or be related to the provision of both primary care and behavioral health services, payers may apportion or allocate payments into the primary care and behavioral health service types; these payments should not be double counted. Alternately, the “all other services” categories may be used.

¹ For the 2020 submission cycle, because payers will be submitting PCBH expenditure data for the same data period later than TME-APM, slight differences in total expenditures due to claims lag are expected.

When reporting capitation arrangements, payers should use fee-for-service (FFS) equivalents rather than reporting the arrangements within the Non-Claims categories. Any balance can be included in the Non-Claims field.

Physician Group Guidelines

- Payers shall report Primary Care & Behavioral Health expenditures by Physician Group according to the following categorization of Massachusetts resident members as of December 31st of the reporting year. Member months for members who were attributed to more than one PCP in a calendar year should be allocated based on the number of months associated with each PCP:
 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 were attributed during the reporting year to a PCP, pursuant to a risk contract between the payer and provider.
 3. Members not included in (1) or (2), attributed to a PCP by the payer's own attribution methodology²
 4. Members not attributable to a PCP (aggregate line)
- Payers must calculate and report Primary Care & Behavioral Health expenses by Physician Group for any Physician Group for which the payer has 36,000 Massachusetts resident 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 and insurance category for the Physician Group. Payers must report the CHIA numeric identifier, the "OrgID," for all Physician Groups. Refer to Appendix A, Physician Group OrgID List, for this identifier.
- Data must be reported in aggregate for all practices in which the Physician Group's member months are below 36,000. This group is to be identified as "Groups below minimum threshold" with an OrgID of 999996.
- Payers must report all incurred and cost-sharing amounts for members regardless of whether services are provided by providers located in Massachusetts.

3b. Claims Run-Out Period Specifications

² Chapter 224 of the Acts of 2012 amended chapters 175 and 176 of the Massachusetts General Laws (M.G.L.) to stipulate that "to the maximum extent possible [carriers] shall attribute every member to a primary care provider." Please see M.G.L. [C. 175 §108L](#), [C. 176A §36](#), [C. 176B §23](#), [C. 176G §31](#), and [C. 176J §16](#).

For preliminary PCBH expenditures, payers shall allow for a claims run-out period of at least 90 days after December 31 of the prior Calendar Year. To request a variance on this specification, email Erin.Bonney@state.ma.us

4. Field Definitions

Tab A: Front Page

Table A.1

- Payer Name: The name of the reporting payer
- Payer Org ID: The CHIA-assigned organization ID for the payer or carrier submitting the file.
- Submission Year: Year in which the data is submitted (e.g., 2020)
- Reporting Year: Year for which Primary Care & Behavioral Health data is being reported (e.g., 2019)
- Claims Paid Through Date: Date for which Primary Care & Behavioral Health claims data is paid through.

Table A.2

- Massachusetts residents only? Confirm that the reported data include Massachusetts residents only.
- Primary payer only? Confirm that the reported data include only claims data for which the payer was the primary payer, exclude any paid claims for which they were the secondary or tertiary payer.
- Comments: Payers may use this field to provide any additional information or describe any data caveats for the PCBH file.

Tab B: Expenditure and Member Month Data

- Submission Type: Indicates whether file contains preliminary or final PCBH reporting period.
- Reporting Year: Indicates the year for which the data is being reported.
- 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 “Groups below minimum threshold”, data should be reported using aggregate OrgID 999996
- Insurance Category: 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 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. *Stand-alone Medicare Part D Prescription Drug Plan members and payments should not be reported in the data.* For payers reporting in the “Other” category, payers should report in the comments field on the Front Tab what is included in the “Other” category.

Insurance Category Code	Definition
1	Medicare & Medicare Advantage
2	Medicaid (e.g., MCO, ACO)
3	Commercial – Full Claims
4	Commercial – Partial Claims
5	SCO
6	OneCare
7	PACE
8	Other

- Product Type: The product type under the insurance category reported.

Product Type Code	Definition
1	HMO
2	PPO
3	Indemnity
4	Other
5	POS

- PCP Type Indicator: The method used to attribute members to a specific physician group.

PCP Indicator	Definition
1	Data for members who select a PCP as part of plan design
2	Data for members who are attributed to a PCP during reporting period pursuant to payer-provider risk contract
3	Data for members who are attributed to a PCP by payer’s own attribution methodology

4	Data for members who are not attributed to a PCP
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- Pediatric Indicator: Indicates if the Physician 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

- MassHealth ACO Indicator: Indicates if the Local Practice Group is part of the MassHealth Accountable Care Organization (ACO) program. The ACO indicator should be used to report these groups. Medicaid payers should identify ACOs for the entirety of 2018, do not split data before and after the start of the program on 3/1/2018. Payers with no Medicaid business should report a “0” for all providers.

ACO Indicator	Definition
0	Not an ACO or no Medicaid business
1	ACO

- Group Insurance Commission (GIC) Indicator: Indicates the member population covered under a contract with the Group Insurance Commission. Payers with no GIC membership should report a “0” for all providers.

GIC Indicator	Definition
0	Non-GIC population
1	GIC population

- Member Months (annual): The number of members participating in a plan over the specified period of time expressed in months of membership. The member months count should be repeated on all applicable rows (a unique combination of columns A through I) for all service categories and provider types.
- BH Member Months (annual): The number of members participating in a plan over the specified period of time expressed in member months, who have a Behavioral Health principal diagnosis at any point during the reporting year. The member months count should be repeated on all applicable rows (a unique combination of columns A through I) for all service categories and provider types.

Service Categories

General definitions of each service category are described below; however, payers should classify claims-based expenditures based on the standard code sets provided by CHIA; coding logic and summaries of these sets are included in Appendix D. A reference table of all codes is included in Appendix B. Expenditures shall be categorized into mutually-exclusive, hierarchal categories that distinguish: (1) Behavioral Health Services, (2) Primary Care, and (3) All Other Services. Note that not all categories will be applicable to each reported Physician Group; data submitters should only report lines for services categories that had expenditures. Service categories for non-claims payments are included in each service type. If non-claims base payments cannot be attributed to behavioral health or primary care service categories, all non-claims payments should be reported in the appropriate All Other Services non-claims categories.

Behavioral Health: Behavioral health services are classified based on ICD-10-CM Principal Diagnosis Code and *combinations of* Current Procedure Terminology (CPT) Codes, Revenue Codes, Place of Service (POS) Codes, and Provider Types. Data submitters will report expenses within the following mutually-exclusive spending service categories:

- **BH Inpatient**: All payments made for claims associated with services provided at an acute or non-acute inpatient facility with a behavioral health principle diagnosis.
- **BH Emergency Department and Observation**: All payments made for emergency or observation services in an acute or non-acute facility for claims with a behavioral health principal diagnosis.
- **BH Outpatient**: All payments for behavioral health specific services, including intensive outpatient services, medication assisted treatment, and other diversionary care and residential treatment with a behavioral health principal diagnosis, delivered by any provider type. Additionally includes outpatient face-to-face and telehealth services, including evaluation and management and

integrated behavioral health primary care services, with a behavioral health diagnosis **and** delivered by a behavioral health provider. **Ancillary services should not be included.**

- **BH Prescription Drugs:** All payments made for prescription drugs prescribed to address behavioral health needs, based on the specified set of National Drug Codes (NDC) listed in Appendix B.
- **Non-Claims: Incentive Programs:** All payments made to providers for achievement in specific pre-defined goals for quality, cost reduction, or infrastructure development related to the provision of behavioral health care services. Examples include, but are not limited to, pay-for-performance payments, performance bonuses, and EMR/HIT adoption incentive payments related to the provision of behavioral health care services.
- **Non-Claims: Capitation:** All payments made to providers *not* on the basis of claims related to the provision of behavioral health care services. Capitation should not include payments to non-provider third party entities that manage behavioral health care services. Amounts reported as capitation should not include any incentives or performance bonuses.
- **Non-Claims: Risk Settlements:** All payments made to providers as a reconciliation of payments made for the provision of behavioral health care services. Amounts reported as 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 related to behavioral health care.
- **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 in other non-claims categories related to the provision of behavioral health care services. 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

Service Category Code	Service Category Definition
11	BH Inpatient

Service Category Code	Service Category Definition
12	BH Emergency Department-Observation
13	BH Outpatient
14	BH Prescription Drugs
41	Non-Claims: Incentive Programs
42	Non-Claims: Capitation
43	Non-Claims: Risk Settlements
44	Non-Claims: Care Management
45	Non-Claims: Other

Primary Care: Primary care will be identified based on CPT codes and Provider Types. Data submitters will report expenses not included in the above behavioral health service categories within the following mutually-exclusive subcategories. All primary care spending categories should include only professional claims payments:

- **Office Type Visits³:** All payments made for professional evaluation and management services, delivered in an office or other outpatient setting, including telehealth delivered by a primary care provider type included in Appendix D.
- **Home/Nursing Facility Visits:** All payments made for professional evaluation and management services, delivered in the home, rest home, or nursing facility delivered by a primary care provider type included in Appendix D.
- **Preventive Visits³:** All payments made for professional preventive medicine services, including exams, screenings, and counseling delivered by a primary care provider type included in Appendix D.
- **Other Primary Care Visits:** All payments made for professional services, including initial Medicare enrollment visits, annual wellness visits, and chronic disease care delivered by a primary care provider type included in Appendix D.
- **Immunizations and Injections:** All payments made for the administration of injections, infusions, and vaccines by a primary care provider type included in Appendix D.

- **Obstetric Visits³:** All payments made for the professional components of routine obstetric care, as well as OB/GYN evaluation and management services.
- **Non-Claims: Incentive Programs:** All payments made to providers for achievement in specific pre-defined goals for quality, cost reduction, or infrastructure development related to the provision of primary care services. Examples include, but are not limited to, pay-for-performance payments, performance bonuses, and EMR/HIT adoption incentive payments.
- **Non-Claims: Capitation:** All payments made to providers *not* on the basis of claims related to the provision of primary care services. Amounts reported as capitation should not include any incentives or performance bonuses.
- **Non-Claims: Risk Settlements:** All payments made to providers as a reconciliation of payments made for the provision of primary care services. Amounts reported as 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 related to primary health care.
- **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 in other non-claims categories, related to the provision of primary care services. 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.

Service Category Code	Service Category Definition
21	Office Type Visits
22	Home-Nursing Facility Visits

³ Services delivered by OB/GYN practitioners may be reported in this category only for procedure codes listed in the code set.

23	Preventive Visits
24	Other Primary Care Visits
25	Immunizations and Injections
26	Obstetric Visits
41	Non-Claims: Incentive Programs
42	Non-Claims: Capitation
43	Non-Claims: Risk Settlements
44	Non-Claims: Care Management
45	Non-Claims: Other

All Other Services: All other services paid for that are not classified as Behavioral Health or Primary Care. Data submitters will report expenses not included in the above behavioral health or primary care service categories within the following mutually-exclusive subcategories:

- **Other Medical:** All payments for claims based medical services, including facility and professional components not previously categorized as behavioral health or primary care.
- **Other:** All other claims based expenditures not previously categorized as behavioral health or primary care, or included in Other Medical expenses above.
- **Other Prescription Drugs:** All other payments made for prescription drugs not previously categorized as behavioral health.
- **Non-Claims: Incentive Programs:** All payments made to providers for achievement in specific pre-defined goals for quality, cost reduction, or infrastructure development not directly related to the provision of primary care or behavioral health services. Examples include, but are not limited to, pay-for-performance payments, performance bonuses, and EMR/HIT adoption incentive payments.
- **Non-Claims: Capitation:** All payments made to providers *not* on the basis of claims and not related to the provision of primary care or behavioral health services. Amounts reported as capitation should not include any incentives or performance bonuses.

- **Non-Claims: Risk Settlements:** All payments made to providers as a reconciliation of payments made for services other than for the provision of primary care and behavioral health services. Amounts reported as 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 not related to primary care or behavioral health services.
- **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 in other non-claims categories, and are not related to the provision of primary care or behavioral health services. 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.

Service Category Code	Service Category Definition
31	Other Medical
32	Other
33	Other Prescription Drugs
41	Non-Claims: Incentive Programs
42	Non-Claims: Capitation
43	Non-Claims: Risk Settlements
44	Non-Claims: Care Management
45	Non-Claims: Other

Provider Type: The type of provider rendering the services:

- Facility: The facility or non-professional component
- Professional: All professional services combined, including licensed physicians and other professional staff
- Professional- Physician: Services are provided by a doctor of medicine or osteopathy

- Professional- Other: Services are 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
- No Provider: No applicable facility or licensed practitioner

Provider Type Code	Provider Type Definition
1	Facility
2	Professional Physician
3	Professional Other
4	No Provider

Expenditures- Incurred Expenses (Payer Liability): The total incurred expenses/ payer paid amounts for claims-based services and non-claims payments to providers.

Expenditures- Member Cost Share: Total member cost share/member paid amounts for claims-based services.

5a. Data Dictionary

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Front Page		Payer OrgID	Integer	#####	This is the Payer's OrgID. This must match the Submitter's OrgID.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Front Page		Payer Name	Text	Text	Name of the Payer.
Front Page		Submission Year	Date	YYYY	Year in which the file is being submitted.
Front Page		Reporting Year	Date Period	YYYY	Year for which Behavioral Health and Primary Care data is being reported.
Front Page		Claims Paid Through Date	Date Period	MMDDYYYY	Date of claims data runout. At least 90 days of claims runout is required.
Front Page		MA residents only?	Text	Text	Confirm that the reported members are limited only to Massachusetts residents. Response must be 'yes' or 'no'.
Front Page		Primary Payer only?	Text	Text	Confirm that the reported members are limited only to members for whom the payer is the primary payer. Response must be 'yes' or 'no'.
Front Page		Comments	Text	Free Text Comments	Additional file comments.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Data	A	Submission Type	Text	Flag	P= Preliminary F = Final
Data	B	Data Year	Integer	#####	Year for which data is being reported.
Data	C	Physician Group OrgID	Integer	#####	Physician Group OrgID. Must be a CHIA-issued OrgID. For aggregation of sites that fall below the threshold, use OrgID 999996.
Data	D	Insurance Category	Integer	#	Indicates the insurance category that is being reported: 1 = Medicare & Medicare Advantage 2 = Medicaid (e.g., MCO, ACO) 3 = Commercial: Full-Claim 4 = Commercial: Partial-Claim 5= SCO 6 = OneCare 7 = PACE 8 = Other Value must be an integer between '1' and '8'. For payers reporting in the "Other" category, payers should report in the zip code comments field on the front tab what is included in the "Other" category.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Data	E	Product Type	Integer	#	<p>Indicates the product type that is being reported:</p> <p>1= HMO 2= PPO 3= Indemnity 4= Other (e.g. EPO) 5 = POS</p> <p>Value must be an integer between '1' and '5'.</p>
Data	F	PCP Type Indicator	Integer	#	<p>Indicates Primary Care Physician attribution:</p> <p>1 = Members required to select a PCP by plan design 2 = Members attributed to a PCP during reporting period pursuant to payer – provider risk contract 3 = Members attributed to PCP by payer’s own attribution methodology 4 = Members not attributed to a PCP</p> <p>Value must be an integer between '1' and '4'.</p>
Data	G	Pediatric Indicator	Integer	#	<p>Indicates if the physician group is a practice in which at least 75% of its patients are children up to the age of 18.</p> <p>0 = No, 1 = Yes</p> <p>Value must be either a '0' or '1'.</p>
Data	H	MassHealth Accountable Care Organization (ACO) Indicator	Integer	#	<p>Indicates provider is a MassHealth Accountable Care Organization (ACO).</p> <p>0 = not an ACO or no Medicaid business, 1= ACO</p> <p>Value must be either a '0' or '1'.</p>
Data	I	Group Insurance Commission (GIC) Indicator	Integer	#	<p>Indicates population in following columns reflects Group Insurance Commission (GIC) contract members.</p> <p>0 = no GIC contract, 1= GIC contract</p> <p>Value must be either a '0' or '1'.</p>

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Data	J	Member Months	Integer	#####	<p>The number of members participating in a plan over a specified period of time expressed in months of membership.</p> <p>The member months count should be repeated on all applicable rows (a unique combination of columns A through I) for all service categories and provider types.</p> <p>No negative values.</p>
Data	K	BH Member Months	Integer	#####	<p>The number of members participating in a plan over a specified period of time expressed in months of membership, that had a Behavioral Health principal diagnosis at any point during the reporting year.</p> <p>The member months count should be repeated on all applicable rows (a unique combination of columns A through I) for all service categories and provider types.</p> <p>No negative values.</p>
Data	L	Service Type	Integer	#	<p>Type of Service 1= Behavior Health 2= Primary Care 3= All Other Services</p> <p>No negative values.</p>

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Data	M	Spending Service Category	Integer	##	<p>Specific category of spending. See category descriptions for additional detail and Appendix B for applicable code lists</p> <p>11= BH Inpatient 12= BH ED/Observation 13= BH Outpatient 14= BH Prescription Drugs 21= PC Office Visit 22= PC Home/Nursing Facility Visit 23= PC Preventive Visit 24= PC Other Primary Care Visit 25= PC Immunization and Injection 26= PC Obstetric Visit 31=Other Medical 32= Other 33= Other Prescription Drugs 41= Non-Claims: Incentive Payments 42= Non-Claims: Capitation 43= Non-Claims: Risk Settlements 44= Non-Claims: Care Management 45= Non-Claims: Other</p> <p>No negative values.</p>
Data	N	Provider Type	Integer	#	<p>Type of Provider rendering services reflected in columns K and L. See provider descriptions for additional detail, and Appendix B for specific code sets</p> <p>1= Facility 2= Professional: Physician 3= Professional: Other 4= No Provider</p> <p>No negative values.</p>

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Data	O	Expenditures: Incurred Expenses (Payer Liability)	Integer	#####	Total incurred expenses/ payer paid amounts for service category spending by a particular type of provider by service type as designated in columns L-N No negative values for claims-based expenses. Negative values allowed for non-claims spending service categories only.
Data	P	Expenditures: Member Cost Share	Integer	#####	Total member cost share/member paid amounts for service category spending by a particular type of provider by service type as designated in columns L-N No negative values.
Summary	-	No payer data entry needed	-	-	The summary tab will automatically populate with data from the data entry. Please review this tab prior to submitting data to CHIA to confirm that totals and trends are correct.

Appendix A: Physician Group OrgIDs

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

Payers should report physician group data based on their individual contracting structures with providers.

Appendix B: Service Categorization Code Lists

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

Payers should use these lists as reference tables **in conjunction with the methodology and coding logic outlined in Appendices C and D**. Note, these reference tables separately identify service codes and provider types to facilitate data compilation; however, for categorization of claims, payers should follow the methodology outlined in Appendix D, in which claims are categorized by combinations of service codes and provider types.

Appendix C: Payment Allocation Methodology

Identify claims with a principal behavioral health diagnosis
Based on ICD-10 diagnosis code

Allocate spending for the claim **sequentially** through the Behavioral Health specific service categories based on code sets/logic in Appendices B & D:

BH Outpatient

BH Inpatient



Note: Behavioral Health allocations are based on combinations of CPT and Revenue codes, POS codes, as well as Provider Types.

All Claims Spending not previously allocation above, plus claims without a principal behavioral health diagnosis

Allocate spending for the claim **sequentially** through the Primary Care specific service categories base on code sets/logic in Appendices B&D:



PC Office Visit



PC Home/Nu Facility V

All Claims Spending not previously allocation above to Behavioral Health or Primary Care

Other Medical

Other



Non-Claims Payments

Allocate non-claims payments into the below categories by service type. If non-claims cannot be separated into Behavioral Health or Primary Care, the "All Other" service type should be used in combination with the spending categories below. For payments that may combine or be related to the provision of both primary care and behavioral health services, payers may apportion or allocate payments into the primary care and behavioral health service types; these payments should not be double counted.

Non-Claims:
Incentive Payments

Non-Claims:
Capitation

Non-Claims:
Risk Settlements

Non-Claims: Care
Management

Non-Claims:
Other



Pharmacy Claims



Allocate pharmacy claims spending base on the NDC codes provide in Appendix B:

BH Prescription Drugs



Other Prescription Drugs

Appendix D: Summary of Code Lists and Coding Logic

The tables below summarize the code lists found in Appendix B, and include the combinations of code type required for spending service categories within each Service Type. For “professional” measure categories below, it should be noted that physician and other professional types are reported separately using the provider type field outlined in the [Data Dictionary](#).

Behavioral Health Diagnosis Codes

ICD-10 Code	Description	Notes and Exclusions
F01 - F09	Organic, including symptomatic, mental disorders	
F10 – F16. 99	Mental and behavioral disorders due to psychoactive substance use	
F17	Nicotine Dependence	
F18 - F19.99	Inhalant Related Disorders	
F20 - F29	Schizophrenia and Delusional disorders	
F30 - F39	Mood disorders	Excluding F38 Other mood [affective] disorders
F40 - F48	Neurotic, stress-related, somatoform disorders	
F50 - F59	Behavioral syndromes	Excluding F54 (Psychological and behavioral factors associated with disorders or diseases classified elsewhere), F55 (Abuse of non-dependence-producing substances)

ICD-10 Code	Description	Notes and Exclusions
F60 -F69	Disorders of adult personality and behavior	Excluding F61 (Mixed and other personality disorders) and F62 (Enduring personality changes, not attributable to brain damage and disease)
F80-F89	Disorders of psychological development	Excluding F83 (Mixed specific developmental disorders)
F90-F98	Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	Excluding F92 (Mixed disorders of conduct and emotions)
F99	Mental disorder, not otherwise specified	
T14.91	Suicide attempt	

Behavioral Health Service Codes

Note: A principal diagnosis of BH from ICD-10 codes above is required for claims to be allocated through the categories below.

Measure Category	Specifications
Inpatient; Facility	Report payer paid and member cost-share amounts across all claims lines when a Facility claim has one or more of the following Revenue codes: (100-219; 1000-1002)
Inpatient; Professional	Report payer paid and member cost-share amounts across all medical claim lines for Professional claims with the following Place of Service codes (21, 31, 32, 34, 51, 55, 56)
Emergency Department / Observation; Facility (no inpatient admission)	Report payer paid and member cost-share amounts across all claim lines for Facility claims with one or more of the following Revenue codes: (450-452; 456, 459; 760 - 762; 769; 981)

Measure Category	Specifications
Emergency Department / Observation; Professional (no inpatient admission; with a behavioral health provider)	Report payer paid and member cost-share amounts for only those claim lines on which a Professional claim has a POS code of 23 <i>and</i> CPT codes in (99217-99220), (99281-99285), or 99234 with a behavioral health provider
Outpatient Professional: Behavioral Health Providers Only	Report payer paid and member cost-share amounts for only those claim lines on which a Professional claim has: POS codes in (02, 03, 04 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 24, 33, 49, 50, 52, 53, 57, 71, 72) <i>and</i> , CPT/HCPCS Codes in (96372; 97530; 97535; 97110-97112; 97803; 98960-98962, 98966-98969; 99078; 99199; 99201-99205; 99211-99215; 99221-99223; 99231-99233; 99238-99239; 99241-99245; 99251-99255; 99291; 99304; 99341-99350; 99354-99359; 99441-99444; 99483-99484; 99487; 99489-99491; 99510; 99534; 99381-99387; 99391-99397; 99510; 99401-99404; 99406-99409; 99411-99412; G0463; G0480-G0483; G0506; G8427; G9004-G9012; T1006; T1012; T1015, T1023, T1027) with a behavioral health provider
Outpatient Professional: Any Provider Type	Report payer paid and member cost-share amounts for only those claim lines when a Professional claim has: POS codes in (02, 03, 04, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 24, 33, 49, 50, 52, 53, 57, 71, 72) <i>and</i> , CPT/HCPCS codes (90785; 90791- 90792; 90832-90840, 90845, 90846, 90847, 90849, 90853, 90863, 90865, 90867-90870, 90875, 90876, 90880, 90882, 90887, 96105, 96110, 96112, 96113, 96116, 96121, 96125, 96127, 96130-96133, 96136-96139; 96146; 99492-99494; G0396, G0397, G0155, G0176, G0177, G0409, G0410, G0411, G0442, G0443, G0451, G0468-G0469-G0470; G0512; G2067-G2080; H0001, H0002, H0004, H0007, H0010-H0020, H0022-H0023, H0031-H0040, H0047; H0049; H0050, H1005, H2000, H2001, H2010-H2020, H2027, H2035, H2036, J0571-J0575, J1230, J2315, J3490, S0109, S0201, S9475, S9480, S9484, S9485)
Outpatient Facility: Behavioral Health Providers Only	Report payer paid and member cost-share amounts across all claim lines when a Facility claim has: Revenue codes in (510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 982, 983, 944, 945) with a behavioral

Measure Category	Specifications
	health provider
Outpatient Facility: Any Provider Type	Report payer paid and member cost-share amounts across all claim lines when a Facility claim has: Revenue codes in (900, 901, 902, 903, 904, 905, 906, 907, 911, 912, 913, 914, 915, 916, 917, 918, 919)

Behavioral Health Provider Types

Provider Type	Practitioner Type
Professional: Physician	Physician - Addiction Specialist
Professional: Physician	Physician - Psychiatrist
Professional: Other	Community Mental Health Center
Professional: Other	Counselor (including LMHC and LADC)
Professional: Other	Early Intervention Agency
Professional: Other	Licensed Social Worker
Professional: Other	Local Education Agency
Professional: Other	Marriage and Family Therapist
Professional: Other	Peer Recovery Specialist
Professional: Other	Nurse practitioner, psychiatric
Professional: Other	Psychiatric Rehabilitation Practitioners
Professional: Other	Psychologist
Professional: Other	Registered Behavior Technician
Professional: Other	Single Specialty Group

Primary Care Service Codes

For claims not identified as Behavioral Health above

Measure Category	Specifications
Office Type Visits	Report payer paid and member cost-share amounts only for claim lines for Professional claims with CPT codes in (96160, 96161, 98966; 98967; 98968; 99078; 99201-99205; 99211-99215; 99234; 99241-99245, 99360, 99366-99368; 99483; G0396-G0397; G0442-G0443; G0466-G0468; G0505; G0511; S9117)
Home/Nursing Facility Visits	Report payer paid and member cost-share amounts only for claim lines for Professional claims with CPT codes in (99324-99328; 99334-99337; 99304-99310, 99315-99316; 99318; 99339-99345; 99347-99350; 99354-99355; 99357-99359; 99374-99378; G0179-G0182)
Preventive Visits	Report payer paid and member cost-share amounts only for claim lines for Professional claims with CPT codes in (11981-11983; 57170; 58300-58301; 90650-90651; 98966-98969; 99173; 99381-99387; 99391-99397; 99401-99404; 99406-99409; 99411-99412; 99420; 99429; 99441-99444; 99446-99449; 99451-99452; 99495-99496; G0101-G0103; G0123; G0202; G0436-G0437; G0473; G0475; G0476; G0513-G0514; Q0091; S0610-S0613; S4981; T2024)
Medicare Visits	Report payer paid and member cost-share amounts only for claim lines for Professional claims with HCPCS codes in (G0008-G0009; G0402; G0438-G0439; G0444; G0463; G0506; G0151; T1015; 99487; 99489; 99490; 99491; 99497; 99498; 99506)
Immunizations and Injections	Report payer paid and member cost-share amounts only for claim lines for Professional claims with CPT codes in (90460-90461; 90471-90474; 90649; 90670; 90658; 90686; 90688; 90715; 90732; 90736; 96372, G0010)
Obstetric Visits	Report payer paid and member cost-share amounts only for claim lines for Professional claims with CPT codes in (59400; 59410; 59425-59426; 59430; 59510; 59515; 59610; 59614; 59618; 59622; 99460-99465)

Primary Care Provider Types

Provider Type	Practitioner Type
Professional: Physician	Physician: Family Medicine
Professional: Physician	Physician: Internal Medicine
Professional: Physician	Physician: General Practice
Professional: Physician	Physician: Pediatrics
Professional: Physician	Physician: Adolescent Medicine
Professional: Physician	Physician, general internal medicine
Professional: Physician	Physician, geriatric medicine
Professional: Physician	Physician, gynecology ⁴
Professional: Physician	Physician, obstetrics and gynecology ⁴
Professional: Physician	Physician, preventive medicine
Professional: Other	Certified clinical nurse specialist
Professional: Other	Federally Qualified Health Center
Professional: Other	Homeopathic medicine
Professional: Other	Naturopathic medicine
Professional: Other	Nurse Practitioner: Adult Health
Professional: Other	Nurse Practitioner: Family
Professional: Other	Nurse Practitioner: Gerontology
Professional: Other	Nurse Practitioner: Pediatrics
Professional: Other	Nurse Practitioner: Primary Care
Professional: Other	Nurse Practitioner: Women's Health
Professional: Other	Nurse Practitioner
Professional: Other	Nurse Practitioner: Obstetrics and gynecology ⁴
Professional: Other	Nurse, non-practitioner
Professional: Other	Physician's assistant
Professional: Other	Physician's assistant, medical
Professional: Other	Primary care clinic

⁴ Services delivered by OB/GYN practitioners may be reported only for procedure codes listed in the Office Type, Preventive, and Obstetric measure categories.

Provider Type	Practitioner Type
Professional: Other	Rural Health Clinic