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| Data Specification Manual |
| 957 CMR 2.00:Payer Reporting of Primary Care and Behavioral Health Expenses |
| **September 8, 2022** |

**Table of Contents**

1. [Summary of Changes](#_bookmark0)
2. [Introduction](#_bookmark1)
3. [File Submission Instructions and Schedule](#_bookmark2)
4. [Data Submission Guidelines](#_bookmark3)
	1. [Overview](#_bookmark4)
	2. [Capturing Substance Use Disorder Spending](#_bookmark5)
	3. [Capturing Telehealth Spending](#_bookmark6)
5. [Data Dictionary](#_bookmark7)
	1. [Field Definitions](#_bookmark8)

[Appendix A:](#_bookmark10) Physician Group OrgID List and Medical Group NPI Crosswalk [Appendix B:](#_bookmark11) Service Categorization Code Lists

[Appendix C:](#_bookmark12) Payment Allocation Methodology [Appendix D:](#_bookmark13) Summary of Code Lists and Coding Logic

## Summary of Changes

* + Updated code lists to capture primary care and behavioral health spending. Behavioral health sections include a service subtype column to differentiate between Behavioral Health (BH) and Substance Use Disorder (SUD)
	+ Updated code lists to add taxonomy codes for both behavioral health and primary care providers
	+ Added a Substance Use Disorder (SUD) aggregate expenditures by insurance category table on the front tab (required for CY2021), please see section 4b of the data specifications manual and the accompanying code list for guidance
	+ Added a supplemental telehealth collection by service category (requested for CY2020, required for CY2021), please see section 4c of the data specifications manual and the accompanying code list for guidance
	+ Moved member months by managing physician group into a separate data tab in the data collection template.

## 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 2021 collection year, payers are required to submit final data for calendar year 2021**. **Payers may resubmit data for calendar year 2020 for run out or nonclaims adjustments.** Files will contain different tabs, including:

* + Front page, including data confirmation and payer comments
	+ Supplemental telehealth collection by service category
	+ Primary Care & Behavioral Health expenses by managing physician group
	+ Member months 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.](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](http://www.chiamass.gov/assets/docs/p/inetuseragreementinsurancecarrier.pdf) and email the completed form to CHIA-DL-Data-Submitter-HelpDesk@chiamass.gov. For technical issues, please email CHIA-DL-Data-Submitter- HelpDesk@chiamass.gov. For additional questions about timelines or data submission requirements, please reach out to Erin Bonney at Erin.Bonney@chiamass.gov.

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

|  |  |
| --- | --- |
| **Date** | **Files Due** |
| October 12, 2022 | * CY 2021 Final PCBH
 |

### Data Validation and Verification

Within the template, Tab E automatically calculates totals with data entered in Tabs C and D. 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. CHIA will compare the totals reported in the PCBH data file and the TME-APM data file to confirm consistency.

## Data Submission Guidelines

### 4a. 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.

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 methodology1
	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

1 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,](https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter175/Section108L) [C. 176A §36,](https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176A/Section36) [C. 176B §23,](https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176B/Section23) [C. 176G §31 ,](https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176G/Section31) and [C. 176J §16.](https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176J/Section16)

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.

### 4b. Capturing Aggregate Spending for Substance Use Disorder Services

For reporting purposes on data tab C, substance use disorder spending continues to be reported within the behavioral health service type. Table A.3 on tab A captures aggregate substance use disorder spending by insurance category. Substance use disorder spending criteria is identified in the code list by the ‘BH or SUD Service Subset’ column on the applicable behavioral health tabs: POS, CPT BH & SUD, and ICD-10 Codes. Substance use disorder spending is identified following the same methodology as capturing behavioral health spending, a primary ICD-10 SUD diagnosis in combination with SUD specific CPT, revenue, DRG, or NDC codes.

### 4c. Capturing Telehealth Spending

The codes listed below are intended to be used as guides and may not be exhaustive of all codes related to telehealth. If additional codes are used by a payer to capture telehealth spending, these codes should be included in calculations for telehealth related spending in PCBH submissions. To ensure all spending related to telehealth is captured, please refer to your organization’s internal methodology.

* Place of Service (POS) code 02
* Modifiers: 93, 95, GT, GQ, G0
* CPT codes: 98966-98972, 99091, 99201-99205, 99211-99215, 99421-99423, 99441-99443, 99453, 99454, 99457, 99458, 99473,

99474

* HCPCS codes: G0071, G0406, G0407, G0408, G0425, G0426, G0427, G0459, G0508, G0509, G2010, G2012, G2025, G2061, G2062, G2063, Q3014, T1014

## Data Dictionary

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Tab** | **Col** | **Data Element Name** | **Type** | **Format** | **Element Submission Guideline** |
| Front Page |  | Payer Name | Text | Text | Name of the Payer. |
| Front Page |  | Payer OrgId | Integer | ######## | This is the Payer’s OrgID. This must match the Submitter’s OrgID. |
| Front Page |  | Submission Year | Date | YYYY | Year in which the file is being submitted. |
| Front Page |  | Reporting Years | 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’. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Tab** | **Col** | **Data Element Name** | **Type** | **Format** | **Element Submission Guideline** |
| 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. |
| Front Page |  | Substance Use Disorder Expenditures | Integer | # | Complete the table with an estimated spending for services related to Substance Use Disorder. Please list the insurance category for which SUD services are reported. |
|  |  |  |  |  |  |
| Supp Telehealth Data | A | Reporting Year | Integer | #### | Year for which data is being reported. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Tab** | **Col** | **Data Element Name** | **Type** | **Format** | **Element Submission Guideline** |
| Supp Telehealth Data | B | Insurance Category | Integer | # | Indicates the insurance category that is being reported:1 = Medicare & Medicare Advantage2 = Medicaid (e.g., MCO, ACO)3 = Commercial: Full-Claim4 = Commercial: Partial-Claim 5= SCO6 = OneCare7 = PACE8 = OtherValue must be an integer between ‘1’ and ‘8’.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. |
| Supp Telehealth Data | C | Service Category | Integer | ## | Specific category of spending. See category descriptions for additional detail and Appendix B for applicable code lists11= BH Inpatient12= BH ED/Observation13= BH Outpatient 21= PC Office Visit22= PC Home/Nursing Facility Visit 23= PC Preventive Visit24= PC Other Primary Care Visit 25= PC Immunization and Injection 26= PC Obstetric Visit31=Other Medical 32= OtherNo negative values. For payers reporting in the “Other” category, payers should reportin the comments field on the front tab what is included in the “Other” category. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Tab** | **Col** | **Data Element Name** | **Type** | **Format** | **Element Submission Guideline** |
| Supp Telehealth Data | D | Telehealth Expenditures | Integer | # | Telehealth expenditures as defined in section 3c. |
|  |  |  |  |  |  |
| Expenditures Data | A | Submission Type | Text | Flag | F = Final |
| Expenditures Data | B | Reporting Year | Integer | #### | Year for which data is being reported. |
| Expenditures 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. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Tab** | **Col** | **Data Element Name** | **Type** | **Format** | **Element Submission Guideline** |
| Expenditures Data | D | Insurance Category | Integer | # | Indicates the insurance category that is being reported:1 = Medicare & Medicare Advantage2 = Medicaid (e.g., MCO, ACO)3 = Commercial: Full-Claim4 = Commercial: Partial-Claim 5= SCO6 = OneCare7 = PACE8 = OtherValue must be an integer between ‘1’ and ‘8’.For payers reporting in the “Other” category, payers should report in the commentsfield on the front tab what is included in the “Other” category. |
| Expenditures Data | E | Product Type | Integer | # | Indicates the product type that is being reported:1= HMO2= PPO3= Indemnity4= Other (e.g. EPO) 5 = POSValue must be an integer between ‘1’ and ‘5’. |
| Expenditures Data | F | PCP Type Indicator | Integer | # | Indicates Primary Care Physician attribution:1 = Members required to select a PCP by plan design2 = Members attributed to a PCP during reporting period pursuant to payer – provider risk contract3 = Members attributed to PCP by payer’s own attribution methodology4 = Members not attributed to a PCPValue must be an integer between ‘1’ and ‘4’. |

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| --- | --- | --- | --- | --- | --- |
| **Tab** | **Col** | **Data Element Name** | **Type** | **Format** | **Element Submission Guideline** |
| Expenditures Data | G | Pediatric Indicator | Integer | # | Indicates if the physician group is a practice in which at least 75% of its patients are children up to the age of 18.0 = No, 1 = YesValue must be either a ‘0’ or ‘1’. |
| Expenditures Data | H | MassHealth Accountable Care Organization (ACO) Indicator | Integer | # | Indicates provider is a MassHealth Accountable Care Organization (ACO). 0 = not an ACO or no Medicaid business, 1= ACOValue must be either a ‘0’ or ‘1’. |
| Expenditures Data | I | Group Insurance Commission (GIC) Indicator | Integer | # | Indicates population in following columns reflects Group Insurance Commission (GIC) contract members.0 = no GIC contract, 1= GIC contractValue must be either a ‘0’ or ‘1’. |
| Expenditures Data | J | Service Type | Integer | # | Type of Service1= Behavioral Health2= Primary Care3= All Other ServicesNo negative values. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Tab** | **Col** | **Data Element Name** | **Type** | **Format** | **Element Submission Guideline** |
| Expenditures Data | K | Spending Service Category | Integer | ## | Specific category of spending. See category descriptions for additional detail and Appendix B for applicable code lists11= BH Inpatient12= BH ED/Observation13= BH Outpatient14= BH Prescription Drugs 21= PC Office Visit22= PC Home/Nursing Facility Visit 23= PC Preventive Visit24= PC Other Primary Care Visit 25= PC Immunization and Injection 26= PC Obstetric Visit31=Other Medical 32= Other33= Other Prescription Drugs41= Non-Claims: Incentive Payments 42= Non-Claims: Capitation43= Non-Claims: Risk Settlements 44= Non-Claims: Care Management 45= Non-Claims: OtherNo negative values. 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. |
| Expenditures Data | L | Provider Type | Integer | # | Type of Provider rendering services reflected in columns K and L. See provider descriptions for additional detail, and Appendix B for specific code sets1= Facility2= Professional: Physician3= Professional: Other4= No ProviderNo negative values. |

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| **Tab** | **Col** | **Data Element Name** | **Type** | **Format** | **Element Submission Guideline** |
| Expenditures Data | M | 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-NNo negative values for claims-based expenses. Negative values allowed for non-claims spending service categories only. |
| Expenditures Data | N | 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-NNo negative values. |
|  |  |  |  |  |  |
| Member Months Data | A | Submission Type | Text | Flag | F = Final |
| Member Months Data | B | Reporting Year | Integer | #### | Year for which data is being reported. |
| Member Months 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. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Tab** | **Col** | **Data Element Name** | **Type** | **Format** | **Element Submission Guideline** |
| Member Months Data | D | Insurance Category | Integer | # | Indicates the insurance category that is being reported:1 = Medicare & Medicare Advantage2 = Medicaid (e.g., MCO, ACO)3 = Commercial: Full-Claim4 = Commercial: Partial-Claim 5= SCO6 = OneCare7 = PACE8 = OtherValue must be an integer between ‘1’ and ‘8’.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. |
| Member Months Data | E | Product Type | Integer | # | Indicates the product type that is being reported:1= HMO2= PPO3= Indemnity4= Other (e.g. EPO) 5 = POSValue must be an integer between ‘1’ and ‘5’. |
| Member Months Data | F | PCP Type Indicator | Integer | # | Indicates Primary Care Physician attribution:1 = Members required to select a PCP by plan design2 = Members attributed to a PCP during reporting period pursuant to payer – provider risk contract3 = Members attributed to PCP by payer’s own attribution methodology4 = Members not attributed to a PCPValue must be an integer between ‘1’ and ‘4’. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Tab** | **Col** | **Data Element Name** | **Type** | **Format** | **Element Submission Guideline** |
| Member Months Data | G | Pediatric Indicator | Integer | # | Indicates if the physician group is a practice in which at least 75% of its patients are children up to the age of 18.0 = No, 1 = YesValue must be either a ‘0’ or ‘1’. |
| Member Months Data | H | MassHealth Accountable Care Organization (ACO) Indicator | Integer | # | Indicates provider is a MassHealth Accountable Care Organization (ACO). 0 = not an ACO or no Medicaid business, 1= ACOValue must be either a ‘0’ or ‘1’. |
| Member Months Data | I | Group Insurance Commission (GIC) Indicator | Integer | # | Indicates population in following columns reflects Group Insurance Commission (GIC) contract members.0 = no GIC contract, 1= GIC contractValue must be either a ‘0’ or ‘1’. |
| Member Months Data | J | Member Months | Integer | ######### | The number of members participating in a plan over a specified period of time expressed in months of membership.No negative values. |
| Member Months Data | K | BH Member Months | Integer | ######### | 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.No negative values. |
|  |  |  |  |  |  |
| Summary | - | No payer data entry needed | - | - | The summary tab will automatically populate with data from data entry for Expenditures Data and Member Months Data. Please review this tab prior to submitting data to CHIA to confirm that totals and trends are correct. |

5a. Field Definitions

### Tab A: Front Page Table A.1: File Overview

* 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., 2021)
* Reporting Year: Year for which Primary Care & Behavioral Health data is being reported (e.g., 2021)
* Claims Paid Through Date: Date for which Primary Care & Behavioral Health claims data is paid through.

### Table A.2: Additional Data Confirmation

* 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.

### Table A.3: Aggregate Substance Use Disorder Expenditures by Insurance Category

For each Calendar Year, complete table with an estimated total spending for Substance Use Disorder services, as outlined in section 4b and as defined in the accompanying code list. Please list the insurance category in which SUD services are reported.

### Tab B: Supplemental Telehealth Data

* Reporting Year: Indicates the year for which the data is being reported.
* Insurance Category: A number that indicates the insurance category being reported.

|  |  |
| --- | --- |
| **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 |

* Service Category: A number that indicates the service category being reported.

|  |  |
| --- | --- |
| **Service Category****Code** | **Service Category Definition** |
| 11 | BH Inpatient |
| 12 | BH Emergency Department-Observation |
| 13 | BH Outpatient |
| 21 | Office Type Visits |
| 22 | Home-Nursing Facility Visits |
| 23 | Preventive Visits |
| 24 | Other Primary Care Visits |
| 25 | Immunizations and Injections |
| 26 | Obstetric Visits |
| 31 | Other Medical |
| 32 | Other |

* Telehealth Expenditures: Telehealth expenditures as defined in section 3c.

### Tab C: Expenditures Data Tab

* Submission Type: Indicates that the file contains 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.

|  |  |
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| **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 topayer-provider risk contract |
| 3 | Data for members who are attributed to a PCP by payer’s own attributionmethodology |
| 4 | Data for members who are not attributed to a PCP |

* 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

|  |  |
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| **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.

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| **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 |

**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 |
| 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 |

|  |  |
| --- | --- |
| **Service Category****Code** | **Service Category Definition** |
| 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 Visits2:** All payments made for the professional components of routine obstetric care, as well as OB/GYN evaluation and management services.

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

* **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 |
| 23 | Preventive Visits |
| 24 | Other Primary Care Visits |
| 25 | Immunizations and Injections |
| 26 | Obstetric Visits |
| 41 | Non-Claims: Incentive Programs |
| 42 | Non-Claims: Capitation |

|  |  |
| --- | --- |
| **Service Category****Code** | **Service Category Definition** |
| 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, dieticians, 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.

### Tab D: Member Months Data Tab

* Submission Type: Indicates that the file contains 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 topayer-provider risk contract |
| 3 | Data for members who are attributed to a PCP by payer’s own attributionmethodology |
| 4 | Data for members who are not attributed to a PCP |

* 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.
* 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.

# Appendix A: Physician Group OrgIDs

Please visit: [https://www.chiamass.gov/payer-data-reporting-primary-and-behavioral-health-care-](https://www.chiamass.gov/payer-data-reporting-primary-and-behavioral-health-care-expenditures) [expenditures](https://www.chiamass.gov/payer-data-reporting-primary-and-behavioral-health-care-expenditures)

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-material](http://chiamass.gov/reference-materials)s

Payers should use these lists as reference tables **in conjuction with the metholodogy 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 in excel reference file*

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



BH Inpatient

BH ED/Observation

BH Outpatient

*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/Nursing Facility Visit

PC Preventive Visit

PC Other Primary Care Visit

PC Immunization and Injection

PC Obstetric Visit



.

Other Medical

Other

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



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](#_bookmark9).

**Behavioral Health Diagnosis Codes**

|  |  |  |
| --- | --- | --- |
| **ICD-10 Code** | **Description** | **Notes and Exclusions** |
| **F0150 - F09** | Mental Disorders Due to Known Physiological Conditions | Only include codes listed in the ICD-10 DX Codes tab in the excel reference file. |
| **F1010 – F1999** | Mental and Behavioral Disorders due to Psychoactive Substance Abuse | Only include codes listed in the ICD-10 DX Codes tab in the excel reference file. |
| **F200 - F29** | Schizophrenia, Schizotypal, Delusional and Other Non-Mood Psychotic Disorder | Only include codes listed in the ICD-10 DX Codes tab in the excel reference file. |
| **F30010 – F39** | Mood [Affective] Disorders | Only include codes listed in the ICD-10 DX Codes tab in the excel reference file.Excluding F38 Other mood [affective] disorders |
| **F4000 - F489** | Anxiety, Dissociative, Stress-Related, Somatoform and Other Nonpsychotic Mental Disorders | Only include codes listed in the ICD-10 DX Codes tab in the excel reference file. |
| **F5000 - F59** | Behavioral Syndromes Associated with Physiological Disturbances and Physical Factors | Only include codes listed in the ICD-10 DX Codes tab in the excel reference file.Excluding F54 (Psychological and behavioral factors associated with disorders or diseases classified elsewhere), F55 (Abuse of non-dependence-producing substances) |
| **F60 -F69** | Disorders of Adult Personality and Behavior | Only include codes listed in the ICD-10 DX Codes tab in the excel reference file. |

|  |  |  |
| --- | --- | --- |
| **ICD-10 Code** | **Description** | **Notes and Exclusions** |
|  |  | Excluding F61 (Mixed and other personality disorders) and F62 (Enduring personality changes,not attributable to brain damage and disease) |
| **F800 - F89** | Pervasive and Specific Developmental Disorders | Only include codes listed in the ICD-10 DX Codes tab in the excel reference file.Excluding F83 (Mixed specific developmentaldisorders) |
| **F90 - F98** | Behavioral and Emotional Disorders with Onset Usually Occurring in Childhood and Adolescence | Only include codes listed in the ICD-10 DX Codes tab in the excel reference file.Excluding F92 (Mixed disorders of conduct and emotions) |
| **F99** | Unspecified Mental Disorder | Only include codes listed in the ICD-10 DX Codes tab in the excel reference file. |
| **R45851; R4588** | Suicidal ideations & Nonsuicidal self-harm | Only include codes listed in the ICD-10 DX Codes tab in the excel reference file. |
| **T149** | Injury of Unspecified Body Region | Includes T14.91XA, T14.91XD, T14.91XS onlyOnly include codes listed in the ICD-10 DX Codes tab in the excel reference file. |
| **T400X1S – T887XXS** | Injury, Poisoning and Certain Other Consequences of External Causes | Only include codes listed in the ICD-10 DX Codes tab in the excel reference file. |

**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: (1000 - 1006) |
| **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 (02, 21, 31, 32, 35,51, 54, 55, 56, 61) *and* CPT codes in (99221-99223, 99231-99233, 99234-99236, 99238-99239, 99251-99255, 99356-99357, G0425-G0427, G0459) |
| **Emergency Department / Observation; Facility** (no inpatient admission) | Report payer paid and member cost-share amounts across all claim lines forFacility claims with one or more of the following Revenue codes: (0450-0452, 0456, 0459, 0760-0762, 0769, 0981) |
| **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 *and* CPT codes in (99217-99220, 99224-99226, 99234-99236, 99281-99285, 99291-99292, 99356-99357, G0425-G0427, G0378-G0384, G0427, G2213 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, 06, 07, 08, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20,22, 24, 33, 49, 50, 52, 53, 57, 58, 71, 72, 99) *and*, CPT/HCPCS Codes in (90901,90912-90913, 99201-992015, 99211-99215, 99241-99245, 99304-99310, 99315-99316, 99318, 99324-99328, 99334-99337, 99339-99345, 99347-993350, 99354-993355, 99358-99359, 99366-99368, 99374-99375, 99378-99387, 99391-99397,99401-99404, 99406-99407, 99411-99412, 99415-99417, 99421-99423, 99441-99444, 99446-99449, 99451-99452, 99483-99484, 99487, 99489, 99490, 99439,99491, 99495-99496, 99510, 99605-99607, 96372-96376, 96379, 97110, 97112,97530, 97535, 97537, 97802-97804, 97810-97811, 97813, 98960-98962, 98966-98972, 99050-99051, 99053, 99056, 99058, 99060, 99078, 99199, G0071, G0076- G0087, G0156, G0162, G0270-G0721, G0299-G0300, G0406-G0408, G0442, G0444, G0451, G0463, G0480-G0483, G0490, G0506, G0513-G0514, G2001- G2015, G2021, G2058, G2061-G2605, G2211-G2212, G2250-G2252, G8427 G9001-G9012, G9016, G9475, G9477-G9478, G9685, G9978-G9986, H0033- H0034, H0038-H0040, H2000-H2001, H2010, H2014-H2016, H2023-H2026, H2028-H2029, H2032-H2033, T100-T1005, T1015-T1021, T1023-T1028, T1502-T1503, T2024) with a behavioral health provider |

|  |  |
| --- | --- |
| **Measure Category** | **Specifications** |
| **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, 06, 07, 08, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20,22, 24, 33, 49, 50, 52, 53, 57, 71, 72, 99) *and*, CPT/HCPCS codes (99408-99409,99492-99494, 90785, 90791-90792, 90832-90840, 90845-90847, 90849, 90853,90863, 90865, 90867-90870, 90875-90876, 90880, 90882, 90885, 90887, 90899,96105, 96125, 96127, 96116, 96121, 96130-96133, 96136-96139, 96146, 96156,96158-96159, 96164-96165, 96167-96168, 96170-96171, 96160-96161, 97129,97151-97158, G0155, G0176-G0177, G0396-G0397, G0409-G0411, G0443, G0468-G0470, G0473, G0511-G0512, G2011, G2067-G2080, G2082-G2083, G2086-G2088, G2214, H0001-H0029) |
| **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 (0500, 0509, 0510, 0511, 0512, 0513, 0514, 0515, 0516, 0517,0519, 0520, 0521, 0522, 0523, 0525, 0526, 0527, 0528, 0529, 0780, 0790, 0940,0941, 0942, 0943, 0944, 0945, 0946, 0947, 0948, 0949, 0951, 0952, 0953, 0960,0961, 0962, 0964, 0969, 0982, 0983, 0984, 0985, 0986, 0987, 0988, 0989, 2100,2101, 2102, 2103, 2104, 2105, 2106, 2109, 3101, 3102, 3103, 3104, 3105, 3106 )with a behavioral 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 (0900, 0901, 0902, 0903, 0904, 0905, 0906, 0907, 0911, 0912,0913, 0914, 0915, 0916, 0917, 0918, 0919) |

**Behavioral Health Provider Types**

|  |  |  |
| --- | --- | --- |
| **Taxonomy** | **Practitioner Type** | **Provider Type** |
| **101YA0400X** | Addiction (Substance Use Disorder) Counselor | Professional: Other |
| **103TA0400X** | Addiction (Substance Use Disorder) Psychologist | Professional: Other |
| **163WA0400X** | Addiction (Substance Use Disorder) Registered Nurse | Professional: Other |

|  |  |  |
| --- | --- | --- |
| **Taxonomy** | **Practitioner Type** | **Provider Type** |
| **207LA0401X** | Addiction Medicine (Anesthesiology) Physician | Professional: Physician |
| **207QA0401X** | Addiction Medicine (Family Medicine) Physician | Professional: Physician |
| **207RA0401X** | Addiction Medicine (Internal Medicine) Physician | Professional: Physician |
| **2083A0300X** | Addiction Medicine (Preventive Medicine) Physician | Professional: Physician |
| **2084A0401X** | Addiction Medicine (Psychiatry & Neurology) Physician | Professional: Physician |
| **2084P0802X** | Addiction Psychiatry Physician | Professional: Physician |
| **261QM0855X** | Adolescent and Children Mental Health Clinic/Center | Facility |
| **103TA0700X** | Adult Development & Aging Psychologist | Professional: Other |
| **261QM0850X** | Adult Mental Health Clinic/Center | Facility |
| **364SP0809X** | Adult Psychiatric/Mental Health Clinical Nurse Specialist | Professional: Other |
| **163WP0809X** | Adult Psychiatric/Mental Health Registered Nurse | Professional: Other |
| **106E00000X** | Assistant Behavior Analyst | Professional: Other |
| **3104A0630X** | Assisted Living Facility (Behavioral Disturbances) | Facility |
| **103K00000X** | Behavior Analyst | Professional: Other |
| **106S00000X** | Behavior Technician | Professional: Other |
| **2084B0040X** | Behavioral Neurology & Neuropsychiatry Physician | Professional: Physician |
| **171M00000X** | Case Manager/Care Coordinator | Professional: Other |
| **364SP0807X** | Child & Adolescent Psychiatric/Mental Health Clinical Nurse Specialist | Professional: Other |
| **163WP0807X** | Child & Adolescent Psychiatric/Mental Health Registered Nurse | Professional: Other |
| **2084P0804X** | Child & Adolescent Psychiatry Physician | Facility |
| **364SP0810X** | Child & Family Psychiatric/Mental Health Clinical Nurse Specialist | Professional: Other |
| **385HR2055X** | Child Mental Illness Respite Care | Facility |
| **3245S0500X** | Children's Substance Abuse Rehabilitation Facility | Facility |
| **364SP0811X** | Chronically Ill Psychiatric/Mental Health Clinical Nurse Specialist | Professional: Other |
| **103TC2200X** | Clinical Child & Adolescent Psychologist | Professional: Other |
| **103G00000X** | Clinical Neuropsychologist | Professional: Other |
| **103TC0700X** | Clinical Psychologist | Professional: Other |
| **1041C0700X** | Clinical Social Worker | Professional: Other |
| **103TB0200X** | Cognitive & Behavioral Psychologist | Professional: Other |
| **364SP0812X** | Community Psychiatric/Mental Health Clinical Nurse Specialist | Professional: Other |

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| --- | --- | --- |
| **Taxonomy** | **Practitioner Type** | **Provider Type** |
| **251S00000X** | Community/Behavioral Health Agency | Facility |
| **103TC1900X** | Counseling Psychologist | Professional: Other |
| **101Y00000X** | Counselor | Professional: Other |
| **2080P0006X** | Developmental - Behavioral Pediatrics Physician | Professional: Physician |
| **252Y00000X** | Early Intervention Provider Agency | Facility |
| **322D00000X** | Emotionally Disturbed Children's' Residential Treatment Facility | Facility |
| **103TF0000X** | Family Psychologist | Professional: Other |
| **2084P0805X** | Geriatric Psychiatry Physician | Professional: Physician |
| **364SP0813X** | Geropsychiatric Psychiatric/Mental Health Clinical Nurse Specialist | Professional: Other |
| **103TP2701X** | Group Psychotherapy Psychologist | Professional: Other |
| **103TH0004X** | Health Psychologist | Professional: Other |
| **103TH0100X** | Health Service Psychologist | Professional: Other |
| **167G00000X** | Licensed Psychiatric Technician | Professional: Other |
| **106H00000X** | Marriage & Family Therapist | Professional: Other |
| **261QM0801X** | Mental Health Clinic/Center (Including Community Mental Health Center) | Facility |
| **101YM0800X** | Mental Health Counselor | Professional: Other |
| **320800000X** | Mental Illness Community Based Residential Treatment Facility | Facility |
| **310500000X** | Mental Illness Intermediate Care Facility | Facility |
| **261QM2800X** | Methadone Clinic | Facility |
| **101YP1600X** | Pastoral Counselor | Professional: Other |
| **175T00000X** | Peer Specialist | Professional: Other |
| **103TP0016X** | Prescribing (Medical) Psychologist | Professional: Other |
| **101YP2500X** | Professional Counselor | Professional: Other |
| **283Q00000X** | Psychiatric Hospital | Facility |
| **273R00000X** | Psychiatric Hospital Unit | Facility |
| **323P00000X** | Psychiatric Residential Treatment Facility | Facility |
| **364SP0808X** | Psychiatric/Mental Health Clinical Nurse Specialist | Professional: Other |
| **363LP0808X** | Psychiatric/Mental Health Nurse Practitioner | Professional: Other |
| **163WP0808X** | Psychiatric/Mental Health Registered Nurse | Professional: Other |
| **2084P0800X** | Psychiatry Physician | Professional: Physician |

|  |  |  |
| --- | --- | --- |
| **Taxonomy** | **Practitioner Type** | **Provider Type** |
| **103TP0814X** | Psychoanalysis Psychologist | Professional: Other |
| **102L00000X** | Psychoanalyst | Professional: Other |
| **103T00000X** | Psychologist | Professional: Other |
| **2084P0015X** | Psychosomatic Medicine Physician | Professional: Physician |
| **261QR0800X** | Recovery Care Clinic/Center | Facility |
| **103TR0400X** | Rehabilitation Psychologist | Professional: Other |
| **104100000X** | Social Worker | Professional: Other |
| **324500000X** | Substance Abuse Rehabilitation Facility | Facility |
| **261QR0405X** | Substance Use Disorder Rehabilitation Clinic/Center | Facility |
| **276400000X** | Substance Use Disorder Rehabilitation Hospital Unit | Facility |

**Primary Care Service Codes**

*For claims not identified as Behavioral Health above*

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| **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 (99201-99205, 99211-99215, 99241-99245, 99354-9935, 99358-99359, 99421-99423, 99441-99444, 99446-99449,99451-99454, 99473, 99457-99458, 99474, 99483, 99487, 99489-99491,99495-99498, 96110, 96112-96113, 96160-96161, 96372-96374, 98960-98962,98966-98969, 99050-99051, 99056, 99058, 99078, 99173, 99366-99368,99374-99375, 99377-99380, G0396-G0397, G0463, G0473, G0506, G2010,G2064-G2065, S9117) with a primary care provider |
| **Home/Nursing Facility Visits** | Report payer paid and member cost-share amounts only for claim lines for Professional claims with CPT codes in (99304-99310, 99315-99316, 99318,99324-99328, 99334-99337, 99339-99345, 99347-99350, 99502, 99506,G0179-G0182) with a primary care provider |

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| **Measure Category** | **Specifications** |
| **Preventive Visits** | Report payer paid and member cost-share amounts only for claim lines for Professional claims with CPT codes in (11976, 11981-11983; 57170; 58300-58301; 99173; 99381-99387; 99391-99397; 99401-99404; 99406-99409;99411-99412; 99429; G0473; Q0091; S0610; S0612-S0613; S4981) with aprimary care provider |
| **Immunizations and Injections** | Report payer paid and member cost-share amounts only for claim lines for Professional claims with CPT codes in (90281; 90283-90284; 90287-90288;90291; 90296; 90371; 90375-90378; 90384-90386; 90389; 90393; 90396;90399; 90460-90461; 90471-90474; 90746-90477; 90581; 90585-90587;90619-90621; 90625; 90630; 90632; 90633-90634; 90636; 90644; 90647;90648-90651; 90653-90658; 90660-90662; 90664; 90666-90668; 90670;90672-90676; 90680-90682; 90685-90691; 90694; 90696-90698; 90700; 90702;90707; 90710; 90713-90717; 90723; 90732-90734; 90736; 90738-90740;90743-90744; 90745-90750; 90756; G008-G0010; Q2034-Q2039) with aprimary care provider |
| **Obstetric Visits** | Report payer paid and member cost-share amounts only for claim lines for Professional claims with CPT codes in (59400; 59409-59410; 59425-59426;59430; 59510; 59515; 59610; 59614-59515; 59610; 59612; 59614;59618;59620; 59622; 99460-99465) with a primary care provider |
| **Other Primary Care Visits** | Report payer paid and member cost-share amounts only for claim lines for Professional claims with HCPCS codes in (G0101-G0106; G0117-G0118; G0120- G0124; G0141; G0143-G0145; G0147-G0148; G0327-G0328; G0402-G0405; G0433; G0435; G0438-G0439; G0442-G0444; G0447; G0466-G0468; G0472; G0475-G0476; G0499; G0511; G0513-G0514; T1015; T2024) with a primarycare provider |

**Primary Care Provider Types**

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| **Taxonomy** | **Practitioner Type** | **Provider Type** |
| **207QA0000X** | Adolescent Medicine (Family Medicine) Physician | Professional: Physician |
| **207RA0000X** | Adolescent Medicine (Internal Medicine) Physician | Professional: Physician |
| **364SA2200X** | Adult Health Clinical Nurse Specialist | Professional: Other |
| **363LA2200X** | Adult Health Nurse Practitioner | Professional: Other |
| **207QA0505X** | Adult Medicine Physician | Professional: Physician |
| **367A00000X** | Advanced Practice Midwife[1] | Professional: Other |
| **261QB0400X** | Birthing Clinic/Center[1] | Professional: Other |
| **364S00000X** | Clinical Nurse Specialist | Professional: Other |
| **261QC1500X** | Community Health Clinic/Center | Professional: Other |
| **363LC1500X** | Community Health Nurse Practitioner | Professional: Other |
| **163WC1500X** | Community Health Registered Nurse | Professional: Other |
| **364SC1501X** | Community Health/Public Health Clinical Nurse Specialist | Professional: Other |
| **282NC0060X** | Critical Access Hospital | Professional: Other |
| **261QC0050X** | Critical Access Hospital Clinic/Center | Professional: Other |
| **207Q00000X** | Family Medicine Physician | Professional: Physician |
| **363LF0000X** | Family Nurse Practitioner | Professional: Other |
| **261QP0904X** | Federal Public Health Clinic/Center | Professional: Other |
| **261QF0400X** | Federally Qualified Health Center (FQHC) | Professional: Other |
| **208D00000X** | General Practice Physician | Professional: Physician |
| **163WG0000X** | General Practice Registered Nurse | Professional: Other |
| **207QG0300X** | Geriatric Medicine (Family Medicine) Physician | Professional: Physician |
| **207RG0300X** | Geriatric Medicine (Internal Medicine) Physician | Professional: Physician |
| **363LG0600X** | Gerontology Nurse Practitioner | Professional: Other |
| **207VG0400X** | Gynecology Physician[1] | Professional: Physician |
| **207R00000X** | Internal Medicine Physician | Professional: Physician |
| **363AM0700X** | Medical Physician Assistant | Professional: Other |
| **176B00000X** | Midwife[1] | Professional: Other |
| **363L00000X** | Nurse Practitioner | Professional: Other |
| **363LX0001X** | Obstetrics & Gynecology Nurse Practitioner[1] | Professional: Other |
| **207V00000X** | Obstetrics & Gynecology Physician[1] | Professional: Physician |

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| **Taxonomy** | **Practitioner Type** | **Provider Type** |
| **207VX0000X** | Obstetrics Physician[1] | Professional: Physician |
| **2080A0000X** | Pediatric Adolescent Medicine Physician | Professional: Physician |
| **364SP0200X** | Pediatric Clinical Nurse Specialist | Professional: Other |
| **363LP0200X** | Pediatric Nurse Practitioner | Professional: Other |
| **208000000X** | Pediatrics Physician | Professional: Physician |
| **261QP2300X** | Primary Care Clinic/Center | Professional: Other |
| **363LP2300X** | Primary Care Nurse Practitioner | Professional: Other |
| **163W00000X** | Registered Nurse | Professional: Other |
| **282NR1301X** | Rural Acute Care Hospital | Professional: Other |
| **261QR1300X** | Rural Health Clinic/Center | Professional: Other |
| **261QP0905X** | State or Local Public Health Clinic/Center | Professional: Other |
| **364SW0102X** | Women's Health Clinical Nurse Specialist | Professional: Other |
| **363LW0102X** | Women's Health Nurse Practitioner | Professional: Other |