COMMONWEALTH OF MASSACHUSETTS ~ STANDARD CONTRACT FORM

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CONTRACTOR LEGAL NAME: Tufts Health Public Plans, Inc. **(and d/b/a):**		**COMMONWEALTH DEPARTMENT NAME:** Executive Office of Health and Human Services **MMARS Department Code:** EHS	
Legal Address: (W-9, W-4): 1 Wellness Way, Canton, MA, 02021		**Business Mailing Address:** One Ashburton Place, 11th Fl., Boston, MA 02108	
Contract Manager: Ashley Hague	**Phone:** 617-972-9400 x87089	**Billing Address (if different):**	
E-Mail: Ashley_Hague@tufts-health.com	**Fax:**	**Contract Manager:** Alejandro Garcia Davalos	**Phone:** 617-838-3344
Contractor Vendor Code: VC0000577707		**E-Mail:** Alejandro.E.GarciaDavalos@mass.gov	**Fax:**
Vendor Code Address ID (e.g., "AD001"): AD002. **(Note: The Address ID must be set up for EFT payments.)**		**MMARS Doc ID(s):** N/A	
		RFR/Procurement or Other ID Number: BD-17-1039-EHS01-EHS01-00000009207	

☐ **NEW CONTRACT**

PROCUREMENT OR EXCEPTION TYPE: (Check one option only)

☐ **Statewide Contract** (OSD or an OSD-designated Department)
☐ **Collective Purchase** (Attach OSD approval, scope, budget)
☐ **Department Procurement** (includes all Grants - 815 CMR 2.00) (Solicitation Notice or RFR, and Response or other procurement supporting documentation)
☐ **Emergency Contract** (Attach justification for emergency, scope, budget)
☐ **Contract Employee** (Attach Employment Status Form, scope, budget)
☐ **Other Procurement Exception** (Attach authorizing language, legislation with specific exemption or earmark, and exception justification, scope and budget)

☒ **CONTRACT AMENDMENT**

Enter **Current Contract End Date *Prior*** to Amendment: **December 31, 2022.**
Enter **Amendment Amount**: $ no change. (or "no change")

AMENDMENT TYPE: (Check one option only. Attach details of amendment changes.)

☒ **Amendment to Date, Scope or Budget** (Attach updated scope and budget)
☐ **Interim Contract** (Attach justification for Interim Contract and updated scope/budget)
☐ **Contract Employee** (Attach any updates to scope or budget)
☐ **Other Procurement Exception** (Attach authorizing language/justification and updated scope and budget)

The Standard Contract Form Instructions and Contractor Certifications and the following Commonwealth Terms and Conditions document are incorporated by reference into this Contract and are legally binding: (Check ONE option): ☒ Commonwealth Terms and Conditions ☐ Commonwealth Terms and Conditions For Human and Social Services ☐ Commonwealth IT Terms and Conditions

COMPENSATION: (Check ONE option): The Department certifies that payments for authorized performance accepted in accordance with the terms of this Contract will be supported in the state accounting system by sufficient appropriations or other non-appropriated funds, subject to intercept for Commonwealth owed debts under 815 CMR 9.00.
☒ **Rate Contract.** (No Maximum Obligation) Attach details of all rates, units, calculations, conditions or terms and any changes if rates or terms are being amended.)
☐ **Maximum Obligation Contract.** Enter total maximum obligation for total duration of this contract (or ***new*** total if Contract is being amended). $_____.

PROMPT PAYMENT DISCOUNTS (PPD): Commonwealth payments are issued through EFT 45 days from invoice receipt. Contractors requesting **accelerated** payments must identify a PPD as follows: Payment issued within 10 days _____% PPD; Payment issued within 15 days _____ % PPD; Payment issued within 20 days _____ % PPD; Payment issued within 30 days _____% PPD. If PPD percentages are left blank, identify reason: ☒ agree to standard 45 day cycle ☐ statutory/legal or Ready Payments (M.G.L. c. 29, § 23A); ☐ only initial payment (subsequent payments scheduled to support standard EFT 45 day payment cycle. See Prompt Pay Discounts Policy.)

BRIEF DESCRIPTION OF CONTRACT PERFORMANCE or REASON FOR AMENDMENT: (Enter the Contract title, purpose, fiscal year(s) and a detailed description of the scope of performance or what is being amended for a Contract Amendment. Attach all supporting documentation and justifications.)

This **Amendment 2 to the Fourth Amended and Restated ACPP Contract** with Boston Children's Health Accountable Care Organization in partnership with Tufts Health Public Plans incorporates policy and fiscal updates to the Contract effective January 1, 2022.

ANTICIPATED START DATE: (Complete ONE option only) The Department and Contractor certify for this Contract, or Contract Amendment, that Contract obligations:

☐ 1. may be incurred as of the Effective Date (latest signature date below) and **no** obligations have been incurred **prior** to the Effective Date.
☐ 2. may be incurred as of _____, a date **LATER** than the Effective Date below and **no** obligations have been incurred **prior** to the Effective Date.
☒ 3. were incurred as of **January 1, 2022,** a date **PRIOR** to the Effective Date below, and the parties agree that payments for any obligations incurred prior to the Effective Date are authorized to be made either as settlement payments or as authorized reimbursement payments, and that the details and circumstances of all obligations under this Contract are attached and incorporated into this Contract. Acceptance of payments forever releases the Commonwealth from further claims related to these obligations.

CONTRACT END DATE: Contract performance shall terminate as of **December 31, 2022,** with no new obligations being incurred after this date unless the Contract is properly amended, provided that the terms of this Contract and performance expectations and obligations shall survive its termination for the purpose of resolving any claim or dispute, for completing any negotiated terms and warranties, to allow any close out or transition performance, reporting, invoicing or final payments, or during any lapse between amendments.

CERTIFICATIONS: Notwithstanding verbal or other representations by the parties, the **"Effective Date"** of this Contract or Amendment shall be the latest date that this Contract or Amendment has been executed by an authorized signatory of the Contractor, the Department, or a later Contract or Amendment Start Date specified above, subject to any required approvals. The Contractor certifies that they have accessed and reviewed all documents incorporated by reference as electronically published and the Contractor makes all certifications required under the Standard Contract Form Instructions and Contractor Certifications under the pains and penalties of perjury, and further agrees to provide any required documentation upon request to support compliance, and agrees that all terms governing performance of this Contract and doing business in Massachusetts are attached or incorporated by reference herein according to the following hierarchy of document precedence, the applicable Commonwealth Terms and Conditions, this Standard Contract Form, the Standard Contract Form Instructions and Contractor Certifications, the Request for Response (RFR) or other solicitation, the Contractor's Response (excluding any language stricken by a Department as unacceptable, and additional negotiated terms, provided that additional negotiated terms will take precedence over the relevant terms in the RFR and the Contractor's Response only if made using the process outlined in 801 CMR 21.07, incorporated herein, provided that any amended RFR or Response terms result in best value, lower costs, or a more cost effective Contract.

AUTHORIZING SIGNATURE FOR THE CONTRACTOR:

X: Philip Barr. Date: 10/3/2022.
DocuSigned by: Philip Barr EA40C8E74208455...
(Signature and Date Must Be Captured At Time of Signature)
Print Name: Philip Barr.
Print Title: President, Markets.

AUTHORIZING SIGNATURE FOR THE COMMONWEALTH:

X: Amanda Cassel Kraft. Date: 10/13/2022.
Amanda Cassel Kraft (Oct 13, 2022 17:21 EDT)
(Signature and Date Must Be Captured At Time of Signature)
Print Name: Amanda Cassel Kraft.
Print Title: Assistant Secretary for MassHealth.

AMENDMENT #2

TO THE

FOURTH AMENDED AND RESTATED

ACCOUNTABLE CARE PARTNERSHIP PLAN CONTRACT

FOR THE

ACCOUNTABLE CARE ORGANIZATION PROGRAM

WHEREAS, the Executive Office of Health and Human Services ("EOHHS") and the Contractor identified in **Appendix X** ("Contractor") entered into the Contract effective August 25, 2017, and with an Operational Start Date of March 1, 2018, to improve the MassHealth Member experience of care, health of the population, and efficiency of the MassHealth program by substantially shifting towards accountable and integrated models of care and to provide comprehensive health care coverage to MassHealth Members; and

WHEREAS, EOHHS and the Contractor amended and restated the Contract effective January 1, 2022, (the Fourth Amended and Restated Accountable Care Partnership Plan Contract), and further amended the Contract through Amendment #1;

WHEREAS, in accordance with **Section 6.8** of the Contract, EOHHS and the Contractor desire to further amend the Contract effective January 1, 2022; and

WHEREAS, EOHHS and the Contractor agree that the terms stated herein are subject to all required approvals of the federal Centers for Medicare and Medicaid Services (CMS);

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein, the Contractor and EOHHS agree as follows:

1. **Section 1, Definitions**, is hereby amended by adding the following definition in alphabetical order:

   Behavioral Health Urgent Care – the delivery of same-day or next-day appointments for evaluation or assessment for new clients and urgent appointments for existing clients; psychopharmacology appointments and Medication Assisted Treatment (MAT) within a timeframe defined by EOHHS; all other treatment appointments within 14 calendar days; and extended availability outside of weekday hours between 9am and 5pm, as specified by EOHHS by certain Mental Health Centers (MHC), approved by the Contractor as Behavioral Health Urgent Care Providers, as specified by EOHHS.

2. **Section 2.6.B.1.c** is hereby amended by adding a new **Section 2.6.B.1.c.10** as follows:

"10) As further directed by EOHHS, the Contractor shall establish policies to prevent Enrollees from paying pharmacies out-of-pocket for medications, including medications reported to the Massachusetts Prescription Awareness tool (MassPAT), when coverage is not available, including but not limited to policies requiring explicit verification that coverage is not available."

3. **Section 2.6.B.1.d.2** is hereby amended by:

   a. Inserting "and Rural Health Centers (RHCs)" following "(FQHCs)"; and

   b. Inserting at the end the following: "For purposes of this section, pharmacies associated with FQHCs or RHCs include, but are not limited to, pharmacies with a contractual relationship with an FQHC or RHC and pharmacies at the same location as an FQHC or RHC."

4. **Section 2.7.A.3.e** is hereby amended by adding a new Section **2.7.A.3.e.8** as follows:

   "8) Include, in its Provider Network, Community-Based Acute Treatment Providers with the clinical expertise to provide specialized CBAT services to youth with ASD/IDD as described in **Appendix C** and as directed by EOHHS. The Contractor shall pay such Providers in accordance with **Section 2.7.D.7.a**."

5. **Section 2.7.C.2.e.1** is hereby amended by deleting the section in its entirety and inserting in place thereof a new **Section 2.7.C.2.e.1** as follows:

   "1) Pay EOHHS approved rates for CPT code 90791 with modifier HA for initial Behavioral Health Clinical Assessments using the CANS Tool for Enrollees under the age of 21 that are at least $15.00 more than the Contractor's rates for CPT code 90791 without modifier HA. The Contractor shall ensure that any failure to include an "HA" modifier using CPT Service Code 90791 will result in a denial of the claim for Enrollees under the age of 21, if billed without the HA modifier. For Enrollees under the age of 21, the Contractor shall allow Network Providers up to two 90791 "HA" claims per Enrollee per site in a 90-day period. The Contractor shall also allow a new set of 90791 "HA" claims when the Enrollee experiences a lapse in service of six months or more with the original provider;"

6. **Section 2.7.D.6.b** is hereby amended by inserting "Through September 30, 2022," at the beginning of **Section 2.7.D.6.b.2**.

7. **Section 2.7.D.6** is hereby amended by adding a new **Section 2.7.D.6.d** as follows:

   "d. Effective October 1, 2022, notwithstanding **Sections 2.7.D.6.a** and **b**, the Contractor shall:

      1) In accordance with **Section 2.7.D.6.d.2**, increase its payment rates to in-state acute hospitals for:

a) adjudicated inpatient discharges by a uniform dollar amount specified by EOHHS; and

b) adjudicated outpatient episodes by a uniform dollar amount specified by EOHHS.

2) The increased payment rates shall be uniform dollar amounts through lump sum payments as directed by EOHHS and consistent with the uniform dollar amount increase payment methodology set forth in the RFA. If directed by EOHHS, the Contractor shall pay in-state acute hospitals an additional uniform dollar amount based on the reconciliation set forth in **Section 4.3.J** by a date specified by EOHHS."

8. **Section 2.7.D.7.g** is hereby amended by deleting "Residential Rehabilitation Services" and inserting in place thereof, "Residential Rehabilitation Services for Substance Use Disorders (ASAM Level 3.1) (RRS), including Adult RRS, Family RRS, Transitional Age Youth and Young Adult RRS, Youth RRS, and Co-Occurring Enhanced RRS"

9. **Section 2.7.D.7** is hereby amended by adding a new **Section 2.7.D.7.n** as follows:

"n. For dates of service on or after February 1, 2022, the Contractor is required to pay a fifteen percent (15%) rate increase over the Contractor's negotiated rates starting on the effective date of the Contractor's Behavioral Health Urgent Care contract for the specified services provided at Mental Health Center locations in the Contractor's network that are designated as Behavioral Health Urgent Care provider sites. The Contractor is required to pay these rates by using the appropriate codes, as detailed in Table 1 of Managed Care Entity Bulletin 83, with the Urgent Care modifier, GJ. These codes may be subject to modification or change as directed by EOHHS. EOHHS will inform the Contractor which MHCs have been designated as Behavioral Health Urgent Care providers."

10. **Section 2.7.D.12** is hereby amended by deleting "product infusion" and inserting in place thereof, "products"**.**

11. **Section 2.7.D.** is hereby amended by adding a new **Section 2.7.D.14** as follows:

"14. Effective July 26, 2022, for monkeypox vaccine administration and testing, the Contractor shall establish provider rates at or above the rate floor set by EOHHS in 101 CMR 317 and 320, respectively, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services."

12. **Section 2.8.C.3.j** is hereby amended by the deleting the section in its entirety and inserting in place thereof a new **Section 2.8.C.3.j** as follows:

"j. The Contractor shall make available the intensive hospital diversion (IHD) program, through its network of qualified In-Home Therapy providers, for youth up to age 21, as an alternative to 24-hour level of care. The program will support

youth in crisis after the initial crisis evaluation and intervention has been rendered. The program shall provide intensive, short-term therapy to stabilize youth and their families with the goal of ameliorating the need for hospitalization and establishing community linkages such as Children's Behavioral Health Initiative (CBHI) services and other Behavioral Health services to maintain the youth in the community. The Contractor shall adopt the IHD performance specifications specified by EOHHS."

13. **Section 2.8.C** is hereby amended by adding a new **Section 2.8.C.13** as follows:

"13. Community Behavioral Health Center (CBHC) Program

The Contractor shall, as directed by EOHHS, take all steps and perform all activities necessary to implement the CBHC Program that will be effective January 1, 2023, or a different date as directed by EOHHS, including but not limited to, by December 31, 2022, having executed contracts with the CBHC providers as further specified by EOHHS."

14. **Section 2.8** is hereby amended by adding a new **Section 2.8.N** as follows:

"N. FQHCs

The Contractor shall:

1. Ensure that its payments to Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) for services to Enrollees are greater than or equal to the payment amounts described in 42 USC § 1396a(bb). In order to comply with this requirement, the Contractor shall pay FQHCs and RHCs at least the amount MassHealth would pay for such services on a fee-for-service basis as specified in 101 CMR 304.04, et seq., excluding any supplemental rate paid by MassHealth to FQHCs or RHCs.

2. Institute certain policies to align with MassHealth's investment in FQHCs, as set forth in MassHealth Managed Care Entity Bulletins and other guidance, including but not limited to MassHealth implementing a new rate structure that includes an updated prospective payment system (PPS) rate methodology and MassHealth increasing rates as part of an alternative payment methodology (APM) that requires payment at or above the individual PPS rates. Specifically, the Contractor shall:

    a. Conform its coverage policies with respect to medication therapy management (MTM), collaborative drug therapy management (CDTM), behavioral health integration (BHI), and collaborative care management (CoCM) services to align with MassHealth's coverage policies as further specified by EOHHS;

    b. Require FQHCs to bill for services and visits specified by EOHHS using the codes specified by EOHHS;

c. Pay for out-of-network FQHC claims submitted by FQHCs for the codes set forth by EOHHS at a rate equal to or above the MassHealth FFS rate specified by EOHHS;

d. Cooperate with EOHHS in EOHHS' review of the Contractor's Encounter Data to monitor compliance with these Contract requirements as further specified by EOHHS.

1) If EOHHS determines that the Contractor did not pay at or above the MassHealth FFS rates as specified by EOHHS, the Contractor shall reconcile any discrepancy in paid amounts.

2) If the Contractor does not reconcile a discrepancy identified by EOHHS within a reasonable time as determined by EOHHS, EOHHS may impose an intermediate sanction as set forth in **Section 5.4**.

e. Provide, in the form and format specified by EOHHS, any information or data requested regarding claims and payments related to the codes for FQHC services and visits specified by EOHHS."

15. **Section 2.20.B.2** is hereby amended by adding "For Contract Year 2020," at the beginning of the section.

16. **Section 2.20.B.3** is hereby amended by adding "For Contract Year 2021," at the beginning of the section.

17. **Section 2.20.B** is hereby amended by renumbering **Section 2.20.B.4-9** as **2.20.B.5-10** and by inserting a new **Section 2.20.B.4** as follows:

"4. For Contract Year 2022, the Contractor shall pay a uniform rate increase of $954.59 per diem over the Contractor's contracted rates for inpatient mental health services or administratively necessary day services immediately following inpatient mental health services for COVID-19-positive Enrollees admitted to Department of Mental Health (DMH)-licensed psychiatric hospitals and all units with DMH-licensed beds. The temporary per diem rate increase is applicable for up to 14 days when a member is admitted for inpatient mental health services or receives administratively necessary day services immediately following inpatient mental health services, is confirmed positive for COVID-19 at the time of admission or within 96 hours of admission, and is not suspected of having become COVID-19 positive after admission due to exposure occurring within the admitting hospital. This rate increase shall remain in effect until May 1, 2022, or as otherwise directed by EOHHS."

18. **Section 4.3** is hereby amended by adding a new **Section 4.3.K** as follows:

"K. In-state Acute Hospital Rate Add-on/Increase Pursuant to **Section 2.7.D.6.d**

1. At a frequency to be specified by EOHHS, EOHHS shall pay the Contractor an amount equal to the sum of provider payments described in **Section 2.7.D.6.d** for the applicable time period.

2. For each Contract Year, EOHHS shall perform an annual reconciliation after the end of the Contract Year to correct the amount of any payments described in **Section 2.7.D.6.d**. EOHHS shall remit to the Contractor the full amount of any underpayments it identifies. The Contractor shall remit to EOHHS the full amount of any overpayments identified by EOHHS. Such payments shall be made either through a check or, at the discretion of EOHHS, through recoupment from future capitation and/or reconciliation payments described in **Section 4**."

19. **Appendix B, Quality Improvement Goals**, is hereby added as the attached **Appendix B**.

20. **Appendix C, Covered Services, Exhibit 1** is hereby amended by deleting within the description of "Pharmacy" the following: "Non-Drug Pharmacy Products: non-drug pharmacy products as listed in MassHealth ACPP/MCO Unified Pharmacy Product List" and replacing it with the following: "Non-Drug Pharmacy Products: non-drug pharmacy products as listed in either the MassHealth ACPP/MCO Unified Pharmacy Product List or in the MassHealth Non-Drug Product List as specified by EOHHS".

21. **Appendix D, Payment**, is hereby amended by deleting and replacing **Exhibit 1**, attached hereto.

22. **Appendix E, Encounter Data Set Specifications**, is hereby deleted and replaced with the attached **Appendix E**.

23. **Appendix Q, EOHHS Accountable Care Organization Quality Appendix**, is hereby deleted and replaced with the attached **Appendix Q**.

24. **Appendix T, Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule**, is hereby deleted and replaced with the attached **Appendix T**.

25. **Appendix AA, Directed Payments Related to Certain HCBS Services and Certain Behavioral Health Services**, is hereby deleted and replaced with the attached **Appendix AA, Directed Payments related to Certain ACO Covered Services**.

APPENDIX B
Quality Improvement Goals

1. Introduction

This appendix describes the requirements for the Quality Improvement Goals and Performance Measures as specified in **Section 2.13** of the Contract.

2. QI Goal Improvement Cycle

The QI Goal measurement cycle typically includes a planning/baseline period and up to 2 remeasurement cycles to allow for tracking of improvement gains. For each QI Goal cycle, EOHHS will establish a series of QI goal domains as well as approve and/or designate measurement and quality improvement activities for each of those domains. The following paragraphs outline the CY22 QI Goal Cycle.

ACOs are expected to conduct and report on a minimum of 2 quality improvement projects (QIPs). QIPs must conducted in accordance with the QI domains as specified in Appendix B or otherwise be approved by EOHHS. Additionally, all QIPs must also be aligned with the quality performance measures outlined in Appendix Q of the contract, unless otherwise specified or approved by EOHHS. EOHHS will provide standardized forms for all required reporting activities, including Quality Improvement Plans, Progress Reports, and Annual Reports.

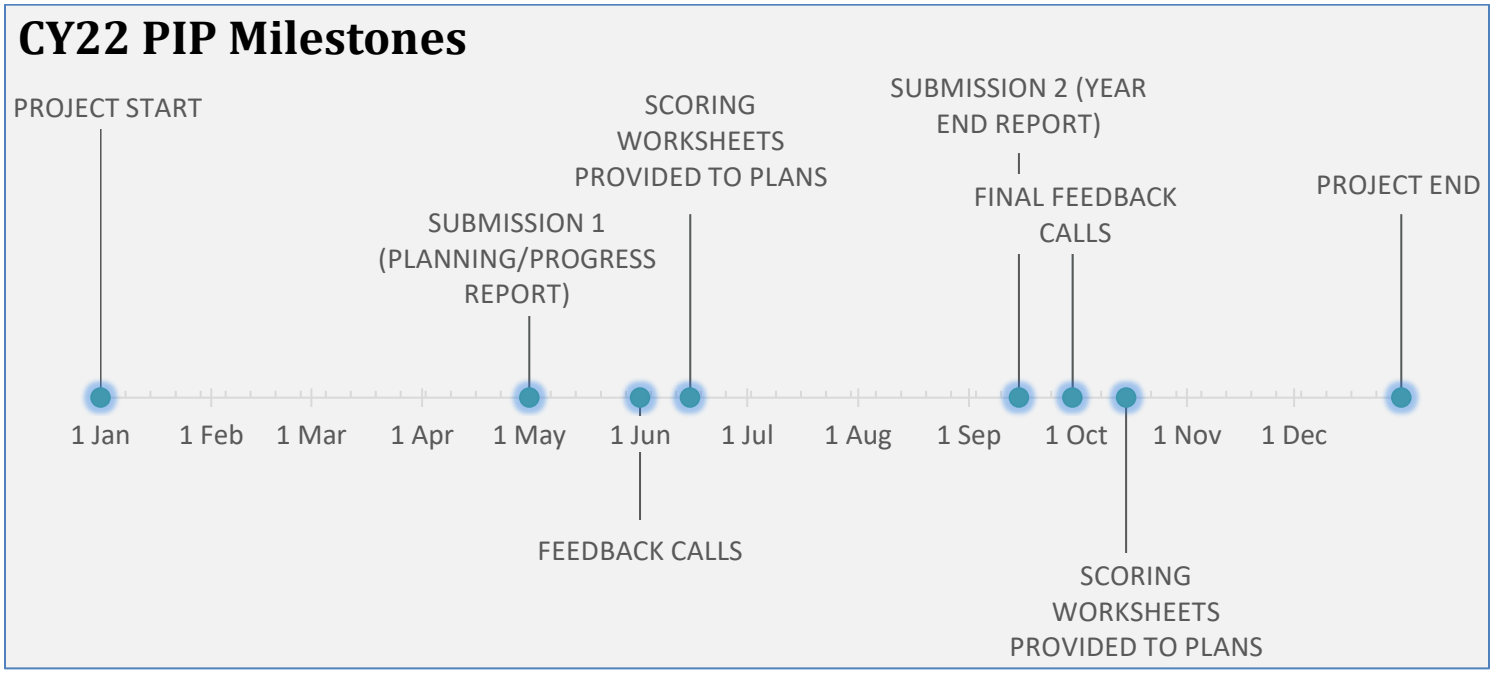
a. QI IMPLEMENATION DETAILS

The following section provides detailed information about the QI Goal implementation periods, their associated activities and timelines.

TABLE 1: QI GOAL IMPLEMENTATION CY22 PERIOD AND ASSOCIATED ACTIVITIES January 1, 2022 – December 31, 2022	
• ***January 2022-April 2022***	Depending upon the project stage (baseline or remeasurement) ACOs engage in either: 1. Project planning: Development of a data-driven, evidence-based plan for interventions using quality improvement principles. Project topics are subject to EOHHS approval before detailed planning begins. Project planning tasks include but are not limited to the development of a problem statement, a review of evidence-based literature, and interventions to address the problem, and completion of quality improvement tools and activities that support project planning including root causes analyses, barrier analyses, development of driver diagrams, population analyses. 2. Project Revision: Modifying/updating projects as the result of feedback or lessons learned in the previous cycle. Plans will update interventions and identify challenges for

	discussion and problem-solving with EOHHS or its designee.
• ***Submission 1: May 2022***	Depending upon the project stage (baseline or remeasurement) ACOs will submit either: 1. QI proposals that describe planned activities and data collection plans for initial implementation; or 2. Project Progress report detailing changes made resulting from feedback or lessons learned in the previous cycle. Plans will provide updates on the current year's interventions and identify challenges for discussion and problem-solving with EOHHS or its designee.
• ***Project Implementation: May – September 2022***	ACOs implement Mid-year interventions and collect data on short-term indicators
• ***Submission 2: September 2022***	ACOs submit annual reports describing current interventions, report on short-term indicators, performance data as applicable, and assess results including success and challenges. Reports will also include plans for modifications in the final quarter and plans to continue work in future cycles.

Figure 1: ACO QI Goals 2, CY22 Timeline:



b. ACO QI DOMAIN AREAS

QIP topics must be consistent with QI domain areas described in Table 2. ACPPs may elect to conduct their two required QIPs in the domain area of health equity; otherwise it is expected that ACPPs will conduct a QIP from 2 of the 3 domains identified in Table 2.

Table 2: QI Domain Areas	
Domain 1: Health Equity: Reducing or eliminating health disparities with the goal of attaining the highest level of health for all people.	
2021 Project Focus:	• Plans may select to focus their PIPs on the following disparity-sensitive measures: ➢ Controlling High Blood Pressure ➢ Comprehensive Diabetes Care ➢ Initiation and Engagement in Treatment ➢ Childhood Immunization Status ➢ Prenatal and Postpartum Care.
Domain 2: Prevention and Wellness. – Reducing the occurrence and complexity of disease while improving level of functioning and quality of life.	
2021 Project Focus:	• Increasing vaccinations rates with at least one specific intervention focused on reducing health inequities.
Domain 3: Access to Care: Ensuring the timeliness and availability of health care services to achieve optimal health outcomes.	
	• Reducing barriers to accessing telehealth services for either behavioral or physical health.

c. DOMAIN MEASURES AND INTERVENTIONS

ACOs shall identify specific measures and interventions within their QIPs that are reflective of the quality performance measures identified in Appendix Q.

d. ACO REPORTS, SUBMISSIONS, AND TEMPLATES

ACOs will submit to MassHealth or its designee:

- One Planning/Progress report and one Annual/End-of-Year Report during the CY22 Implementation period.

ACOs should refer to Table 1 (QI Goal Implementation Period and Associated Activities) for reporting timeframes.

ACOs will submit Quality Improvement Reports using the QI Goals Submission Templates developed and distributed by EOHHS or its designee on or before March 1, 2022. QI Goal Reporting submissions shall include quantitative and qualitative data as well as specific progress made on each measure, barriers encountered, lessons learned, and planned next steps. For specific instructions on the submission process and detail on the submission templates, ACOs shall refer to guidance to be distributed on or before March 1, 2022.

Reporting on the interventions should at a minimum include the following items (to be described with greater specificity in the forthcoming Submission Guide Document):

- Rationale for selecting proposed/implemented interventions
- Description of current interventions
- Analysis of short-term indicators, HEDIS rates as applicable, data collection procedures and methodology, and interpretation of results
- Assessment of intervention successes and challenges, and potential intervention modifications for future implementation periods.

Evaluation of QI Reports: EOHHS or its designee will review QI Goal Reports using a standardized Evaluation Template. The scoring elements in the Evaluation Template will correspond directly with the elements documented on the reporting templates. Feedback will be provided to the ACOs for each implementation period.

Cultural Competency

Participating ACOs shall design and implement all QI Goal activities and interventions in a culturally competent manner.

3. Performance Measures

EOHHS has defined performance measures pursuant to **Section 2.13.C.6** of the Contract and reserves the right to modify this of performance measures as deemed necessary and determined by EOHHS. The list of performance measures may be found in Appendix Q of this contract. In accordance with the Medicaid Managed Care Rule, the performance measures may be used by EOHHS to publicly report ACO performance. EOHHS reserves the right to withhold reporting of a measure(s) as determined by EOHHS. All measures referenced in Appendix Q are calculated by EOHHS (with clinical data submitted by the Accountable Care Partnership for hybrid measures).

4. Quality Assessment and Performance Improvement Plans

In accordance with **Section 2.13.B.5** of the Contract, ACPPs must submit to EOHHS an annual QI workplan that broadly describes ACPP QI initiatives that are conducted as part of the plan's comprehensive quality assurance and performance improvement (QAPI) program. The QI plan should minimally include the QIPs and performance measures referenced in Appendices B and Q.

APPENDIX D
PAYMENT

EXHIBIT 1
BASE CAPITATION RATES AND ADD-ONS
Contract Year 5

Listed below are the Per Member Per Month (PMPM) Base Capitation Rates for Contract Year 5 (January 1, 2022 through December 31, 2022) (also referred to as Rate Year 2022 or RY22), subject to state appropriation and all necessary federal approvals;

Base Capitation Rates do not include EOHHS adjustments described in **Sections 4.2.C** and **4.2.E**. of the Contract.

In addition to the Base Capitation Rates tables below, additional tables include the add-ons for the Contract Year for CBHI Services as described in **Section 4.5.D**, for ABA Services as described in **Section 4.5.E**, and for SUD Risk Sharing Services as described in **Section 4.5.I**. The add-ons for CBHI Services, ABA Services and SUD Risk Sharing Services are the same for all Regions and will be added to the Risk Adjusted Capitation Rates as defined in **Section 4.2.E**.

ACO Base Capitation Rates / RC I Adult					
Effective January 1, 2022 – June 30, 2022					
REGION	NON-HIGH COST DRUG / NON-HCV MEDICAL COMPONENT (per member per month)	HCV COMPONENT (per member per month)	NON-HCV HIGH COST DRUG COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$528.32	$3.26	$2.03	$38.75	$572.36
Greater Boston	$540.39	$2.93	$2.06	$35.80	$581.18
Southern	$573.38	$4.75	$4.14	$36.79	$619.06
Central	$485.92	$3.13	$3.40	$34.31	$526.76
Western	$473.31	$2.79	$1.13	$33.77	$511.00

ACO Base Capitation Rates / RC I Child					
Effective January 1, 2022 – June 30, 2022					
REGION	NON-HIGH COST DRUG / NON-HCV MEDICAL COMPONENT (per member per month)	HCV COMPONENT (per member per month)	NON-HCV HIGH COST DRUG COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$206.10	$0.02	$4.95	$32.67	$243.74
Greater Boston	$204.02	$0.02	$6.66	$30.78	$241.48
Southern	$200.78	$0.03	$4.07	$29.60	$234.48
Central	$196.28	$0.02	$6.85	$29.04	$232.19
Western	$193.80	$0.02	$1.94	$28.92	$224.68

ACO Base Capitation Rates / RC II Adult					
Effective January 1, 2022 – June 30, 2022					
REGION	NON-HIGH COST DRUG / NON-HCV MEDICAL COMPONENT (per member per month)	HCV COMPONENT (per member per month)	NON-HCV HIGH COST DRUG COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$1,862.51	$15.07	$27.23	$101.44	$2,006.25
Greater Boston	$1,993.93	$17.94	$27.02	$95.81	$2,134.70
Southern	$2,032.71	$19.67	$17.24	$93.61	$2,163.23
Central	$1,817.15	$13.96	$24.70	$87.23	$1,943.04
Western	$1,593.42	$11.78	$19.64	$77.46	$1,702.30

ACO Base Capitation Rates / RC II Child					
Effective January 1, 2022 – June 30, 2022					
REGION	NON-HIGH COST DRUG / NON-HCV MEDICAL COMPONENT (per member per month)	HCV COMPONENT (per member per month)	NON-HCV HIGH COST DRUG COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$987.33	$0.13	$105.65	$83.79	$1,176.90
Greater Boston	$1,010.27	$0.18	$190.24	$83.87	$1,284.56
Southern	$915.76	$0.18	$38.91	$71.99	$1,026.84
Central	$964.66	$0.11	$111.24	$74.26	$1,150.27
Western	$696.81	$0.08	$37.78	$57.13	$791.80

ACO Base Capitation Rates / RC IX					
Effective January 1, 2022 – June 30, 2022					
REGION	NON-HIGH COST DRUG / NON-HCV MEDICAL COMPONENT (per member per month)	HCV COMPONENT (per member per month)	NON-HCV HIGH COST DRUG COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$628.22	$7.91	$6.50	$44.21	$686.84
Greater Boston	$607.59	$7.89	$8.41	$39.54	$663.43
Southern	$689.25	$10.97	$8.51	$42.69	$751.42
Central	$627.13	$7.52	$11.13	$40.00	$685.78
Western	$570.06	$7.64	$2.24	$38.13	$618.07

ACO Base Capitation Rates / RC X					
Effective January 1, 2022 – June 30, 2022					
REGION	NON-HIGH COST DRUG / NON-HCV MEDICAL COMPONENT (per member per month)	HCV COMPONENT (per member per month)	NON-HCV HIGH COST DRUG COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$1,911.83	$32.27	$4.36	$105.42	$2,053.88
Greater Boston	$1,816.68	$40.39	$44.52	$90.31	$1,991.90
Southern	$1,896.23	$61.17	$2.70	$89.36	$2,049.46
Central	$1,819.00	$45.89	$1.67	$90.29	$1,956.85
Western	$1,616.11	$35.19	$3.62	$81.07	$1,735.99

ACO Base Capitation Rates / RC I Adult					
Effective July 1, 2022 – December 31, 2022					
REGION	NON-HIGH COST DRUG / NON-HCV MEDICAL COMPONENT (per member per month)	HCV COMPONENT (per member per month)	NON-HCV HIGH COST DRUG COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$522.31	$3.26	$2.03	$38.75	$566.35
Greater Boston	$535.51	$2.93	$2.06	$35.80	$576.30
Southern	$566.50	$4.75	$4.14	$36.79	$612.18
Central	$480.48	$3.13	$3.40	$34.31	$521.32
Western	$467.40	$2.79	$1.13	$33.77	$505.09

ACO Base Capitation Rates / RC I Child					
Effective July 1, 2022 – December 31, 2022					
REGION	NON-HIGH COST DRUG / NON-HCV MEDICAL COMPONENT (per member per month)	HCV COMPONENT (per member per month)	NON-HCV HIGH COST DRUG COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$202.07	$0.02	$4.95	$32.67	$239.71
Greater Boston	$201.04	$0.02	$6.66	$30.78	$238.50
Southern	$196.99	$0.03	$4.07	$29.60	$230.69
Central	$192.83	$0.02	$6.85	$29.04	$228.74
Western	$189.93	$0.02	$1.94	$28.92	$220.81

ACO Base Capitation Rates / RC II Adult					
Effective July 1, 2022 – December 31, 2022					
REGION	NON-HIGH COST DRUG / NON-HCV MEDICAL COMPONENT (per member per month)	HCV COMPONENT (per member per month)	NON-HCV HIGH COST DRUG COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$1,833.91	$15.07	$27.23	$101.44	$1,977.65
Greater Boston	$1,969.37	$17.94	$27.02	$95.81	$2,110.14
Southern	$2,005.62	$19.67	$17.24	$93.61	$2,136.14
Central	$1,792.49	$13.96	$24.70	$87.23	$1,918.38
Western	$1,571.06	$11.78	$19.64	$77.46	$1,679.94

ACO Base Capitation Rates / RC II Child					
Effective July 1, 2022 – December 31, 2022					
REGION	NON-HIGH COST DRUG / NON-HCV MEDICAL COMPONENT (per member per month)	HCV COMPONENT (per member per month)	NON-HCV HIGH COST DRUG COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$970.25	$0.13	$105.65	$83.79	$1,159.82
Greater Boston	$996.04	$0.18	$190.24	$83.87	$1,270.33
Southern	$900.25	$0.18	$38.91	$71.99	$1,011.33
Central	$949.57	$0.11	$111.24	$74.26	$1,135.18
Western	$684.08	$0.08	$37.78	$57.13	$779.07

ACO Base Capitation Rates / RC IX					
Effective July 1, 2022 – December 31, 2022					
REGION	NON-HIGH COST DRUG / NON-HCV MEDICAL COMPONENT (per member per month)	HCV COMPONENT (per member per month)	NON-HCV HIGH COST DRUG COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$619.20	$7.91	$6.50	$44.21	$677.82
Greater Boston	$598.42	$7.89	$8.41	$39.54	$654.26
Southern	$678.54	$10.97	$8.51	$42.69	$740.71
Central	$617.63	$7.52	$11.13	$40.00	$676.28
Western	$559.80	$7.64	$2.24	$38.13	$607.81

ACO Base Capitation Rates / RC X					
Effective July 1, 2022 – December 31, 2022					
REGION	NON-HIGH COST DRUG / NON-HCV MEDICAL COMPONENT (per member per month)	HCV COMPONENT (per member per month)	NON-HCV HIGH COST DRUG COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$1,881.05	$32.27	$4.36	$105.42	$2,023.10
Greater Boston	$1,784.47	$40.39	$44.52	$90.31	$1,959.69
Southern	$1,858.95	$61.17	$2.70	$89.36	$2,012.18
Central	$1,787.61	$45.89	$1.67	$90.29	$1,925.46
Western	$1,582.67	$35.19	$3.62	$81.07	$1,702.55

CBHI Add-On to Risk Adjusted Capitation Rates

Effective January 1, 2022 – June 30, 2022

CBHI Add-On to Risk Adjusted Capitation Rates PMPM	
RC-I Child	$28.63
RC-II Child	$166.85

CBHI Add-On to Risk Adjusted Capitation Rates
Effective July 1, 2022 – December 31, 2022

CBHI Add-On to Risk Adjusted Capitation Rates PMPM	
RC-I Child	$26.09
RC-II Child	$152.39

ABA Add-On to Risk Adjusted Capitation Rates
Effective January 1, 2022 – June 30, 2022

ABA Add-On to Risk Adjusted Capitation Rates PMPM	
RC-I Child	$8.83
RC-II Child	$206.99

ABA Add-On to Risk Adjusted Capitation Rates

Effective July 1, 2022 – December 31, 2022

ABA Add-On to Risk Adjusted Capitation Rates PMPM	
RC-I Child	$7.98
RC-II Child	$187.78

SUD Risk Sharing Services Add-On to Risk Adjusted Capitation Rates Effective January 1, 2022 – June 30, 2022

SUD Risk Sharing Services Add-On to Risk Adjusted Capitation Rates PMPM	
RC-I Adult	$6.77
RC-I Child	$0.27
RC-II Adult	$17.11
RC-II Child	$0.76
RC-IX	$21.22
RC-X	$188.38

SUD Risk Sharing Services Add-On to Risk Adjusted Capitation Rates

Effective July 1, 2022 – December 31, 2022

SUD Risk Sharing Services Add-On to Risk Adjusted Capitation Rates PMPM	
RC-I Adult	$6.12
RC-I Child	$0.24
RC-II Adult	$15.63
RC-II Child	$0.69
RC-IX	$19.19
RC-X	$172.25

COMMONWEALTH OF MASSACHUSETTS

EXECUTIVE OFFICE
OF
HEALTH AND HUMAN SERVICES

MASSHEALTH DATA WAREHOUSE
PAID ENCOUNTER DATA SET REQUEST

Version 4.12

March 25, 2022

Revision History

Date	Revision	Name

Nov 2021 – Jan 2022	Clarifications/Updates include:
	• Acronym Table: Added ACPP, FFSE, ICO
	• Table of contents
	• Section 1.0 Introduction: Added clarification to encounter definition, uses for encounters, expectation for reporting medical costs, submission-rejection-resubmission cycle. Introduced list of files included in encounter submission, introduced a new encounter email address for question.
	• Segment 1.1 Data Requirements:
	  ○ Clarifications to paid vs. denied, zero paid claims, preventing multiple versions of claims / MH use of "last in chain", claim integrity, encounter submission timeliness, expectations for data completeness and validity for all fields.
	  ○ Removed redundant submission-rejection-resubmission cycle paragraph.
	• Section 2.0 Data Element Clarifications: Added "Record Type Submission Options and Explanations" reference table (including use cases to encourage better use of the "Replacement" Record Type); added further explanation of unique claim number/suffix requirement; added clarity to Dollar Amounts segment; clarified Record Indicator use, clarified diagnosis code requirements, decommissioned Record Indicator #3 and removed example #4; added clarity to Bundle Indicator examples as well as Former Claim Number and Suffix examples.
	• Section 2.0, 3.1 Provider File Data Set: Clarified requirement for plans to report MassHealth Provider Identification number in the "Medicaid Number" field of their Provider file pursuant to 42 CFR 438.602(b)(1).
	• Section 2.0 / 3.0 field requirements: Clarified requirement for recovery reporting through "Void Reason Code" field, ICD10-PCS reporting, 340b reporting through the "Submission Clarification Code"
	• Section 3.0 Encounter Data Set Elements with Record Layout:
	  ○ Updated MCE Names in "Org. Code" field and added clarity to descriptions in the fields: "Record Indicator", "Claim Category", "Primary Diagnosis", "Dispense As Written Indicator", "Paid Date", "Billed Charge", "Gross Payment Amount", "Copay", "Coinsurance", "Deductible", "Patient Pay Amount", "Net Payment", "New Member ID", "Service Category", "Allowable Amount", "Void Reason Code", "Surgical Procedure Code", "Total Charges", "Metric Qty"/"Unit of Measure", "Quantity", "Void Reason Code"
	  ○ Changed field name of Copay/Coinsurance to just Copay.
	  ○ Replaced datatype SN with N in all the monetary fields and "Quantity" field.
	  ○ Length for "Claim Number", "Former Claim Number" and "Service Category" fields were updated in the specs to reflect longer actual acceptable length. The following Fields are not required for retail pharmacy encounters ("R") and the "X" was removed: "Claim Type", "Service Class", "PCC Internal Provider ID", "Authorization Type", "Family Planning Indicator", "PCC Internal Provider ID Type", "Employment", "Auto Accident", "Other Accident", "Non-Covered charges", "Bundle Claim Number", "Bundle Claim Suffix", and "PCP Provider ID Address Location Code".
	  ○ Added clarity to descriptions in the fields "Provider ID", "Provider ID Type", "Provider ID Address Location Code", "Medicaid Number"
	  ○ Added clarity to Provider File Requirements, including reporting of "Medicaid Number" and "Provider Bundle ID" in examples.
	• Section 4.0 Error Handling:
	  ○ Added Error Code 75 "Codes on record are not in sequence" for gaps in Diagnosis Code and Surgical Procedure Code sequence.
	• Section 6.0 Media Requirements:
		Alla Kamenetsky
		Robert Sellers

Date	Revision	Name
	○ Name “Media Requirements" replaced with “Media Requirements / Encounter Claims Files Submission Requirements” ○ Added clarity to segments Manual Override File, Secure FTP Server, Sending Encounter Data, Receiving Error Reports. ○ CMS Internet Policy was removed. ○ Removed Segment “Monthly Financial Report” ○ Removed “Care Management Provider” file • Section 7 Standard Data Values: Reviewed and confirmed CMS value sets; updated CMS Place of Service Telehealth description; added clarity to Table D table name; for Table G, allow use of 00 value if Servicing Provider Type is not listed, provided additional guidance / links for choosing appropriate Unit of Measure (Table O). • Section 8.0 Quantity and Quality Edits, Reasonability and Validity Checks ○ Added expectation that fields must be valid as well as complete. ○ MassHealth adding checks for gaps in fields “Diagnosis Code” and “Surgical Procedure Code” sequence. ○ MassHealth clarification for validations for fields “Void Reason Code”, “Diagnosis code(s)”, “Servicing Provider Specialty”, “Bundle Indicator”, “Bundle Claim Number”, and “Bundle Claim Suffix”. ○ Enhanced readability and description consistency • Section 9.0 Appendices / Member File / Member Enrollment File Specifications ○ Removed references to Care Management file ○ Added completeness validity expectations for Race, Language and Ethnicity and Entity PIDSL. ○ Revised validation language for consistency ○ Revised headers for Table of Contents clarity • Standardized terminology throughout for consistency and readability • Updated MCE Names in “Org. Code” fields in all applicable sections. • All references to “PCC Internal Provider ID” changed to match “PCC Provider ID” for consistency, including in Revision History. • Added formatting and minor language changes throughout to improve readability • Updated language to reflect ICD10 and HIPAA EDI use cases	
05/03/2019	RENAMED: • Field #232 • old name - “FILLER” • new name - “Provider Payment”	Alla Kamenetsky
03/19/2019	Removed all the mentioning of potentially duplicate claims	Alla Kamenetsky
February, 2019	ADDED: • Field #232 “Filler” • Field #233 “Filler” • “Physician-Administered Drug Claim” Definition - Segment 2.0 “Data Elements Clarification” UPDATED: • Field # 11 “Medicare Code” – added value “Part D Only” • Table O “Unit of Measure” • Field 11 “Medicare Code” description • Table I – B1 “Service Category (Using the SCO reporting groups) “– added value “309 B – Pharmacy/Drug (Non-Part D)”	Alla Kamenetsky
12/15/2018	REMOVED: • Table N “Submission Clarification Code” • Section 1.1 – Removed requirements for Monthly Financial Reports ADDED:	Alla Kamenetsky

Date	Revision	Name
	• TABLE O - Unit Of Measure values • Field # 11 "Medicare Code" – added values (4 = Part A and D, 5 = Part B and D, 6 = Part A, B, and D) • Field #229 "Submission Clarification Code 2" • Field #230 "Submission Clarification Code 3" • Field #231 "Unit of Measure" • Submission Clarification Code description - Segment 2.0 "Data Elements Clarification" UPDATED: • TABLE C - Place of Service (HCFA 1500) Place of Service Codes for Professional Claims • TABLE M - POA Indicator Options and Definitions	
3/14/2018	• The length of all Address Location Code fields has been increased to 15 C • The length of MMIS Plan type (MBH only) has been increased to 5 C Additions and corrected typos: • SEGMENT "Data Requirements" ADDED: • "MCO claims where "From Service Date" is prior to 03/01/2018, the value of MCO PIDSL should be entered in "Entity PIDSL" field (#3)" ENCOUNTER • Field # 3: Entity PIDSL – added to the description "an ACO with which a PCC is contracted with" • Field # 13: Submission Clarification Code – is required on Pharmacy claim lines only • Field # 33: Type Of Bill – should be submitted on Hospital (H) and LTS (L) claims only • Field # 36: Quantity - the values should be submitted on claims of all types, but Pharmacy (R – Prescription Drug) • Field # 49: PCC Provider ID – should be submitted on claims of all types • Field # 92: PCC Provider ID Type - should be submitted on claims of all types PROVIDER To the list "The following fields are 100% required on all records" Added: • 19. Entity PIDSL • Field# 35: Entity PIDSL - description changed to: MCO/ACO providers: if the provider is enrolled with MCO only (not with ACO) - MCO PIDSL in ENTITY_PIDSL if the provider is enrolled with ACO only - ACO PIDSL if the provider is enrolled with both, ACO and MCO - ACO PIDSL if provider is enrolled with multiple ACOs (e.g., a specialist), and a plan is an active MCO - MCO PIDSL if provider is enrolled with multiple ACOs (e.g., a specialist) and a plan is not an active MCO - old MCO PIDSL • SCO PIDSL for SCO providers One Care PIDSL for One Care providers" *Authorization Type Data Set Elements* table • Field # 1: Org. Code - the length of the field corrected to 4	Alla Kamenetsky
12/06/2017	• 1.1. Data Requirements segment: Added new bullets that are marked as "Bullet introduced in this version of the document" • 2.0 Data Elements Clarifications segment ○ Provider IDs: added new lines marked as "Line introduced in this version of the document". **"Org. Code", field # 1 in all the files, is set to accept 3 N values. ○ Encounter data set ○ Provider Data Set ○ MCE Internal Provider Type Data Set Elements with Record Layout ○ Provider Specialty Data Set Elements	Alla Kamenetsky

Date	Revision	Name
	○ Additional Reference Data Set Elements ○ Member File Layout ○ Member Enrollment File Layout ○ Care Management Provider File Layout • 3.1 Provider Data Set with Record Layout • To "Reject the file if:" • Added line: "Provider ID, or Provider ID Type, or Provider ID Location Code are missing" ADDED: • New segment "Potential Duplicate Claims" • Table N – Submission Clarification Code Changes to the fields: ENCOUNTER • Field # 49: PCC Provider ID (PCC Provider ID removed) • Field # 92: PCC Provider ID Type (PCC Provider ID Type removed) • Field # 228: PCC Provider ID Address Location Code	
11/16/2017	Field #1 in all the files: • "MCE PIDSL" renamed to "Org. Code" • Description – "Unique ID assigned by MH DW to each submitting organization." • The length of the field is changed from 10 to 3 • Data Type of the values in the field changes from "C" to "N" • "ACI PIDSL" in all the files has been renamed to "Entity PIDSL", • Description "ACO PIDSL for the ACO claims and MCO PIDSL for the MCO claims" • The length and data type remain the same – 10/C Encounter file: • Field #61: Gross Payment Amount - added missing length of the field (9) and datatype (SN) • Field #73: EPSDT Indicator - corrected data type to "N" Provider File: • Field #16: Provider Type – corrected datatype to "N"	Alla Kamenetsky
11/09/2017	Few typos corrected	Alla Kamenetsky
10/10/2017	ADDED: • Provider Data Set file • Field#40: Provider Bundle ID • Field#41: Provider ID Primary Address Location Indicator • 2.0 Data Element Clarifications Provider ID submission in Encounter and Provider Files segment with an example to illustrate how Provider IDs in claims file should correlate with the values in provider file • To the list of required fields in Provider file: ○ Provider ID Address Location Code (Field#36) ○ Provider Bundle ID (Field #40) CHANGED: • All Provider ID Address Location Code fields: Length of the field = 5; Data Type = C • Narrations In segment "3.1 Provider Data Set with Record Layout"	Alla Kamenetsky

<table>
<tr><th>Date</th><th>Revision</th><th>Name</th></tr>
<tr><td>09/20/2017</td><td>Add to the list of changes:
Field#37: NDC Number – now will be required on Hospital and Professional claims in addition to the Pharmacy ones.
Field#38: Metric Quantity - now will be required on Hospital and Professional claims in addition to the Pharmacy ones.
Removed ACO PIDSL field from:
Internal Provider Type Data Set table
Provider Specialty Data Set Elements table
Member File Layout</td><td>Alla Kamenetsky</td></tr>
<tr><td>08/14/2017</td><td>Secure FTP Server - changes to the server related information in the section
Data Requirements section – mentioning of ACO program implementation
Data Set Elements tables are enhanced with Record Layout information.
Obsolete:
Encounter Record Layout section
Provider Record Layout section
Encounter Data Set
Changes to the existing fields:
Field#1: MCE PIDSL (former Claim Payer)
Field#3: ACO PIDSL (Former “Plan Identifier”)
Field#7:
Pricing Indicator (former “Filler”)
the length changed from 9 to 20
Field#13: Submission Clarification Code” (former “Filler”)
Field#32: Gender Code, added value of “O” for “Other”
Field #33: Type of Bill (former “Place of Service Type”)
Field#71: Added values of “7 = ACO-A”, “8 = ACO-B” and “9= ACO-C”
Field#195: ACO Categories, added value ‘ACO’ for ACO Service Category Type
Introducing new fields
Field #204: Value Code
Field #205: Value Amount
Field # 206 - 221: Surgical Procedure Codes 10-25
Field#222: Attending Prov. ID Address Location Code
Field#223: Billing Provider ID Address Location Code
Field#224: Prescribing Prov. ID Address Location Code
Field#225: PCP Provider ID Address Location Code
Field#226: Referring Provider ID Address Location Code
Field#227: Servicing Provider ID Address Location Code
Field#228: PCC Provider ID
Field#229: PCC Provider ID Type
Field#230: PCC Provider ID Address Location Code
Provider Data Set Elements related tables and Additional Reference Data Set Elements:
Changed and added fields
Field #1 “Claim Payer” is replaced with “MCE PIDSL”
Added field “ACO PIDSL” at the end of the files
Provider Data Set file
<table>
<tr><th>Field #</th><th>Field Name</th><th>Former Field Name</th></tr>
<tr><td>1</td><td>MCE PIDSL</td><td>Claim Payer</td></tr>
<tr><td>22</td><td>PCC Provider ID</td><td>IPA/PMG ID</td></tr>
<tr><td>31</td><td>PCC Provider ID Type</td><td>IPA/PMG ID_Type</td></tr>
</table>
</td><td>Alla Kamenetsky</td></tr>
</table>

<table>
<tr><th>Date</th><th>Revision</th><th>Name</th></tr>
<tr><td></td><td>
<table>
<tr><td>35</td><td>ACO PIDSL</td><td></td></tr>
<tr><td>36</td><td>Provider ID Address Location Code</td><td></td></tr>
<tr><td>37</td><td>PCC ID Address Location Code</td><td></td></tr>
<tr><td>38</td><td>Provider Network ID TYPE</td><td></td></tr>
<tr><td>39</td><td>Provider Network ID Address Location Code</td><td></td></tr>
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Internal Provider Type Data Set
<table>
<tr><th>Field #</th><th>Field Name NEW</th><th>Former Field Name</th></tr>
<tr><td>1</td><td>MCE PIDSL</td><td>Claim Payer</td></tr>
<tr><td>6</td><td>ACO PIDSL</td><td></td></tr>
<tr><td>7</td><td>Provider ID Address Location Code</td><td></td></tr>
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Provider Specialty Data Set Elements
<table>
<tr><th>Field #</th><th>Field Name NEW</th><th>Former Field Name</th></tr>
<tr><td>1</td><td>MCE PIDSL</td><td>Claim Payer</td></tr>
<tr><td>7</td><td>ACO PIDSL</td><td></td></tr>
<tr><td>8</td><td>Provider ID Address Location Code</td><td></td></tr>
</table>
Member Enrollment File
<table>
<tr><th>Field #</th><th>Field Name</th><th>Former Field Name</th></tr>
<tr><td>1</td><td>MCE PIDSL</td><td>Claim Payer</td></tr>
<tr><td>12</td><td>PCC Provider ID Address Location Code</td><td></td></tr>
<tr><td>13</td><td>PCC Practice ID Address Location Code</td><td></td></tr>
<tr><td>14</td><td>ACO PIDSL</td><td></td></tr>
</table>
</td><td></td></tr>
<tr><td>06/06/2017</td><td>III. Error Handling
<table>
<tr><td>New error codes added 72*</td><td>Denial Code not in Denied Claims file - Claim Number/Suffix in Denied Claims Reason Code file not in Denied Claims file</td></tr>
<tr><td>73*</td><td>Claim Number/Suffix in Denied Claims file not in Denied Claims Reason Code file</td></tr>
<tr><td>74</td><td>Correction to a claim that is not in MH DW</td></tr>
</table>
* Specific for denied claims only</td><td>Alla Kamenetsky</td></tr>
<tr><td>01/25/2017</td><td>In Service Data segment:

Field # 7 renamed to “Place Holder for Pricing Indicator” (Former “Filler”)
Field # 13 renamed to “Submission Clarification Code”– (Former “Filler”)
Field # 31 “Revenue Code” less than 4-digit codes should be entered with leading zeros.
“Place of Service” and “Type of Bill” values are submitted in separate fields now:

#32 “Place of Service”.
#33 “Type of Bill” – (Former “Place of Service Type”)

Field #33 “Type of Bill” should be sent in 3-digit format including Frequency as 3rd digit.
Field # 35 renamed to “FILLER” (Former “Type of Service”, which is no longer required).
Added Value “Other” to Field #9 “Recipient Gender” in Encounter Data Set Elements
Field # 9 “Member Gender” in Member File Layout”
</td><td>Alla Kamenetsky</td></tr>
</table>

Date	Revision	Name
09/09/2016	• I. In Data Elements Clarifications (section 2.0): • Introduced new Inpatient Claim logic for the claims with DOS on or after October 1, 2016. • II. In Table I-B "Service Category (Using the SCO reporting groups)": • Replaced "100" series values with '300' series values. • New Service Categories are in Table I-B1. • Old Service Categories are in Table I-B2.	Alla Kamenetsky
01/11/2016	• I. In Additional Reference Data Set Elements (Section 3.4): • Table Services Data Set Elements Added 5 new fields – MBHP specific. • Additional Reference Data Layout (Section 4.5) • Table Services Data Set Layout Added 5 new fields – MBHP specific. • Added information about new BMC SCO to the list of all SCOs throughout the document. • Replaced ICD-9-CM with ICD throughout the document.	Alla Kamenetsky
09/29/2015	• I. In Data Elements Clarifications (section 2.0): • Changed Inpatient Claim logic back to the old definition. • II. In Encounter Data Set Elements (section 3.0): • Changed field #7 description back to "Filler". • "New Member ID" (field#76) - missing or invalid value in this field will be considered as a fatal error resulting in rejection of the record. • III. In 3.1 Provider Data Set: • Edited File Processing section • Added a list of the fields that are 100% required to be complete with valid values on all the records. • Removed proposed "Health Policy Commission Registered Provider Organization ID (RPO)" (field#35). • Updated definition of "APCD ORG ID" (field#34) • IV. In 4.0 Encounter Record Layout: • The length of "Recipient ZIP Code" (field #10) remains 5 N. • V. In 8.0 Quantity and Quality Edits, Reasonability and Validity Checks: • Updated definitions of MassHealth Standards in: "Admission Date'' (field#15) "Discharge Date''(field#16) ''Type of Admission" (field#24) "Source of Admission" (field#25) "Place of Service" (field#32) "Patient Discharge Status" (field#34) "Days Supply" (field#39) "Refill Indicator" (field#40) "Dispense as Written Indicator" (field#41) "Admitting Diagnosis" (field#85) "ICD Version Qualifier" (field#193)	
08/31/2015	I. In Data Elements Clarifications (section 2.0): Added Capitation Payments clarification. Updated Inpatient Claim clarification II. In Encounter Data Set Elements (section 3.0): "Claim Category" (field #2) removed option "7 = Other (should be rarely used)" Changed definition of "Plan Identifier" (field #4) o. Replaced "Filler" (field #7) with "Header / Detail Claim Line Indicator" Updated definitions of: "Admission Date" (field#15)	Rima Kayyali Alla Kamenetsky

Date	Revision	Name
	"Discharge Date" (field#16) "Type of Admission" (field#24) "Source of Admission" (field#25) "Procedure Code" (field #26), "Procedure Code Indicator" (field #30)" "Revenue Code" (field# 31) "Place of Service" (field # 32) Place of Service Type" (field#33) "Patient Discharge Status" (field#34) "Quantity" (field#36) "NDC Number" (field# 37) "Metric Quantity" (field #38) "Dispense As Written Indicator" (field#41) "DRG" (field#72) "Prescribing Prov. ID" (field#81) "DRG Severity of Illness Level" (field#122) "DRG Risk of Mortality Level" (field#123) III. In 3.2 Provider Data Set: Added "File Processing" paragraph. Updated definitions of: "Provider ID" (field#2) "Medicaid Number" (field#5) "Provider Last Name" (field#6) "Provider Fist Name" (field#7) "Provider Type" (field16) "Social Security Number" (field#28) "Tax ID Number" (field#30) Added two new fields: "APCD ORG ID" (field#34) and "Health Policy Commission Registered Provider Organization ID (RPO)" (field#35). IV. In 4.0 Encounter Record Layout: Replaced "Filler" (field #7) with "Header / Detail Claim Line Indicator". Increased fields length: "Recipient ZIP Code" (field#10) from 5 N to 9 N. "Quantity" (field#36) from 5 N to 9 N. "Metric Quantity" (field#38) from 5N to 9 N V. In 4.1 Provider Record Layout: 1. Increased fields length: "Provider Last Name" (Field # 6) from 30 C to 200 C "Provider Fist Name" (Field#7) from 30 C t0 100 C 2. Added two new fields: "APCD ORG ID" (field 34) – 6 C "Health Policy Commission registered Provider Organization ID (RPO)" (field#35) – 30C In Table B "Source of Admission (UB)" Added values A-F In Table G "Servicing Provider type" removed option "-4 -Incomplete/No information". VI. In 8.0 Quantity and Quality Edits, Reasonability and Validity Checks: 1. Replaced "Filler" with "Header / Detail Claim Line Indicator" (field#7) 2. Updated definitions of MassHealth Standards in: "Admission Date'' (field#15) '\Discharge Date''(field#16) ''From Service Date''(field#17)	

Date	Revision	Name
	‘’To Service Date” (field#18) ‘’Primary Diagnosis” (field#19) ‘’Type of Admission” (field24) “Source of Admission” (field25) “Procedure Code” (field26) “Revenue Code” (field 31) “Place of Service” (field 32) “Place of Service Type” (field 33) “Patient Discharge Status” (field 34) “Quantity” (field#36) “Servicing Provider ID” (field#50) “Billing Provider ID” (field#58) “DRG” (field#72) “New Member ID” (field#76) “Prescribing Prov. ID” (field#81) “Date Script Written” (field#82) “Admitting Diagnosis” (field#85) “Frequency” (field#91) “ICD Version Qualifier” (field#193)	
04/15/2015	Updated a name of: Monthly Financial Report in the examples with the current dates on pgs. 62-63.	Alla Kamenetsky
10/30/2014	• Added reference to One Care-ICO • Changed Instructions on Monthly Financial Report. pg62-63 • Changed format of Provider_IDs paragraph on pg.10 • Changed length value in field #86 to 9. pg.47 • Changed length value in field #12 to 10. pg.55. • Changed format of zip file name. pgs. 59-60 • Added Table I-C “Service Category (Using the One Care - ICO reporting groups)” pg.92	Alla Kamenetsky
4/23/2014	• Added clarification in section 2.0 (Diagnosis Codes). • Added clarification in section 8.0 on validation of ICD Version Qualifier (Field # 193), ICD Diagnosis and ICD Procedure codes	Rima Kayyali
12/31/2013	Deleted ICO Reference	Rima Kayyali
12/17/2013	Added value “5” for CarePlus population to field Group Number (field # 71)	Rima Kayyali
11/26/2013	Updated Appendix C (Section 9.3) for Member Enrollment File Specifications	Rima Kayyali
8/13/2013	Added Appendix C in Section 9.3 for Member Enrollment File Specifications	Rima Kayyali
4/26/2013	• Changed Encounter Data files submission requirement from fixed-length files to Pipe-delimited text files (delimiter=|) - Section 6.0 • Modified Table I – B (SCO Service Category) – Section 7.0 • Added an appendix for Provider Data File Guidelines – Section 9.0 • Modified “Inpatient Claim” Clarification – Section 2.0 • Added “Administrative Fees” Clarification – Section 2.0 • Added a value of ‘0’ to “Primary Care Eligibility Indicator” field # 33 in Provider Data set – Section 3.1 • Added a clarifying note to “Rate Increase Indicator” Field # 200 – Section 3.0 • Clarified that the monthly financial report should include both MH and Compare Populations (Section 1.1), and that it should be submitted subsequent to submission of Manual Override (Section 6.0)	Rima Kayyali
2/21/2013	Modified Provider Data Record Layout, MCE Internal Provider Type and Metadata	Rima Kayyali
1/17/2013	Modified based on feedback received from MCE in 1/17/2013 meeting	Rima Kayyali

Date	Revision	Name
1/15/2013	Added Flags for "ACA 1202 Rate Increase" eligibility	Rima Kayyali
11/05/2012	Final Updates	Rima Kayyali
8/16/2012	Updates Based on Meeting Discussions	Rima Kayyali
6/6/2012	Updated Encounter Data Set Elements with additional fields. Updated Tables.	Rima Kayyali
11/22/2010	Added more detailed descriptions	Kelly Zeeh

CONTENTS

Acronyms

Acronym	Meaning
ACO	Accountable Care Organization
ACPP	Accountable Care Partnership Plan (MCE that submits encounter claims to MassHealth on behalf of Model A ACOs).
DW	Data Warehouse
EOHHS	Executive Office of Health and Human Services
FFSE	Fee-For-Service-Equivalent. The amount that would have been paid by the MCE for a specific service or encounter on a fee for service basis if the service or encounter had not been capitated, paid under a bundled payment, paid partially (such as a withhold), overpaid to be recouped later, or otherwise paid under a risk sharing arrangement.
ICO	One Care Plans
MBHP	Mass Behavioral Health Partnership
MCE	Managed Care Entity (MCO, SCO, One Care, and MBHP collectively)
MCO	Managed Care Organization
MH	MassHealth
PCC	Primary Care Center
PIDSL	Provider ID Service Location
SCO	Senior Care Organization

1.0 Introduction

MassHealth Data Warehouse (MH DW) was required to build and maintain a database of health care services provided to Massachusetts Medicaid recipients enrolled in managed care programs. EHS is using the data for many critical workstreams, including Centers for Medicare and Medicaid Services (CMS, formerly HCFA) reporting, program evaluation, Monthly report production, financial determinations, risk/premium adjustment, performance evaluation in quality measures and utilization, and rate development. It is critical that each Managed Care Entity (MCE), ACO/MCO, MBHP, SCO, and One Care, provides MH DW with encounter claim records accurately reflecting all services provided to Medicaid recipients enrolled in MCEs' managed care program and the total medical cost of care. Only with complete and accurate encounter data can MassHealth fairly assess the effectiveness of MCEs and the managed care program.

All MCEs are required to submit complete, accurate, and timely encounter information on paid claims and related data. Unless otherwise directed by MassHealth, encounter claims are expected to reflect the MCE's actual payment or a Fee-for-Service-Equivalent (FFSE) for the MCE's medical cost of care for the encounter or service as it would be reflected in the MCE's financial reports (excluding IBNR). With the implementation of the ACO project, encounters for both, MCO and ACO, should be submitted in the same file.

For denied claims submissions, please see denied claims submission requirements specifications document.

These specifications provide the requirements for the Paid Encounter file, Provider files, Member file, and Member Enrollment file. All the MCEs, including SCO and One Care, should follow the same format of the files in their submissions.

For the Paid Encounter file submission requirements, please see section 6.0.

For Member and Member Enrollment file submission requirements, please see Appendix C.

MassHealth expects the MCEs to provide new, replacement, and void claims in each submission. MassHealth processes the data and returns rejected claims to the MCEs with the appropriate error codes. MCEs are generally expected to correct the offending claims and send them in a correction file within 5 business days from the date the error reports are posted on SFTP server. The submission-rejection-resubmission cycle must be completed within a month of submission. The number of rejected claims must be below a MassHealth defined threshold. If you cannot submit data in this fashion, or if you have any questions about any of these documents, please send us an email at "EHS-DL-ENCSPECS@@MassMail.State.MA.US".

1.1 Data Requirements

- The data referred to in this document are encounter data – a record of health care services, health conditions and products delivered for Massachusetts Medicaid managed care beneficiaries. An encounter is defined as a visit with a unique set of services/procedures performed for an eligible recipient. Each service should be documented on a separate encounter claim detail line completed with all the data elements including date of service, revenue and/or procedure code and/or NDC number, units, and MCE payments/cost of care for a service or product.

- All encounter claim information must be for the member identified on the claim by Medicaid ID. Claims must not be submitted with another member's identification (e.g., newborn claims must not be submitted under the Mom's ID).

- All claims should reflect the final status of the claim on the date it is pulled from the MCE's Data Warehouse.

- For MassHealth, only the latest version of the claim line submitted to MassHealth is "active". Previously submitted versions of claim lines get offset (no longer "active" with MassHealth) and payments are not netted.

- An encounter is a fully adjudicated service (with all associated claim lines) where the MCE incurred the cost either through direct payment or sub-contracted payment. Generally, at least one line would be adjudicated as "paid". All adjudicated claims must have a complete set of billing codes. There may also be fully adjudicated claims where the MCE did not incur a cost but would otherwise like to inform MassHealth of covered services provided to Enrollees/Members, such as for quality measure reporting (e.g., CPT category 2 codes for A1c lab tests and care/patient management).

- All claim lines should be submitted for each Paid claim, including zero paid claim lines (e.g., bundled services paid at an encounter level and patient copays that exceeded the fee schedule). Denied lines should not be included in the Paid submission. Submit one encounter record/claim line for each service performed (i.e., if a claim consisted of five services or products, each service should have a separate encounter record). Pursuant to contract, an encounter record must be submitted for all covered services provided to all enrollees. Payment amounts must be greater than or equal to zero. There should not be negative payments, including on voided claim lines.

- Records/services of the same encounter claim must be submitted with same claim number. There should not be more than one active claim number for the same encounter. All paid claim lines within an encounter must share the same active claim number. If there is a replacement claim with a new version of the claim number, all former claim lines must be replaced by the new claim number or be voided. The claim number, which creates the encounter, and all replacement encounters must retain the same billing provider ID or be completely voided.

- Plans are expected to use current MassHealth MCE enrollment assignments to attribute Members to the MassHealth assigned MCE. The integrity of the family of claims should be maintained when submitting claims for multiple MCEs (ACOs/MCO). Entity PIDSL, New Member ID, and the claim number should be consistent across all lines of the same claim.

- Data should conform to the Record Layout specified in Section 3.0 of this document. Any deviations from this format will result in claim line or file rejections. Each row in a submitted file should have a unique Claim Number + Suffix combination.

- A feed should consist of new (Original) claims, Amendments, Replacements (a.k.a. Adjustments) and/or Voids. The replacements and voids should have a former claim number and former suffix to associate them with the claim + suffix they are voiding or replacing. See Section 2.0, Data Element Clarifications, for more information.

- While processing a submission, MassHealth scans the files for the errors. Rejected records are sent back to the MCEs in error reports in a format of the input files with two additional columns to indicate an error code and the field with the error.

- Unless otherwise directed or allowed by MassHealth, all routine monthly encounter submissions must be successfully loaded to the MH DW on or before the last day of each month with corrected rejections successfully loaded within 5 business days of the subsequent month for that routine monthly encounter submission to be considered timely and included in downstream MassHealth processes. Routine monthly encounter submissions should contain claims with paid/transaction dates through the end of the previous month.

1.2 How to Use this Document

This Encounter Data Set Request is intended as a reference document. Its purpose is to identify the data elements that MassHealth needs to load into encounter database. The goal of this document is to clarify the standard record layout, format, and values that MassHealth will accept.

Data Element Clarifications

In 2.0 "Data Set Clarification" section provides clarifications and expectations on data elements like DRG, Diagnosis Codes, Procedure Codes, and Provider IDs.

Data Elements

The information contained in the Data Elements sections defines each of the fields included in the record layout. When appropriate, a list of valid values is included there. Nationally recognized coding schemes have been used whenever they exist.

Encounter Record Layout

Section 4.0 "Encounter Record Layout" specifies encounter file layout. All the MCEs must use that format when compiling the Encounter Data file that might contain all or any Claim Category (facility, professional, dental, etc.). MassHealth requests that the encounter data file is provided in a pipe-delimited text file with each service on a separate line.

Contact MassHealth if you need further clarification.

Media Requirements and Data Formats

Section 6.0 "Media Requirements and Data Formats." contains complete information about all the files that should be submitted to EOHHS MassHealth Data Warehouse EHS DW. MCEs submit their data to MassHealth through a secure FTP server. Each MCE has a home directory on this server and is given an ID with public key/private key-based login. Please also note the security requirements for Internet transmissions noted in the Media Requirements section.

Standard Data Values

Section 7.0 "Standard Data Values" contains tables referenced in the specific fields of the Data Elements section (Tables A through H).

Data Quality Checks

Section within 8.0 "Quantity and Quality Edits, Reasonability and Validity Checks" provides the validity and quality criteria that encounter data are expected to meet. Other Data Quality checks are noted in the Provider file, Member file, and Member Enrollment file sections.

NOTE: MCEs must submit valid values for all fields that MassHealth could reasonably expect to be available to MCEs, even if the records are currently not rejected for missing or invalid values in some fields. MassHealth reserves the right to introduce additional completeness validation rules.

2.0 Data Element Clarifications

MassHealth has identified several data elements that require further clarification with respect to the expectations for those elements. The information in this section details MassHealth's expectations for Recipient Identifiers, Provider IDs, DRG, Diagnosis Codes (primary through fifth), and Procedure Codes.

MCEs must submit valid values for all fields that MassHealth could reasonably expect to be available to MCE.

2.1 Record Type Submission Options and Explanations

Choose the correct Record Type for each claim line depending on the use case. Note the Special Submission requirements.

Record Type	A.K.A.	Use	Special Submission Requirements
O = Original	Original	Initial submission of the claim	No special requirements
A = Amendment	Correction	To correct, update, add missing data elements values of a claim previously loaded in MH DW. Example: an incorrect data mapping to an Encounter field was remediated and impacted claim lines are now resubmitted to the MHDW with an "Amendment" Record Type and the correct value.	Submitted with the Original Claim Number and Suffix Nothing should be entered in Former Claim / Suffix Number fields unless the amendment is for a previously adjusted claim, in which case the amendment record would inherit the former claim number/suffix from the claim it is amending.
V = Void or Back Out	Void	To remove a claim line that was previously loaded in MH DW. Example: A paid claim was later denied. All previously submitted claim lines would be resubmitted with a "Void" Record Type.	Submitted with new Claim Number/Suffix. Claim Number/Suffix of the claim to be voided must be placed in Former Claim Number/Suffix fields
R = Replacement	Adjustment	To replace a claim that was previously loaded in the MH DW with one that has a new claim number. Example: the provider has resubmitted a claim under a new claim number. All previously submitted claim lines must be resubmitted with the new claim number and a "Replacement" Record Type.	Submitted with new Claim Number/Suffix. Claim Number/Suffix of the claim that has to be replaced must be placed in Former Claim Number/Suffix fields. All claim lines need to be replaced with the new claim number. If there are more claim lines in the replacement claim than the original, submit the additional claim as an Original. Visa versa, if there are fewer claim lines in the replacement than the original, void the extra claim lines.

2.2 Claim Number and Suffix

Every Original / Void or Replacement claim submitted to MassHealth should have a new, unique claim number + suffix combination. Duplicate claim number + claim suffix combinations will not be loaded into the MassHealth data warehouse.

2.3 Member IDs

Encounter data records must include MassHealth member IDs that are "active" as of the time of data submission.

2.4 Provider IDs

MassHealth is asking MCEs to provide an identifier that is unique to the MCE. The acceptable ID types are:

ID Type	ID Description	Comments
1	NPI	Accepted for any provider including Referring and Prescribing Provider IDs. Note: MassHealth expects MCEs to submit MCE Internal ID in Provider IDs and use NPI as a Provider ID only when necessary and when an internal ID is not available. When NPI is used in Provider ID fields, provider file must have it entered in Field #2 (Provider ID) and in field #26 (NPI). Field #26 (NPI) must also be populated for all other Provider ID types except when it's not available, like in the case of atypical providers.
6	MCE Internal ID	Accepted for any provider
8	DEA Number	Should be used with pharmacy claims only
9	NABP Number	Should be used with pharmacy claims only

- The Provider ID, Provider ID Type, and Provider ID Location Code should be 100 % present on all provider records.
- 100% of Pharmacy and Physician-Administered Drugs claims must have Billing Provider NPI numbers in provider file
- At least 80% of all the records in the Provider file should have NPI numbers included, or the submission file will be rejected.
- At least 80% of all the records in the Provider file should have Provider Type included, or the submission file will be rejected.
- All the provider records in provider file, which are part of the PCC enrollment with MCE, need to have PCC details on the same line.

2.5 NPI

The Centers for Medicare & Medicaid Services (CMS) require all Medicare and Medicaid providers and suppliers of medical services that qualify for a National Provider Identifier (NPI) to include NPI on all claims. Type 1 NPI is for Health care providers who are individuals, including physicians, psychiatrists and all sole proprietors. Type 2 NPI is for Health care providers that are organizations, including physician groups, hospitals, nursing homes, and the corporations formed when an individual incorporates him/herself.

MCEs should submit the individual NPI (Type1) for Servicing/Rendering, Referring, Prescribing, and Primary Care Providers in Provider file. MCEs should submit individual (Type 1) or group (Type 2) NPI for billing providers and PCCs.

MH DW will closely monitor submission of servicing/rendering, billing, and referring provider NPI numbers in Provider File. With a change of the business rules, claims with missing NPI numbers in Provider File might be rejected. MCEs will be notified about the change ahead of time.

The above does not apply to "atypical" providers.

2.6 DRG

The DRG field (field #72) is a field requested by CMS. Not all MCEs collect DRGs so MassHealth has developed a preferred course of action:

1. An MCE that collects DRGs- should provide DRG values in data submissions.
2. An MCE that does not collect DRGs, should ensure that primary, secondary, and tertiary diagnosis values are as complete and accurate as possible, so that MassHealth may use a DRG grouper if necessary. Accurate procedure codes are also required for DRG assignment.
3. In the future, MassHealth may request that all MCEs provide DRGs.
4. MassHealth requests from MCEs that report DRGs to also report in DRG related fields: DRG Type, DRG Version, Severity of Illness level, and Risk of Mortality.

2.7 Diagnosis Codes

The values in all Diagnosis fields listed in Data Elements section should be submitted when available. Submit on Dental claims when available.

Requirements for validity and completeness are detailed in the ICD clinical guide published by the American Medical Association. Current validating process at MH DW requires:

- at least one diagnosis code (in Primary Diagnosis field #19) for all applicable encounter types as specified in section 8.0.
- diagnosis codes contain the required number of digits outlined in the ICD code books.
- code to the seventh digit when applicable (blank filled when less than seven digits are applicable). DO NOT include decimal points in the code. For example, S72.111A must be entered as S72111A.
- Diagnosis Code must be consistent with ICD Version Qualifier.

Other Guidance:

- On Transportation claims for the services like “a ride to the grocery store”, MCEs should use generic diagnosis codes such as:
  - Z993 – Dependence on wheelchair
  - Z87898 – Personal history of other specified conditions

.

2.8 Procedure Codes

Many MCEs accept and use non-standard codes such as State specific and MCE specific codes. Current validating process at EHS DW looks for standard codes only - CPT, HCPCS, and ADA.

HIPPAA regulations require that only standard HCPCS Level I (CPT) and II be used for reporting and data exchange. The only field containing HCPCS Level 1 and II procedure codes is the Procedure Code field (#26). ICD-10 PCS procedure codes should be populated in the Surgical Procedure Code fields (103-111, 206-221).

2.9 Capitation Payments

Capitation payment arrangement refers to a periodic payment per member, paid in advance to health care providers for the delivery of covered services to each enrolled member assigned to them. The same amount is paid for each period regardless of whether the member receives the services during that period or not.

Note: Capitation payment is not "Bundled" payment, which is usually paid for Episodes of care or other bundled services.

2.10 Dollar Amounts

MassHealth wants to ensure that the dollar amounts on the individual lines of the claim represent the actual or computed amounts associated with each encounter. Therefore, whenever dollar amounts are not included at the detail level, and the summary-level line is not available, the MCE should add an extra detail line with a Record Indicator of 0 and report all summary-level amounts/quantities on that line. If the summary-level line is already available in the MCE's source system and is not artificially created, then MassHealth would expect it to have a Record Indicator value of 4 (Per diem), 5 (DRG) or 6 (Bundled Summary-Level line when none of the other payment arrangements apply).

All detail lines with zero-dollar amounts (that are not artificially created and are not summary-level lines) should have any value other than 0 or 6 placed in Record Indicator field. In such case, MCE decides on the value based on the definition of the Record Indicator in the table below.

For the claims covered by sub-capitation payments, MCEs must report the amounts reported by the provider/vendor on their claims in the Net Payment field (#68) or the Fee-For-Service Equivalent (FFSE) and use Record Indicator value 2 to indicate the FFSE type of payment arrangement. See "Acronyms" section for MassHealth's expectation for an FFSE.

Record Indicator Table:

Record Indicator	Dollar Amount Split
0: Artificial Line	Dollar amounts / quantities represent numbers that are available only at a summary level.
1: Fee-For-Service	Dollar amounts should be available at the detail line level in the source system.
2: Encounter Record with Fee-For-Service-Equivalent (FFSE)	Dollar amounts for a service paid under a capitation arrangement or otherwise not reflected in the source system.
3: Encounter Record w/out FFS equivalent	DECOMMISSIONED
4: Per Diem Payment	Use for Per Diem payment arrangements. One line would have the total dollar amount for the day or stay.
5: DRG Payment	Use for DRG payment arrangements. One line would have the total dollar amount for the entire stay.
6: Bundled Summary-Level Line	Total dollar amount for a bundled summary-level claim line where the dollar amounts represent numbers that are available only at a summary line level in the source system and is not artificially created. A record with indicator = 6 for a summary-level line of a bundled claim is used when none of the above payment arrangements apply.

Record Indicator	Dollar Amount Split
7: Bundled detail line with 0 dollar amount	A bundled detail claim line where the dollar amounts are 0 or not available at the detail level. A record with indicator = 7 is used for a detail-level line of a bundled claim when none of the above payment arrangements apply.

Below are few examples of possible scenarios for Record Indictor values:

Example 1 - Artificial Line 0 and Detail Lines with Record Indicator 4:

Claim Number	Claim Suffix	Record Indicator	Revenue Code	Payment Amount
44444444444	1	4 - Per Diem Payment	0112	0
44444444444	2	4 - Per Diem Payment	0300	0
44444444444	3	4 - Per Diem Payment	0250	0
44444444444	4	4 - Per Diem Payment	0720	0
44444444444	5	0 - Artificial Line: dollar amounts available at summary level only	NULL	10000

Example 2 – Per Diem payment on one claim line with the Room and Board Revenue Code:

Claim Number	Claim Suffix	Record Indicator	Revenue Code	Payment Amount
4444444444A	1	4 - Per Diem Payment	0410	0
4444444444A	2	4 - Per Diem Payment	0300	0
4444444444A	3	4 - Per Diem Payment	0250	0
4444444444A	4	4 - Per Diem Payment	0123	10000

Example 3 - Artificial Line 0 and Detail Lines with Record Indicator 7:

Claim Number	Claim Suffix	Record Indicator	Payment Amount
55555555555	1	7 - Bundled detail line with 0 dollar amount	0
55555555555	2	7 - Bundled detail line with 0 dollar amount	0
55555555555	3	0 - Artificial Line: dollar amounts available at summary level only	100

Example 4 – Bundled Summary Line 6 and Detail Lines with Record Indicator 7:

Claim Number	Claim Suffix	Record Indicator	Payment Amount
66666666666	1	7 - Bundled detail line with 0 dollar amount	0
66666666666	2	7 - Bundled detail line with 0 dollar amount	0
66666666666	3	6 - Bundled Summary-Level Line	500

2.11 Claim Number & Suffix

Every Original / Void or Replacement claim submitted to MassHealth should have a new claim number + suffix combination. There can be no duplicate claim number + claim suffix in one feed

2.12 Former Claim Number & Suffix

In order to void or replace old transactions, MassHealth requires for all the MCEs to add former claim number and former claim suffix to the claim lines of record type 'R', 'V'. The objective is to get a snapshot of the claims at the end of each period after all debit or credit transactions have been applied to them.

When there are duplicate services submitted on multiple claim records with different claim number + suffix combinations, MassHealth will consider the record with the latest paid date as the active claim line.

Examples:

Replacements

Claim Payer	Claim Number	Claim Suffix	Claim Category	Record Type	Former Claim Number	Former Claim Suffix	Net Payment (#68)	Paid Date
XXX	11111111111	4	1	O			10	7/15/20
XXX	33333333333	4	1	R	11111111111	4	20	8/1/20
XXX	88888888888	4	1	R	33333333333	4	25	9/1/20

Voids

Claim Number	Claim Suffix	Claim Category	Record Type	Former Claim Number	Former Claim Suffix	Net Payment (#68)	Paid Date	Void Reason Code (#118)
66666666666	1	1	O			15	1/5/2020	
77777777777	2	1	V	66666666666	1	0	3/1/2020	3 (provider audit recovery)

2.13 Record Creation Date

This is the date on which the claim was created in the MCE's database. If a replacement record represents the final result of multiple adjustments to a claim between submissions, Record Creation Date is the date of the last adjustment to that claim. For encounter records where Record Indicator value is 2 or 3, Record Creation Date should be the same as the Paid Date.

2.14 MassHealth Inpatient vs. Outpatient Claim Determinations

Old, pre-November 2016, DW Logic

MassHealth applies a modified logic on encounter data to identify "Inpatient" claims. This new logic is an internal change that does not affect the encounter data submission process and only applies to the claims with "From Service Date" (field# 17) on or after October 1, 2016.

New DW Logic

Claims with Claim Category = 1 (Facility except LTC) and **Type of Bill** values **11x and 41x** are defined as "Inpatient". All other claims with Claim category = 1 are defined as "Outpatient".

2.15 LTC Claims

Claims with Claim Category = 6 (Long Term Care - Nursing Home, Chronic Care & Rehab) are defined as **"LTC"**. MCEs should ***continue*** sending all "Long Term Care" claims with Claim Category='6'.

2.16 Physician-Administered Drug Claim Definition

Claims with Claim Category 1 (Facility except LTC) or 2 (Professional) and value in "NDC Number" field (#37).

2.17 Administrative Fees

Administrative Fees such as PBM fees should not be reported in the encounter data as part of the "Net (" (#68). MCEs should inform EOHHS of any arrangement where these fees are included in their claims processing and should work with their PBM or other vendors to separate out the administrative fees from the encounter cost component in their claim processing.

2.18 Bundle Indicator, Claim Number & Suffix

The Bundle indicator is a Y/N field to indicate that the claim line is part of a bundle. This indicator should always be 'Y' for **all** bundled claims (see example 1 and 2). The Bundle Claim Number and Suffix refer to the claim number and the claim suffix of the claim line with the bundled payment. The examples below illustrate how these two fields should be populated. Example 1 illustrates a scenario with one bundle within a claim, Example 2 illustrates a scenario with multiple bundles within a claim, and Example 3 illustrates a scenario with one bundle across multiple claims.

The assumption is that when a bundled claim line gets adjusted, all bundled claim lines for that claim would be adjusted as well. Please see Examples 4 and 5 below for scenarios where there is a Replacement or Void of a bundled claim. MCE should leave the Bundle claim number and suffix blank when this assumption is inaccurate and when they do not have this information. However, these two fields are expected when MCE have this information in their system. Bundle Indicator should be provided on all bundled claims with no exception.

Example 1 – One Bundle per Claim Number:

Claim Payer	Claim Number	Claim Suffix	Bundle Ind	Bundle Claim Number	Bundle Claim Suffix	Net Payment (#68)
XXX	AAAAAAAA	1	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	2	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	3	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	4	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	5	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	6	Y	AAAAAAAA	6	120

Example 2 – Two Bundles per Claim Number:

Claim Payer	Claim Number	Claim Suffix	Bundle Ind	Bundle Claim Number	Bundle Claim Suffix	Net Payment (#68)
XXX	CCCCCCCC	1	Y	CCCCCCCC	3	0
XXX	CCCCCCCC	2	Y	CCCCCCCC	3	0
XXX	CCCCCCCC	3	Y	CCCCCCCC	3	60
XXX	CCCCCCCC	4	Y	CCCCCCCC	6	0
XXX	CCCCCCCC	5	Y	CCCCCCCC	6	0
XXX	CCCCCCCC	6	Y	CCCCCCCC	6	80

Example 3 – One Bundle for Two Claim Numbers:

Claim Payer	Claim Number	Claim Suffix	Bundle Claim Number	Bundle Claim Suffix	Net Payment (#68)
XXX	DDDDDDDD	1	NNNNNNNN	1	0
XXX	DDDDDDDD	2	NNNNNNNN	1	0
XXX	DDDDDDDD	3	NNNNNNNN	1	0
XXX	NNNNNNNN	1	NNNNNNNN	1	50

Example 4 – Replacement/Void of Bundled Claims with Record Indicator 0:

Claim Payer	Claim Number	Claim Suffix	Record Type	Former Claim Number	Former Claim Suffix	Bundle Claim Number	Bundle Claim Suffix	Net Payment (#68)	Record Indicator	Procedure Code
XXX	44444444444	1	O			44444444444	4	0	4	96360
XXX	44444444444	2	O			44444444444	4	0	4	96375
XXX	44444444444	3	O			44444444444	4	0	4	96376
XXX	44444444444	4	O			44444444444	4	260	0	
XXX	55555555555	1	R	44444444444	1	55555555555	4	0	4	96360
XXX	55555555555	2	V	44444444444	2	55555555555	4	0	4	96375
XXX	55555555555	3	R	44444444444	3	55555555555	4	0	4	96376
XXX	55555555555	4	R	44444444444	4	55555555555	4	200	0	

Example 5 – Replacement/Void of Bundled Claims with Record Indicator 6:

Claim Payer	Claim Number	Claim Suffix	Record Type	Former Claim Number	Former Claim Suffix	Bundle Claim Number	Bundle Claim Suffix	Net Payment (#68)	Record Indicator	Procedure Code
XXX	66666666666	1	O			66666666666	3	0	7	3EA11
XXX	66666666666	2	O			66666666666	3	500	6	G0299
XXX	77777777777	1	R	66666666666	1	77777777777	3	0	7	3EA11

Claim Payer	Claim Number	Claim Suffix	Record Type	Former Claim Number	Former Claim Suffix	Bundle Claim Number	Bundle Claim Suffix	Net Payment (#68)	Record Indicator	Procedure Code
XXX	77777777777	2	R	66666666666	3	77777777777	3	400	6	G029

2.19 Submission Clarification Code

The Submission Clarification Code (#13, 229, and 230) is populated with a 420-DK-Code when the pharmacist is clarifying the submission. MassHealth requires that a Submission Clarification Code value of 20 be included on the claim when the pharmacy has determined the product being billed is purchased pursuant to right available under Section 340B of the Public Health Act of 1992 including sub-celling purchases authorized by section 340B(a)(10) and those made though the Prime Vendor Program 340B(a)(8).

For additional information about submission clarification code values, please refer to the NCPDP standards. For additional information about submission clarification code values, please refer to the NCPDP standards.

2.20 Provider ID Submission in Encounter and Provider Files

Among several elements introduced in Version 4.6 of these specifications were Provider ID Address Location Code fields.

The values in the “Provider ID”, “Provider ID Type”, and “Provider ID Address Location” fields entered in claims file should match the values in corresponding fields of the provider file.

Consistent with MassHealth policy for implementing 42 CFR 438.602(b)(1), plans are asked to store the MassHealth Provider Identification number (PIDSL) information that is provided by MassHealth in their systems and provide that information when submitting their ongoing file exchanges as directed by MassHealth, as well as in the event of an audit. When submitting encounter files, MCEs are required to report the MassHealth PIDSL in the “Medicaid Number” field for each provider in their Provider File (field #5).

Example: Claims File

Entity PIDSL	Claim Number	Claim Suffix	Servicing Provider ID	Servicing Provider ID Type	Servicing Provider ID Address Location Code
999999999R	98765432WS	1	1234569	6	A
999999999R	23568974RV	1	1234568	6	B
999999999R	741852969K	1	1234567	6	C
999999999R	369874123L	1	1234566	6	D

Example: Provider File

Entity PIDSL	Provider ID	Provider ID Type	Address Location Code	Provider Bundle ID	Provider Last Name
999999999R	1234569	6	04	12345	Smith
999999999R	1234568	6	03	12345	Smith
999999999R	1234567	6	02	12345	Smith

Entity PIDSL	Provider ID	Provider ID Type	Address Location Code	Provider Bundle ID	Provider Last Name
999999999R	1234566	6	01	12345	Smith

2.21 Medicare Related Data

For SCO and OneCare plans, Medicare Code (#11) and Medicare Amount (#63) must be populated accurately and consistently per CMS requirements.

2.22 Programs with withhold amount

Some Managed Care programs include withhold risk-sharing arrangements with their providers when a portion of the approved payment amount is withheld from the provider payment amount and placed in a risk-sharing pool for later distribution. In such case, the withheld amount should be recorded in a separate field “Withhold Amount” (#69) and included in Allowable Amount (#86).

2.23 Recoveries

All claim lines with a payment recovery or other adjustment to the Original claim line related to TPL, accident recovery, or provider audit recoveries must have the Void Reason Code populated (#118), including for all Voids and Replacements. Voids and/or Replacements for provider audit recoveries should include all overpayments recovered or otherwise adjusted as a result of program integrity fraud, waste and abuse controls, including but not limited to provider audits, surveillance and utilization reviews, investigations, post-payment claims edits, algorithms, and provider self-disclosures.

3.0 Encounter Data Set Elements with Record Layout

Data Elements

This section contains field names and definitions for the encounter record. It is divided into five sub-sections:

- Demographic Data
- Service Data
- Provider Data
- Financial Data
- Medicaid Program-Specific Data

For the fields that contain codified values (e.g., Patient Status), we use national standard (e.g., UB92 coding standards) values whenever possible.

In the table below "X" indicates a Claim Category the data element is applicable in. The columns are labeled as:

- H – Facility (except Long Term Care)
- P – Professional
- L – Long Term Care
- R – Prescription Drug
- D – Dental

Demographic Data

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization. This code identifies your Organization: **MCO / ACPP** 465 Fallon Community Health Plan 469 Allways Health Partners (a.k.a. Neighborhood Health Plan) 997 Boston Medical Center HealthNet Plan 998 Tufts Health Plan (a.k.a. Network Health) 999 Massachusetts Behavioral Health Partnership 470 CeltiCare - Retired 471 Health New England **SCO** 501 Commonwealth Care Alliance 502 United HealthCare (a.k.a. Evercare) 503 NaviCare 504 Molina Healthcare (a.k.a. Senior Whole Health) 505 Tufts Health Plan Senior Care Options 506 Boston Medical Center HealthNet Plan Senior Care Options **One Care** 601 Commonwealth Care Alliance 602 Tufts Health Unify (a.k.a., Network Health) 603 Fallon Total – Retired 604 United HealthCare Connected (new)	X	X	X	X	X	3	N
2	Claim Category	Assign claim category based on claim source (e.g., 837i, 837p, 837d). Valid values are:	X	X	X	X	X	1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		1 = Facility (except Long Term Care) 2 = Professional (includes transportation claims) 3 = Dental 4 = Vision 5 = Prescription Drug 6 = Long Term Care (Nursing Home, Chronic Care & Rehab) Facility encounters with Type of Bill beginning with 2xx (SNF) or 6xx (Intermediate) should be assigned to LTC (Claim Category = 6) with the remainder to Facility/not LTC (Claim Category = 1). *Note:* Section 2.0 Data Element Clarifications explains how MassHealth uses the MCE assigned Claim Category together with Type of Bill to determine Inpatient vs. Outpatient facility.							
3	Entity PIDSL (Provider ID/ Service Location	ACO PIDSL on the ACO claims (an ACO with which a PCC is contracted with) or MCO PIDSL on the MCO claims or One Care Plan PIDSL on One Care claims or SCO PIDSL for SCO claims Example: 999999999A	X	X	X	X	X	10	C
4	Record Indicator	This information refers to the payment arrangement under which the rendering provider was paid as reported in Net Payment #68. 0. Artificial line – Dollar amounts / quantities represent numbers that are available only at a summary level. 1. Fee for Service - Dollar amounts should be available at the detail line level in the source system 2. Encounter Record with Fee-For-Service-Equivalent (FFSE) - Dollar amounts for a service paid under a capitation arrangement or otherwise not reflected in the source system. 3. DECOMMISSIONED 4. Per Diem Payment - Refers to a record for an inpatient stay paid on a per diem basis. 5. DRG Payment - Refers to a record for an inpatient stay paid on a DRG basis. 6. Bundled Summary-Level Line – Refers to a record with bundled summary-level amounts/quantities as available in the MCE source system. Use this value when none of the above values apply. Bundled detail line with 0 dollar amount – Refers to a bundled detail claim line where the dollar amounts are 0 or not available at the detail level. Use this value when none of the above values apply. See discussion under Dollar Amounts in the ***Data Elements Clarification Section*** for additional instruction.	X	X	X	X	X	1	C
5	Claim Number	A unique number assigned by the administrator to this claim (e.g., ICN, TCN, DCN). It is very important to include a Claim Number on each record since this will be the key to summarizing from the service detail to the claim level. See discussion under ***Claim Number/Suffix*** in the ***Data Elements Clarification*** section.	X	X	X	X	X	20	C
6	Claim Suffix	This field identifies the line or sequence number in a claim with multiple service lines. See discussion under ***Claim Number/Suffix*** in the ***Data Elements Clarification*** section.	X	X	X	X	X	4	C
7	Pricing Indicator	Placeholder for Pricing Indicator. MCEs will be notified if implemented.						20	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
8	Recipient DOB	The birth date of the patient expressed as YYYYMMDD. For example, August 31, 1954 would be coded "19540831."	X	X	X	X	X	8	D/YYYYMMDD
9	Recipient Gender	The gender of the patient: 1 = Male 2 = Female 3 = Other	X	X	X	X	X	1	C
10	Recipient ZIP Code	The ZIP Code of the patient's residence as of the date of service.	X	X	X	X	X	5	N
11	Medicare Code	A code indicating if Medicare coverage applies and, if so, the type of Medicare coverage. Medicare code should indicate what part of Medicare is being used to cover the services billed within the claim, NOT all of the parts of Medicare that the member is enrolled in. 0= No Medicare 1 = Part A Only 2 = Part B Only 3 = Part A and B 4 = Part D Only 5 = Part A and D 6 = Part B and D 7 = Part A, B, and D	X	X	X	X	X	1	N

Service Data

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
12	Other Insurance Code	A Yes/No flag that indicates whether or not third-party liability exists. 1 = Yes; 2 = No	X	X	X	X	X	1	C
13	Submission Clarification Code	420-DK- Code indicating that the pharmacist is clarifying the submission. For 340b drugs the Submission Clarification Code must be populated with a code value of 20. 420-DK- Code indicating that the pharmacist is clarifying the submission. For 340b drugs the Submission Clarification Code must be populated with a code value of 20. Please refer to Segment *2.0 Data Element Clarifications* for further information.				X		7	N
14	Claim Type	MBHP Specific field.	X	X	X		X	18	C
15	Admission Date	For facility services, the date the recipient was admitted to the facility. The format is YYYYMMDD.	X		X				
16	Discharge Date	For facility services, the date the recipient was discharged from the facility. The format is YYYYMMDD. The date cannot be prior to Admission Date.	X		X			8	D/YYYYMMDD
17	From Service Date	The actual date the service was rendered; if services were rendered over a period of time, this is the date of the first service for this record. The format is YYYYMMDD.	X	X	X	X	X	8	D/YYYYMMDD
18	To Service Date	The last date on which a service was rendered for this record. The format is YYYYMMDD.	X	X	X		X	8	D/YYYYMMDD
19	Primary Diagnosis	The ICD diagnosis code chiefly responsible for the hospital confinement or service provided. See discussion about Diagnosis Codes in ***Data Element Clarifications*** section, including decimal requirements. *Note:* Primary diagnosis and co-morbidities are for services rendered and thus may not match Admitting Diagnosis. For institutional claims,	X	X	X		X	7	C/ No decimal points

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		this would be the Principal Diagnosis Code on Admission from the UB04/837i.							
20	Secondary Diagnosis	The ICD diagnosis code explaining a secondary or complicating condition for the service. See discussion about Diagnosis Codes in ***Data Element Clarifications*** section, including decimal requirements.	X	X	X			7	C/ No decimal points
21	Tertiary Diagnosis	The tertiary ICD diagnosis code. See ***Secondary Diagnosis*** format in the row this one. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/ No decimal points
22	Diagnosis 4	The fourth ICD diagnosis code. See above for format. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/ No decimal points
23	Diagnosis 5	The fifth ICD diagnosis code. See above for format. See above for format. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/ No decimal points
24	Type of Admission	Should be valid and present on all Hospital and Long-Term Care claims with hospital admission. For the UB standard values see Table A.	X		X			1	C
25	Source of Admission	Should be valid and present on all Hospital and Long-Term Care claims with hospital admission. For the UB standard values see Table B	X		X			1	C
26	Procedure Code	A code explaining the procedure performed. This code may be any valid code included in the coding systems identified in the Procedure Type field below. Any internal coding systems used must be translated to one of the coding systems identified in field #30 below. Should not contain ICD procedure codes. All ICD procedure codes should be submitted in the surgical procedure code fields (#103 – #111, 206-221) ***including the ICD-treatment procedure codes*** See discussion in Data Element Clarifications section.	X	X	X		X	6	C
27	Procedure Modifier 1	A current procedure code modifier (CPT or HCPCS) corresponding to the procedure coding system used, when applicable.	X	X	X		X	2	C
28	Procedure Modifier 2	Second procedure code modifier, required, if used.	X	X	X		X	2	C
29	Procedure Modifier 3	Third procedure code modifier, required, if used.	X	X	X		X	2	C
30	Procedure Code Indicator	A code identifying the type of procedure code used in field#26: 2= CPT or HCPCS Level 1 Code 3= HCPCS Level II Code 4= HCPCS Level III Code (State Medicare code). 5= American Dental Association (ADA) Procedure Code (Also referred to as CDT code.) 6= State defined Procedure Code 7= Plan specific Procedure Code ICD procedure codes should go in Surgical Procedure code fields (Field # 103 – 111, 206-221). State defined procedure codes should be used, when coded, for services such as EPSDT procedures. ***See discussion in the Data Element Clarifications section.***	X	X	X		X	1	N
31	Revenue Code	For facility services, the UB Revenue Code associated with the service. Only standard UB92 Revenue Codes values are allowed; plans may not	X		X			4	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		use “in house” codes. Values should be sent in 4 digit format. Revenue codes less than 4 digits long should be submitted with leading zeros. For Example: Revenue code -1 - as ‘0001’; Revenue Code 23 - as ‘0023; Revenue code 100 - as ‘0100’; Revenue Code 2100 – as ‘2100’.							
32	Place of Service	This field hosts Place of Service (POS) that comes on the Professional claim). See Table C for CMS 1500 standard		X			X	2	C
33	Type Of Bill	For encounter data supporting UB claims submission the Type of Bill is submitted as a 3-digit bill type in accordance with national billing guideline. The first two digits denote the place of services and the third digits denotes the frequency. See Table D for UB Type of Bill values indicating place. *Note:* for UB Type of Bill, use the 1st and 2nd positions only.) Frequency values can be found in Table K and are documented in field # 91 as well.	X		X			3	C
34	Patient Discharge Status	This is 2-digit Discharge Status Code (UB Patient Status) for hospital admissions. Values from 1 to 9 should always be entered with leading ‘0’. Examples: Patient Discharge Status ‘1’ should be submitted as ‘01’; Patient Discharge Status ‘19’ should be submitted as ‘19’.	X		X			2	C
35	Filler							2	C
36	Quantity	This value represents the actual quantity billed and should be submitted with decimal point when applicable. For inpatient admissions, the number of days of confinement. Count the day of admission but not the day of discharge (for admission and discharge on the same day, Quantity is counted as 1). For all other procedures, the number of units performed for this procedure. For most procedures, this number should be “1”. In some cases, a procedure may be repeated, in which case this number should reflect the number of times the procedure was performed. For anesthesia services, this should be the total number of minutes that make up the beginning and ending clock time of anesthesia service administered. Please make sure that the Quantity corresponds to the procedure code. For example, if the psychiatric code 90844 is used (Individual psychotherapy, 45-50 minutes), the Quantity should be “1” NOT “45” or “50”. For Inpatient records, it should represent number of days of care. Values of 30, 60 or 100 are most common on drug records. Note: Length of this field has been increased to accommodate the actual quantity. Quantity=10 should be submitted as 10; Quantity=10.5 should be submitted as 10.5; Quantity=10.55 should be submitted as 10.55	X	X	X		X	9	N
37	NDC Number	For prescription drugs, the valid National Drug Code number assigned by the Food and Drug Administration (FDA). For Compound drugs claims submit NDC Number for the primary drug, if primary drug is unknown, submit NDC Number for most expensive drug. NDC codes should not be blank on pharmacy and Physician Administered Drug claims, including for compound drugs.	X	X		X		11	N

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
38	Metric Quantity	For prescription and physician administered drugs, the total number of units or volume (e.g., tablets, milligrams) dispensed. Should be submitted with decimal point when applicable. Plans may need to derive the Metric Quantity for physician administered drugs using the procedure code and billed units. Unit of Measure #231 also needs to be populated to indicate the specific type of units counted here (e.g., each tablet, milligrams). *Note:* Length of this field has been increased to accommodate the actual Metric Quantity. Metric Quantity=10 should be submitted as 10; Metric Quantity=10.5 should be submitted as 10.5; Metric Quantity=10.55 should be submitted as 10.55	X	X		X		9	N
39	Days Supply	The number of days of drug therapy covered by this prescription.				X		3	N
40	Refill Indicator	A number indicating whether this is an original prescription (0) or a refill number (e.g., 1, 2, 3, etc.) on Pharmacy claims.				X		2	N
41	Dispense As Written Indicator	An indicator specifying why the product dispensed was selected by the pharmacist and should be entered in a 2-digit format with leading zero: 00=No product Selection Available 01=Substitution Not Allowed by Prescriber 02=Substitution Allowed-Patient Requested Product Dispensed 03=Substitution Allowed-Pharmacist Selected Product Dispensed 04=Substitution Allowed-Generic Drug Not in Stock 05=Substitution Allowed-Brand Drug Dispensed as a Generic 06=Override 07=Substitution Not Allowed-Brand Drug Mandated by Law 08=Substitution Allowed-Generic Drug Not Available in Marketplace 09=Substitution Allowed by Prescriber but Plan Requests Brand				X		2	N
42	Dental Quadrant	One of the four equal sections into which the dental arches can be divided; begins at the midline of the arch and extends distally to the last tooth. 1 = Upper Right 2 = Upper Left 3 = Lower Left 4 = Lower Right					X	1	N
43	Tooth Number	The number or letter assigned to a tooth for identifications purposes as specified by the American Dental Association. A - T (for primary teeth) 1 - 32 (for secondary teeth)					X	2	C
44	Tooth Surface	The tooth surface on which the service was performed: M = Mesial D = Distal O = Occlusal L = Lingual I = Incisal F = Facial B = Buccal A = All 7 surfaces This field can list up to six values. When multiple surfaces are involved, please list the value for each surface without punctuation between values. For example, work on the mesial, occlusal, and lingual surfaces should be listed as “MOL “(three spaces following the third value).					X	6	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
45	Paid Date	For encounter records, the date on which the record was adjudicated (i.e., MCE system generated transaction date).	X	X	X	X	X	8	D/YYYYMMDD
46	Service Class	MBHP Specific field	X	X	X		X	23	C

Provider Data

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
47	PCP Provider ID	A unique identifier for the Primary Care Physician selected by the patient as of the date of service. ***See discussion in the Data Element Clarifications section***.	X	X	X		X	15	C
48	PCP Provider ID Type	A code identifying the type of ID provided in PCP Provider ID above. For example, 6 = Internal ID (Plan Specific)	X	X	X		X	1	N
49	PCC Provider ID	. The Provider ID of the Practice the PCP is associated with. Plan's internal provider ID or NPI for the practice.	X	X	X		X	15	C
50	Servicing Provider ID	A unique identifier for the provider performing the service. ***See discussion in the Data Element Clarifications section***.	X	X	X	X	X	15	C
51	Servicing Provider ID Type	A code identifying the type of ID provided in Servicing Provider ID above. For example, 1 = NPI 6 = Internal ID (Plan Specific) 9 = NAPB Number (for pharmacy claims only)	X	X	X	X	X	1	N
52	Referring Provider ID	A unique identifier for the provider. ***See discussion in the Data Element Clarifications section***.	X	X	X		X	15	C
53	Referring Provider ID Type	A code identifying the type of ID provided in Referring Provider ID above. For example, 1 = NPI 6 = Internal ID (Plan Specific) 8 = DEA Number (for pharmacy claims only)	X	X	X		X	1	N
54	Servicing Provider Class	A code indicating the class for this provider: 1 = Primary Care Provider 2 = In plan provider, non PCP 3 = Out of plan provider *Note:* This code relates to the class of the provider and a PCP does not necessarily indicate the recipient's selected or assigned PCP. PCP class should be assigned only to those physicians whom the plan considers to be a participating PCP.	X	X	X		X	1	C
55	Servicing Provider Type	A custom MassHealth code indicating the type of provider rendering the service represented by this encounter or claim. See Table G for values.	X	X	X	X	X	3	N
56	Servicing Provider Specialty	The specialty code of the servicing provider as reported on professional claims. Use CMS 1500/837p standard; see Table H. Optional for facility claims.		X			X	3	C
57	Servicing Provider ZIP Code	The servicing provider's ZIP code. The ZIP code where the service occurred is preferred.	X	X	X	X	X	5	N

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
58	Billing Provider ID	A unique identifier for the provider billing for the service.	X	X	X	X	X	15	C
59	Authorization Type	MBHP Specific field	X	X	X		X	25	C

Financial Data

Most of the fields below apply to services for which reimbursement is made on a fee-for-service basis. For capitated services, the record should include fee-for-service equivalent information when available. Line item amounts are required for these fields.

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
60	Billed Charge	The amount the provider billed for the service or usual and customary for retail pharmacy if amount provider billed is not available.	X	X	X	X	X	9	N
61	Gross Payment Amount	The amount that the provider was paid in total by all sources for this service. NOTE: This field should include any withhold amount, if applicable. For pharmacy, the amount is what the plan pays the PBM for the drug.	X	X	X	X	X	9	N
62	TPL Amount	Any amount of third-party liability paid by another medical coverage carrier for this service. If this is a recovery, such as an Accident Recovery, the appropriate Void Reason (#118) must also be provided. If the TPL amount is available only at the summary level, it must be recorded on a special line on the claim which will have a record indicator value of 0. See Dollar Amounts.	X	X	X	X	X	9	N
63	Medicare Amount	Any amount paid by Medicare for this service. Must be consistent with Medicare covered services.	X	X	X	X	X	9	N
64	Copay	Any copayment amount the member paid for this service. Patient paid amount for nursing facility stays would be reported in field “Patient Pay Amount”. Medicare copays should not be reported here as it would be Medicaid MCE responsibility and would be reflected in Net Payment (#68).	X	X	X	X	X	9	N
65	Deductible	Any deductible amount the member paid for this service. Medicare deductibles should not be reported here as it would be Medicaid MCE responsibility and would be reflected in Net Payment (#68).	X	X	X	X	X	9	N
66	Ingredient Cost	The cost of the ingredients included in the prescription.				X		9	N
67	Dispensing Fee	The dispensing fee pharmacy charged for filling the prescription.				X		9	N
68	Net Payment	The amount the Medicaid MCE paid for this service and/or FFSE for the cost that the MCE incurred. MassHealth expects that it would generally equal Allowable Amount (#86) less TPL Amount (#62), Medicare Amount (#63), Copay (#64), Coinsurance (#117), Deductible (#65), Patient Pay Amount (#124) and Withhold Amount (#69). See Section 2.0 for more information about use of Record Indicator to	X	X	X	X	X	9	N

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		indicate the payment arrangement under which the rendering provider was paid. For Pharmacy charges, the amount the Plan paid the PBM.							
69	Withhold Amount	Any amount withheld from fee-for-service payments to the provider to cover performance guarantees or as incentives. See Section 2.0 for more information about Withholds.	X	X	X		X	9	N
70	Record Type	A code indicating the type of record: O = Original V = Void or Back Out R = Replacement A = Amendment ***See discussion in Data Elements Clarification section, "Record Type Submission Options and Explanations"***	X	X	X	X	X	1	C
71	Group Number	For non-MHSA MCEs 1 = MCO MassHealth 2 = MCO Commonwealth Care 3 = SCO 5 = CarePlus 6 = One Care (ICO) 7 = ACO-A 8 = ACO-B 9 = ACO-C	X	X	X	X	X	25	C

Medicaid Program-Specific Data

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
72	DRG	The DRG code used to pay for an inpatient confinement and should always be submitted in 3- digit format. One and two-digit codes should be completed with leading zeros to comply. For example: DRG code '1' should be submitted as '001'; DRG code '25' should be submitted as '025'; DRG code '301' should be submitted as '301'. See discussion in the Data Element Clarifications section.	X		X			3	C
73	EPSDT Indicator	A flag that indicates those services which are related to EPSDT: 1 = EPSDT Screen 2 = EPSDT Treatment 3 = EPSDT Referral		X			X	1	N
74	Family Planning Indicator	A flag that indicates whether or not this service involved family planning services, which may be matched by CMS at a higher rate: 1 = Family planning services provided 2 = Abortion services provided 3 = Sterilization services provided 4 = No family planning services provided (see Table I)	X	X				1	C
75	MSS/IS	Please leave this field blank, it will be further defined at a later date. A flag that indicates services related to MSS/IS:		X				1	N

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		1 = Maternal Support Services 2 = Infant Support Services							
76	New Member ID	The "active" MassHealth assigned Medicaid identification number for the enrollee that received the services. This number is assigned by MassHealth and is subject to change.	X	X	X	X	X	25	C

Other Fields

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
77	Former Claim Number	If this is not an Original claim [Record Type = 'O'], then the previous claim number that this claim is replacing/voiding. See discussion under ***Former Claim Number / Suffix*** in the Data Elements Clarification Section	X	X	X	X	X	20	C
78	Former Claim Suffix	If this is not an Original claim [Record Type = 'O'], then the previous claim suffix that this claim is replacing/voiding. See discussion under ***Former Claim Number / Suffix*** in the Data Elements Clarification Section	X	X	X	X	X	4	C
79	Record Creation Date	The date on which the record was created. See discussion under ***Record Creation Date*** in the Data Elements Clarification Section.	X	X	X	X	X	8	D
80	Service Category	Service groupings from financial reports like 4B (see Table I). See report instructions for definitions. Generally, * Assign Service category based on claim source (e.g., 837i, 837p, 837d). * Facility Claims with Type of Bill values 11x and 41x are defined as "Inpatient". Other facility claims would be "Outpatient". * Facility claims with Type of Bill beginning with 2xx (SNF) or 6xx (Intermediate) should be assigned to Institutional Long Term.	X	X	X	X	X	5	C
81	Prescribing Prov. ID	Federal Tax ID or UPIN or other State assigned provider ID for the prescribing provider on the Pharmacy claim.				X		15	C
82	Date Script Written	Date prescribing provider issued the prescription.				X		8	D/YYYYMMDD
83	Compound Indicator	Indicates that the prescription was a compounded drug. 1 = Yes 2 = No Note that this is not consistent with NCPDP.				X		1	C
84	Rebate Indicator	PBM received rebate for drug dispensed. 1 = Yes 2 = No				X		1	C
85	Admitting Diagnosis	Diagnosis upon admission. May be different from principal diagnosis. Should not be External Injury codes. See discussion in Data Element Clarifications section, including clarification on ICD-10	X		X			7	C/No decimal points
86	Allowable Amount	The maximum amount the plan will pay for the service, which is generally the Plan Allowable Fee Schedule. For retail drugs, it is the	X	X	X	X	X	9	N

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		amount allowed in formulary. Amount reported would equal plan payment + member responsibility.							
87	Attending Prov. ID	Provider ID of the provider who attended at facility. Federal Tax ID or UPIN or other State assigned provider ID.	X					15	C
88	Non-covered Days	Days not covered by Health Plan.	X		X			3	N
89	External Injury Diagnosis 1	If there is an External Injury Diagnosis code 1 (ICD V, W, X, Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C
90	Claim Received Date	Date claim received by Health Plan, if processed by a PBM.				X		8	D/YYYYMMDD
91	Frequency	The third digit of the UB92 Bill Classification field. Submitted as a third digit in Type of Bill (#33)	X		X			1	C
92	PCC Provider ID_Type	One code identifying the type of ID provided in the PCC Provider ID in Field # 49 above. For example, 6 = Internal ID (Plan Specific) 8 = DEA Number 9 = NABP Number 1 = NPI	X	X	X		X	1	N
93	Billing Provider ID _Type	A code identifying the type of ID provided in Billing Provider ID above. For example, 6 = Internal ID (Plan Specific) 9 = NABP Number (for pharmacy claims only)	X	X	X	X	X	1	N
94	Prescribing Prov. ID _Type	A code identifying the type of ID provided in Prescribing Provider ID above. For example, 1 = NPI 6 = Internal ID (Plan Specific) 8 = DEA Number				X		1	N
95	Attending Prov. ID _Type	A code identifying the type of ID provided in Attending Prov. ID above. For example, 6 = Internal ID (Plan Specific)	X					1	N
96	Admission Time	For inpatient facility services, the time the recipient was admitted to the facility. If not an inpatient facility, the value should be missing. This field must be in HH24MI format. For example, 10:30AM would be 1030 and 10:30PM would be 2230.	X		X			4	N/HH24MI
97	Discharge Time	For inpatient facility services, the time the recipient was discharged from the facility. If not an inpatient facility, the value should be missing. This field must be in HH24MI format. For example, 10:30AM would be 1030 and 10:30PM would be 2230.	X		X			4	N/HH24MI
98	Diagnosis 6	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/No decimal points
99	Diagnosis 7	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/No decimal points
100	Diagnosis 8	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/No decimal points

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
101	Diagnosis 9	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/No decimal points
102	Diagnosis 10	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/No decimal points
103	Surgical Procedure code 1	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
104	Surgical Procedure code 2	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
105	Surgical Procedure code 3	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
106	Surgical Procedure code 4	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
107	Surgical Procedure code 5	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
108	Surgical Procedure code 6	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
109	Surgical Procedure code 7	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
110	Surgical Procedure code 8	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
111	Surgical Procedure code 9	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
112	Employment	Is the patient's condition related to Employment Y N	X	X	X		X	1	C
113	Auto Accident	Is the patient's condition related to an Auto Accident Y N	X	X	X		X	1	C
114	Other Accident	Is the patient's condition related to Other Accident Y	X	X	X		X	1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		N							
115	Total Charges	This field represents the total charges, covered and uncovered related to the current billing period. For pharmacy claims, may be same amount as Gross Payment Amount (#61) for pharmacy claims if there is no separate charge for uncovered services or copay.	X	X	X	X	X	9	N
116	Non Covered charges	This field represents the uncovered charges by the payer related to the revenue code. This is the amount, if any, that is not covered by the primary payer for this service.	X	X	X		X	9	N
117	Coinsurance	Any coinsurance amount the member paid for this service. Patient paid amount for nursing facility stays would be reported in field “Patient Pay Amount”. Medicare coinsurance should not be reported here as it would be Medicaid MCE responsibility and would be reflected in Net Payment (#68).	X	X	X	X	X	9	N
118	Void Reason Code	The reason the claim line was voided. 1 TPL 2 accident recovery 3 provider audit recoveries 4 Other Must be provided on the record for all adjustments to the Original claim line related to TPL, accident recovery, or provider audit recoveries, including all Voids and Replacements. Recoveries are expected to have a value 1-3. TPL recoveries must also be reflected in TPL Amount field (#62). 4-Other should only be used when 1-3 are not appropriate.	X	X	X	X	X	1	C
119	DRG Description	Description of DRG Code	X		X			132	C
120	DRG Type	Values: 1=Medicare CMS-DRG 2=Medicare MS-DRG 3=Refined DRGs (R-DRG) 4=All Patient DRGs (AP-DRG) 5=Severity DRGs (S-DRG) 6=All Patient, Severity-Adjusted DRGs (APS-DRG) 7=All Patient Refined DRGs (APR-DRG) 8=International-Refined DRGs (IR-DRG) 9=Other Please use the accurate and specific DRG type and avoid using the value “Other”. Please communicate to MassHealth any DRG types you are using that are missing from the above list.	X		X			1	C
121	DRG Version	DRG Version number associated with DRG type	X		X			3	C/ No decimal points (S72.111A as S72111A)
122	DRG Severity of Illness Level	A code that describes the Severity of the claim with the assigned DRG. With the exception of DRG 589, valid values are: 1 = minor 2 = moderate	X		X			1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		3 = major 4 = extreme Associated with DRG Type=APR-DRG (DRT Type =7) or any other DRG that has these fields							
123	DRG Risk of Mortality Level	A code that describes the Mortality of the patient with the assigned DRG code. With the exception of DRG 589, valid values are: 1 = minor 2 = moderate 3 = major 4 = extreme Associated with DRG Type=APR-DRG (DRT Type =7) or any other DRG that has these fields.	X		X			1	C
124	Patient Pay Amount	Patient paid amount for nursing facility stays.	X		X			9	N
125	Patient Reason for Visit Diagnosis 1	ICD diagnosis code describing the patient's (or patient representative's) stated reason for seeking care at the time of outpatient (ER) visit See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
126	Patient Reason for Visit Diagnosis 2	ICD diagnosis code describing the patient's (or patient representative's) stated reason for seeking care at the time of outpatient (ER) visit See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
127	Patient Reason for Visit Diagnosis 3	ICD diagnosis code describing the patient's (or patient representative's) stated reason for seeking care at the time of outpatient (ER) visit See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
128	Present on Admission (POA) 1	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
129	Present on Admission (POA) 2	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
130	Present on Admission (POA) 3	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
131	Present on Admission (POA) 4	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
132	Present on Admission (POA) 5	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
133	Present on Admission (POA) 6	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
134	Present on Admission (POA) 7	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
135	Present on Admission (POA) 8	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
136	Present on Admission (POA) 9	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
137	Present on Admission (POA) 10	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
138	Diagnosis 11	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/ No decimal points
139	Present on Admission (POA) 11	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
140	Diagnosis 12	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/ No decimal points
141	Present on Admission (POA) 12	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
142	Diagnosis 13	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
143	Present on Admission (POA) 13	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
144	Diagnosis 14	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
145	Present on Admission (POA) 14	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
146	Diagnosis 15	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
147	Present on Admission (POA) 15	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
148	Diagnosis 16	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
149	Present on Admission (POA) 16	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
150	Diagnosis 17	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
151	Present on Admission (POA) 17	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
152	Diagnosis 18	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
153	Present on Admission (POA) 18	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
154	Diagnosis 19	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
155	Present on Admission (POA) 19	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
156	Diagnosis 20	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
157	Present on Admission (POA) 20	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
158	Diagnosis 21	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
159	Present on Admission (POA) 21	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
160	Diagnosis 22	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
161	Present on Admission (POA) 22	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
162	Diagnosis 23	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
163	Present on Admission (POA) 23	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
164	Diagnosis 24	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
165	Present on Admission (POA) 24	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
166	Diagnosis 25	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
167	Present on Admission (POA) 25	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
168	Diagnosis 26	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
169	Present on Admission (POA) 26	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
170	Present on Admission (POA) EI 1	This is an indicator associated with External Injury Diagnosis 1 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
171	External Injury Diagnosis 2	If there is an External Injury Diagnosis code 2 (ICD- V,W,X,Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
172	Present on Admission (POA) EI 2	This is an indicator associated with External Injury Diagnosis 2 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
173	External Injury Diagnosis 3	If there is an External Injury Diagnosis code 3 (ICD- V, W, X, Y- Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
174	Present on Admission (POA) EI 3	This is an indicator associated with External Injury Diagnosis 3 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
175	External Injury Diagnosis 4	If there is an External Injury Diagnosis code 4 (ICD- V,W,X,Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
176	Present on Admission (POA) EI 4	This is an indicator associated with External Injury Diagnosis 4 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
177	External Injury Diagnosis 5	If there is an External Injury Diagnosis code 5 (ICD- V,W,X,Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
178	Present on Admission (POA) EI 5	This is an indicator associated with External Injury Diagnosis 5 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
179	External Injury Diagnosis 6	If there is an External Injury Diagnosis code 6 (ICD- V,W,X,Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
180	Present on Admission (POA) EI 6	This is an indicator associated with External Injury Diagnosis 6 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
181	External Injury Diagnosis 7	If there is an External Injury Diagnosis code 7 (ICD- V,W,X,Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
182	Present on Admission (POA) EI 7	This is an indicator associated with External Injury Diagnosis 7 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
183	External Injury Diagnosis 8	If there is an External Injury Diagnosis code 8 (ICD- V,W,X,Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
184	Present on Admission (POA) EI 8	This is an indicator associated with External Injury Diagnosis 8 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
185	External Injury Diagnosis 9	If there is an External Injury Diagnosis code 9 (ICD- V,W,X,Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
186	Present on Admission (POA) EI 9	This is an indicator associated with External Injury Diagnosis 9 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
187	External Injury Diagnosis 10	If there is an External Injury Diagnosis code 10 (ICD- V,W,X,Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
188	Present on Admission (POA) EI 10	This is an indicator associated with External Injury Diagnosis 10 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
189	External Injury Diagnosis 11	If there is an External Injury Diagnosis code 11 (ICD- V,W,X,Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
190	Present on Admission (POA) EI 11	This is an indicator associated with External Injury Diagnosis 11 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
191	External Injury Diagnosis 12	If there is an External Injury Diagnosis code 12 (ICD- V,W,X,Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
192	Present on Admission (POA) EI 12	This is an indicator associated with External Injury Diagnosis 12 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
193	ICD Version Qualifier	ICD9 or ICD10. The value "ICD9" must be populated on claim records with either ICD-9-CM diagnosis codes or ICD-9-CM procedure codes. The value "ICD10" must be populated on claim records with either ICD-10-CM diagnosis codes or ICD-10-CM procedure codes. One claim record must never have a combination of ICD9 and ICD10 codes. See discussion in Data Element Clarifications section, including clarification on ICD-10	X	X	X		X	5	C
194	Procedure Modifier 4	4th procedure code modifier, required, if used.	X	X	X		X	2	C
195	Service Category Type	This field describes the Type of Financial reports the service category is based on. The values are: '4B' for MCO Service Categories 'ACO' for ACO Categories 'SCO' for SCO Service Categories 'ICO' for Care One (ICO) Service Categories	X	X	X	X	X	3	C
196	Ambulance Patient Count	AMBULANCE PATIENT COUNT. REQUIRED WHEN MORE THAN ONE PATIENT IS TRANSPORTED IN THE SAME VEHICLE FOR AMBULANCE OR NON-EMERGENCY TRANSPORTATION SERVICES.		X				3	N
197	Obstetric Unit Anesthesia Count	The number of additional units reported by an anesthesia provider to reflect additional complexity of services.		X				5	N
198	Prescription Number	Rx Number.				X		15	C
199	Taxonomy Code	This is the Taxonomy code for Servicing Provider identified on the claim. Taxonomy codes are National specialty codes used by providers to indicate their specialty. These codes can be found on the Website of Centers for Medicare & Medicaid Service (CMS)	X	X	X		X	10	C
200	Rate Increase Indicator	**DEPRECATED AFTER 2014** Indicates if the provider is eligible to receive the enhanced primary care rate for this service, as specified in the Affordable Care Act – Section 1202 final regulations. 1=Yes 2=No 3=Unknown 4=Not Applicable Note: If a service is considered eligible based on the ACA regulations, then the value should be equal to "1" even if the MCE is already paying the provider at the higher rate.	X	X	X			1	C
201	Bundle Indicator	Indicates if the claim line is part of a bundle. Values: Y=Yes, the claim line is part of a bundle. All bundled lines including the line with the bundled payment should have a value of 'Y' N=No, the claim line is not part of a bundle.	X	X	X		X	1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
202	Bundle Claim Number	This is the claim number of the claim line with the bundled payment. See discussion in Data Element Clarifications section,	X	X	X		X	15	C
203	Bundle Claim Suffix	This the claim suffix of the claim line with the bundled payment. See discussion in Data Element Clarifications section,	X	X	X		X	4	C
204	Value Code	Code used to relate values to identify data elements necessary to process a UB92 claim. Submit only when the value=54 for Newborn claims	X					2	AN
205	Value Amount	Weight of a newborn in grams. Must be present on all newborn claims when the value code “54”is submitted in Field #204	X					9	N
206	Surgical Procedure Code 10	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
207	Surgical Procedure Code 11	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
208	Surgical Procedure Code 12	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
209	Surgical Procedure Code 13	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
210	Surgical Procedure Code 14	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
211	Surgical Procedure Code 15	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
212	Surgical Procedure Code 16	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
213	Surgical Procedure Code 17	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
214	Surgical Procedure Code 18	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
215	Surgical Procedure Code 19	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank.	X					7	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		See discussion in Data Element Clarifications section, including clarification on ICD-10							
216	Surgical Procedure Code 20	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
217	Surgical Procedure Code 21	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
218	Surgical Procedure Code 22	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
219	Surgical Procedure Code 23	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
220	Surgical Procedure Code 24	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
221	Surgical Procedure Code 25	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
222	Attending Prov. ID Address Location Code	Code to identify address location of Attending Provider ID in field #87	X					15	C
223	Billing Provider ID Address Location Code	Code to identify address location of Billing Provider ID in field # 58	X	X	X	X	X	15	C
224	Prescribing Prov. ID Address Location Code	Code to identify address location of Prescribing Provider ID in field # 81				X		15	C
225	PCP Provider ID Address Location Code	Code to identify address location of PCP Provider ID in field # 47	X	X	X		X	15	C
226	Referring Provider ID Address Location Code	Code to identify address location of Referring Provider ID in filed # 52	X	X	X			15	C
227	Servicing Provider ID Address Location Code	Code to identify address location of Servicing Provider ID in field # 50	X	X	X	X	X	15	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
228	PCC Provider ID Address Location Code	Code to identify address location of PCC Provider ID In field # 49	X	X	X	X	X	15	C
229	Submission Clarification Code 2	420-DK- Code indicating that the pharmacist is clarifying the submission. For 340b drugs the Submission Clarification Code must be populated with a code value of 20. Please refer to Segment 2.0 Data Element Clarifications for further information.				X		7	N
230	Submission Clarification Code 3	420-DK- Code indicating that the pharmacist is clarifying the submission. For 340b drugs the Submission Clarification Code must be populated with a code value of 20. Please refer to Segment 2.0 Data Element Clarifications for further information.				X		7	N
231	Unit of Measure	To be provided on all Pharmacy and Physician-Administered Drugs claims. The unit of measure for the value entered in "Metric Quantity" field (# 38), e.g., grams, milliliters. Observe industry standard specific to each drug (e.g., HEDIS measure requirements). Please refer to Table O for the allowed values, standard references and available links.	X	X		X		2	C
232	Provider Payment	The Gross Amount that the Plan/PBM paid to the pharmacy for the claim				X		9	N
233	Filler							9	N

** Key to Data Types*

C - Character

- Includes space, A-Z (upper or lower case), 0-9
- Left justified with trailing blanks.
- Unrecorded or missing values are blank

N - Numeric

- Include 0-9.
- Right justified, lead-zero filled.
- Unrecorded or missing values are blank

D - Date Fields

- Dates should be in a numeric format.
- The format for all dates is eight digits in YYYYMMDD format, where YYYY represents a four-digit year, MM = numeric month indicator (01 - 12); DD = numeric day indicator (01 - 31).

Example: November 22, 1963 = 19631122

Financial Fields

MassHealth prefers to receive both dollars and cents, with an **implied decimal point** before the last two digits in the data.

Example: data string "1234567" would represent $12,345.67

3.1 Provider File Data Set with Record Layout

Data Elements

- This section describes the provider file to be submitted along with each encounter data submission. The file includes a complete snapshot of current provider data at the provider/location level of detail.
- The effective date and termination ("term") date fields provide a history of changes to provider status. The intervals described by these dates should not overlap. All effective date and term date fields should have values. For records describing current status, use '99991231' as the "End of Time" value.
- Provider ID, Provider ID Type and Provider ID Address Location Code values must match the values in corresponding fields in the encounter file.
- Each Provider service location **must** have its own identifier (see definition of the Provider ID Address Location Code below).

#	Field Name	Definition/Description	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization. This code identifies your Organization: **MCO / ACPP** 465 Fallon Community Health Plan 469 Allways Health Partners (a.k.a. Neighborhood Health Plan) 997 Boston Medical Center HealthNet Plan 998 Tufts Health Plan (a.k.a. Network Health) 999 Massachusetts Behavioral Health Partnership 470 CeltiCare - Retired 471 Health New England **SCO** 501 Commonwealth Care Alliance 502 United HealthCare (a.k.a. Evercare) 503 NaviCare 504 Molina Healthcare (a.k.a. Senior Whole Health) 505 Tufts Health Plan Senior Care Options 506 Boston Medical Center HealthNet Plan Senior Care Options **One Care** 601 Commonwealth Care Alliance 602 Tufts Health Unify (a.k.a., Network Health) 603 Fallon Total – Retired 604 United HealthCare Connected (new)	3	N
2	Provider ID	Multiple formats for the same Provider ID must be avoided. For example, ID '00001111' and '001111' should be submitted with one consistent format if it indicates the same ID for the same provider. Will be used to link back to the Provider ID on the claim.	15	C

#	Field Name	Definition/Description	Length	Data Type
3	Provider ID Type	A code identifying the type of ID provided in the Provider ID above. For example, 1 = NPI 6 = Internal Plan ID 8 = DEA Number (For Pharmacy claims ONLY) 9 = NABP Number (For Pharmacy claims ONLY) Will be used to link back to the Provider ID Type on the claim.	1	C
4	License Number	State license number.	9	C
5	Medicaid Number	State Medicaid number (MassHealth/MMIS Provider ID). Plans should use information in their systems pursuant to CFR 438.602(b)(1) to populate this field. See Provider ID Submission segment in Section 2.0 for more information.	10	C
6	Provider Last Name	Last name of provider. In case of an organization or entity or hospital, name should be entered in this field only. Please avoid using abbreviations and enter names consistently. For example, enter “Massachusetts General Hospital” instead of “MGH”. Length increased to 200 characters	200	C
7	Provider First Name	First name of the provider Please submit First Name consistently. In case of an organization or entity or hospital, name should be entered in “Provider Last Name” field above and **not** in this field. Length increased to 100 characters	100	C
8	Provider Office Address Street	Street address where services were rendered. This field has to be a street address. It cannot be a post office or lock box if the provider is the billing provider	45	C
9	Provider Office Address City	City where services were rendered.	20	C
10	Provider Office Address State	State where services were rendered.	2	C
11	Provider Office Address ZIP	Zip where services were rendered. ZIP+4	9	C
12	Provider Mailing Address Street	Street address where correspondence is received. This field has to be a street address. It cannot be a post office or lock box if the provider is the billing provider	45	C
13	Provider Mailing Address City	City where correspondence is received.	20	C
14	Provider Mailing Address State	State where correspondence is received.	2	C
15	Provider Mailing Address ZIP	Zip where correspondence is received. ZIP+4	9	C
16	Provider Type	Please use the values from Table G. **Note** that value “-4” for “Incomplete/No Information” option has been removed.	3	N
17	Filler		3	C

#	Field Name	Definition/Description	Length	Data Type
18	Provider Effective Date	Date provider becomes eligible to perform services.	8	D
19	Provider Term Date	Date provider is no longer eligible to perform services.	8	D
20	Provider Non-par Indicator	Non-participating provider indicator. 0 non-participating provider 1 participating provider	1	C
21	Provider Network ID	The network the provider is affiliated to by the Health Plan (internal plan ID).	15	C
22	PCC Provider ID	Required for PCCs enrolled with the MCE. Plan's internal provider ID or NPI for the practice.	15	C
23	Panel Open Indicator	Is the provider accepting new patients? 1 Accepting new patients 2 Not accepting new patients	1	C
24	Provider DEA Number	Provider DEA Number	11	C
25	Provider Type Description	Description of the provider type	50	C
26	National Provider Identifier (NPI)	National Provider Identifier issued by the National Plan and Provider Enumeration System (NPPES). It is required on all claims.	10	C
27	Medicare ID Number		15	C
28	Social Security Number	Provider's SSN is 9 digits field and should be entered with no dashes (e.g.,04-3333333 should be entered as 043333333 and 099-99-9999 should be entered as 099999999). Values less that 9-character long are invalid.	9	C
29	NABP Number	National Association of Boards of Pharmacy number	9	C
30	Tax ID Number	Tax ID Number is primarily the Federal Employee Identification Number (FEIN); however, when Providers don't have Tax ID Number for the reasons like being sole proprietors or small business owners without employees, provider's SSN should be entered in both fields, # 28 and #30, in same 9 digits format with no dashes (e.g.04-3333333 should be entered as 043333333 and 099-99-9999 should be entered as 099999999). Values less that 9-character long are invalid.	9	C
31	PCC Provider ID Type	A code identifying the type of ID provided in the PCC Provider ID above. 1 = NPI 6 = Internal ID (Plan Specific)	1	C
32	Gender Code	"M" for Male, "F" for Female, and "O" for Other	1	C
33	Primary Care Eligibility Indicator	Provider is eligible to receive enhanced Medicare rate for their primary care services. This indicator should follow the CMS and MassHealth regulations on provider eligibility for Affordable Care Act – Section 1202. 0=Yes, Eligible based on 60% Attestation 1=Yes, Eligible based on-Board Certification 2=No, Not Eligible 3=Unknown	1	C

#	Field Name	Definition/Description	Length	Data Type
		4=Not Applicable **Note:** The values '0' and '1' indicating provider eligibility for the "ACA Section 1202" Rate Increase should be only applicable when providers have active contracts with MCEs. If a provider contract gets terminated then the provider would no longer be eligible for the rate increase, and the value for this flag would be '2' (Not Eligible). The assumption is that eligible providers are either eligible based on-Board Certification or 60% attestation. In the case where the MCE receives a 60% attestation from a provider that has already been determined to be eligible based on-Board Certification then MCE should use value "1".		
34	APCD ORG ID	This is a new field added to get the APCD Provider Organization ID (Org ID) for the provider. Length is 6 characters. It should be submitted for all providers whose Org ID had been submitted to APCD.	6	C
35	Entity PIDSL	MCO/ACO providers - if the provider is enrolled with MCO only (not with ACO) - MCO PIDSL - if the provider is enrolled with ACO only - ACO PIDSL - if the provider is enrolled with both, ACO and MCO, then ACO PIDSL - if provider is enrolled with multiple ACOs (e.g., a specialist), and a plan is an active MCO - MCO PIDSL - if provider is enrolled with multiple ACOs (e.g., a specialist) and a plan is not an active MCO - old MCO PIDSL SCO PIDSL for SCO providers One Care PIDSL for One Care providers Example: 999999999A	10	C
36	Provider ID Address Location Code	Code to identify address location of Provider ID in Field # 2. Will be used to link back to the Provider ID Address Location Code on the claim.	15	C
37	PCC Provider ID Address Location Code	Code to identify address location of PCC Provider ID in Field # 22.	15	C
38	Provider Network ID Type	Type of Provider Network ID in Field # 21.	1	N
39	Provider Network ID Address Location Code	Code to identify address location of Provider Network ID in Field # 21.	15	C
40	Provider Bundle ID	ID to tie together all the IDs for a particular provider	15	C
41	Provider ID Primary Address Location Indicator	Y/N value to indicate primary address location	1	C

Requirements for Acceptance of the Providers File

I. All records must contain values in these fields:

1. diOrg. Code (Field #1)
2. Provider ID (Field #2)
3. Provider ID Type (Field #3)
4. Provider Last Name (Field #6)
5. Provider First Name (Field #7)
6. Provider Office Address Street (Field #8)
7. Provider Office Address City (Field #9)
8. Provider Office Address State (Field #10)
9. Provider Office Address Zip (Field #11)
10. Provider Mailing Address Street (Field #12)
11. Provider Mailing Address City (Field #13)
12. Provider Mailing Address State (Field #14)
13. Provider Mailing Address zip (Field #15)
14. Provider Effective Date (Field #18)
15. Provider Term Date (Field #19)
16. Provider DEA Number when applicable (Field #24)
17. Provider ID Address Location Code (Field#36)
18. Provider Bundle ID (Field #40)
19. Entity PIDSL (Field# 35)

II. NPI must be present on at least 80% of the records.

III. Provider Type must be present on at least 80% of the records.

MCEs must submit valid values for all fields that MassHealth could reasonably expect to be available to MCE. Records are currently not rejected if Medicaid Number/Provider PIDSL (field #5) or Tax ID Number (field #30) are missing values but are nevertheless very important for reporting and decisions. MassHealth reserves the right to introduce additional completeness validation rules.

Example of Provider Bundle ID

This example shows the case when Provider ID is different for every location.

In most cases Provider ID is unique per each provider within the organization and will be the same on every line

Org. Code	Provider ID	Provider ID Type	Address Location Code	Provider Bundle ID	Provider ID Primary Address Location Indicator	Provider Last Name	Provider First Name
888	1234569	6	04	12345	N	Smith	John
888	1234568	6	03	12345	N	Smith	John
888	1234567	6	02	12345	Y	Smith	John
888	1234566	6	01	12345	N	Smith	John

Provider Error Process:

1. Provider records with null ID and/or null ID Type do not get loaded into MH DW. Such records get rejected and returned in the provider error response file.
2. If duplicate records per provider ID, Provider ID Type, Provider Address Location, and Provider Term Date are erroneously submitted, one record will be accepted based on "best fit" logic and all other records will be rejected and returned in the provider error file.
3. "Best" fit logic picks one record per provider ID, provider ID Type and provider Term Date in a provider file, based on the record that has the most populated information (NPI, provider name, address, tax ID, license number, and Medicaid Number, respectively).
4. Records sent with "null" or missing effective/term dates, will also be returned to the MCEs in the provider error response file. The MCE is expected to correct and resubmit these records in the Correction file data submissions.
5. A Correction file for provider records rejected for any of the reasons above should be submitted with a zipped Correction file for the same submission.

3.2 MCE Internal Provider Type Data Set Elements with Record Layout

Data Elements

This section contains field names and definitions for the provider type record that is based on the Provider Types that are internally used by the MCE. This is different from MassHealth Provider Types submitted in the Provider Data Set defined above. This table should only have providers who have an internal provider type code. In other words, this table should not have providers with missing internal provider type code.

#	Field Name	Definition/Description	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization. Code that identifies your Organization: **MCO / ACPP** 465 Fallon Community Health Plan 469 Allways Health Partners (a.k.a. Neighborhood Health Plan) 997 Boston Medical Center HealthNet Plan 998 Tufts Health Plan (a.k.a. Network Health) 999 Massachusetts Behavioral Health Partnership 470 CeltiCare - Retired 471 Health New England **SCO** 501 Commonwealth Care Alliance 502 United HealthCare (a.k.a. Evercare) 503 NaviCare 504 Molina Healthcare (a.k.a. Senior Whole Health) 505 Tufts Health Plan Senior Care Options 506 Boston Medical Center HealthNet Plan Senior Care Options **One Care** 601 Commonwealth Care Alliance 602 Tufts Health Unify (a.k.a., Network Health) 603 Fallon Total – Retired 604 United HealthCare Connected (new)	3	N
2	Provider ID	Provider ID.	15	C

#	Field Name	Definition/Description	Length	Data Type
3	Provider ID Type	A code identifying the type of ID provided in Provider ID above: One code identifying the type of ID provided in the Provider ID above. For example, 6 = Internal ID (Plan Specific)) 8 = DEA Number 9 = NABP Number 1 = NPI	1	N
4	Internal Provider Type Code	Provider Type code as defined internally by the MCE	6	C
5	Internal Provider Type Description	Description of Provider Type code as defined internally by the MCE	120	C
6	Provider ID Address Location Code	Code to identify address location of Provider ID in Field # 2	15	C

3.3 Provider Specialty Data Set Elements

Requirements for Acceptance of the Provider Specialties File

All records must include these fields:

1. Org. Code (Field #1)
2. Provider ID (Field #2)
3. Provider ID Type (Field #5)
4. Provider ID Address Location Code (Field #7)

Data Elements

This section contains field names and definitions for the provider specialty record. If a provider has multiple specialties, please provide one record for each specialty per provider.

#	Field Name	Definition/Description	Length	Data Type
1	Org. Code	DW to each submitting organization. Code that identifies your Organization: MCO / ACPP 465 Fallon Community Health Plan 469 Allways Health Partners (a.k.a. Neighborhood Health Plan) 997 Boston Medical Center HealthNet Plan 998 Tufts Health Plan (a.k.a. Network Health) 999 Massachusetts Behavioral Health Partnership 470 CeltiCare - Retired 471 Health New England SCO 501 Commonwealth Care Alliance 502 United HealthCare (a.k.a. Evercare) 503 NaviCare 504 Molina Healthcare (a.k.a. Senior Whole Health) 505 Tufts Health Plan Senior Care Options	3	N

#	Field Name	Definition/Description	Length	Data Type
		506 Boston Medical Center HealthNet Plan Senior Care Options One Care 601 Commonwealth Care Alliance 602 Tufts Health Unify (a.k.a., Network Health) 603 Fallon Total – Retired 604 United HealthCare Connected (new)		
2	Provider ID	Provider ID, Federal Tax ID, UPIN or Health Plan ID.	15	C
3	Provider Specialty	Please use the values contained in Table H. If there are provider specialties not contained in table H, assign them a new three-digit number. List the description of the new values in the Provider Specialty Description field.	3	C
4	Provider Specialty Date	Date provider becomes eligible to perform specialty services.	8	D
5	Provider ID Type	A code identifying the type of ID provided in Provider ID above: One code identifying the type of ID provided in the Provider ID above. For example: 1 = NPI 6 = Internal ID (Plan Specific)) 8 = DEA Number 9 = NABP Number	1	C
6	Provider Specialty Description	Description of the Provider Specialty	50	C
7	Provider ID Address Location Code	Code to identify address location of Provider ID in Field # 2.	15	C

3.4 Additional Reference Data Set Elements (MBHP only)

These files currently apply only to MBHP.

Authorization Type Data Set Elements

#	Field Name	Description	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization.	3	N
2	ATHTYP	Two-digit code identifying the type of service.	6	C
3	ATHTYP DESCRIPTION	Description for the ATHYTYP codes.	100	C

Claim Type Data Set Elements

#	Field Name	Description	Length	Data Type
1	Org. Code	Unique ID assigned in MassHealth DW to each submitting organization	3	N
2	CLATYP	Code identifying a service.	6	C
3	CLATYP DESCRIPTION	Description for the CLATYP codes	100	C

Group Number Data Set Elements

#	Field Name	Description	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization.	3	N
2	Member Rating Category	Description for the Member Rating Category.	50	C
3	DMA/DMH Indicator	Description for the DMA/DMH Indicator.	50	C
4	Eligibility Group Name	Description for the Eligibility Group Name.	100	C
5	Eligibility Group Number	Six-digit number identifying the Eligibility Group.	10	N
6	MMIS Plan Type	Two-digit code identifying the MMIS Eligibility Plan Type.	2	C

Service Class Data Set Elements

#	Field Name	Description	Length	Data Type
1	Org. Code	Unique ID assigned in MassHealth DW to each submitting organization	3	N
2	Service Class	Code identifying a service class.	10	C
3	Description	Description of service class codes	100	C

Services Data Set Elements

#	Field Name	Description	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization	3	N
2	SVCLVLE	Description of Service Level I.	60	C
3	SVCLVLMHSA	Description of Service Level II.	90	C
4	SVCGRP	Description of Service Level III.	100	C
5	SVCDESC	Description of Service Level IV.	120	C
6	UNITTYP	Description of Unit Type.	4	C
7	UNITCONVE	Unit Conversion Value. This must be a positive number greater than zero.	12	N
8	ATHTYP	Authorization Type Code.	1	C
9	SVCCOD_REFSERVICES	Service Code.	6	C
10	CLATYP_REFSERVICES	Claim Type Code.	2	C
11	MOD1_REFSERVICES	Modifier Code.	2	C
12	ID_SERVICES	ID Services Value.	10	N
13	CBHI_FLAG	An indicator to distinguish CBHI Services	10	C
14	SERVICE_24_HOUR	Specifies if it was 24-Hour or Non-24-Hour Service (or other descriptions such as P4P)	11	C
15	INTERMEDIATE_SVCLVLE	Specifies what kind of Intermediate Service Level was provided	50	C
16	SVCLVLI	Specifies service level provided	60	C

#	Field Name	Description	Length	Data Type
17	MHSAEM	Service provided: whether it was EM, or MH, or NA, or SA	2	C
18	SVCDIRECTORY	Service Directory	82	C

4.0 Encounter Record Layout Amendment Process and Layout

1. Amendment processing has been created to allow MCEs to make retroactive changes to the existing claims. "Existing" are the claims that have been accepted and loaded in MH DW.
2. MH DW expects that amendments are used to reflect retroactive dimension changes, such as Member ID, Servicing Category, etc.
3. There are no constraints on timing for submissions of the amendments.
4. Amendments can be sent as a part of a regular submission or as one-off submission. The one-off submission should contain claims file in the format outlined in segment 3.0 "Encounter Data Set Elements" and a metadata file in the format outlined in segment 6.0 "Media Requirements" of this document.
5. Amendments should be submitted with the Type of Feed 'ENC'
6. In submission amendment record is identified by Record Type 'A'. When inserted in MH DW, it inherits the record type of the record it is amending.
7. If the Claim Number + Claim Suffix combination of the 'A' record is not found in MH DW, the record will be rejected with error code 11" Active Original Claim No-Claim Suffix Not Found"
8. If the claim that has to be amended already has Former Claim Number information on a line, that Former Claim Number information should be repeated precisely on the amendment claim
9. All columns should be populated according to the standards like any other submitted claim and should contain post-change values
10. All provider data on the claim must point to a provider reference data.
11. A claim submitted prior to the introduction of Commonwealth Care must have valid data in the Group Number field.
12. Multiple amendments to the same record in the same feed are not allowed and will be rejected with error code "10 - Duplicate Claim No-Claim Suffix -- in same feed".
13. The amendment file loads with the same iterative error process as the regular submission.
14. Dollar amount changes on the claims that happen in the source system, like Replacements and Voids, should be handled via existing process set up to handle those kinds of transactions.

5.0 Error Handling

MassHealth will validate the feeds received from the MCEs and MBHP and return error files containing erroneous records back to the MCEs and MBHP for correction and resubmission. The error rate in the initial submission should be no more than 3% for the data to be considered complete and accurate. The format of the error files will be the same as the input record layout described above with 2 fields appended as the last 2 fields on the record layout. These will be the erroneous field number and the error code for that field. Section 8.0 Quantity and Quality Edits, Reasonability and Validity Checks lays out the expectation for each field in the record format for the feed. In addition to these edits, MassHealth will also subject the records to some intra-record validation tests. These may include validation checks like "net amount <= gross amount", "non-unique claim number + claim suffix combination", etc. Error checking is likely to evolve with time therefore a complete list of all pseudo-columns and error codes will accompany the rejected records returned to the MCEs and MBHP. A list is published below.

Error Codes

Error Code	Error Code
1	Incorrect Data Type
2	Invalid Format
3	Missing value
4	Code missing from reference data
5	Invalid Date
6	Admissions Date is greater than Discharge Date
7	Discharge Date is less than Admissions Date
8	Paid Date is less than Admission or Discharge or Service Dates
9	Date is prior to Birth Date
10	Duplicate Claim No-Claim Suffix -- in same feed
11	Active Original Claim No-Claim Suffix Not Found
12	Bad Zip Code
13	Replacement received for a voided record
14	Date is in the future
15	From Service Date is greater than To Service Date
16	To Service Date is less than From Service Date
17	Cannot be Negative
18	Non HIPAA/Standard code.
19	Bad Metadata File.
20	Local Code Not present in MassHealth DW.
21	Cannot be Zero.
22	Former Claim No-Claim Suffix fields should not contain data for Original Claim
23	Only Original claims allowed in the Initial feed
24	Duplicate Claim No-Claim Suffix -- from prior submission
25	Filler
26	Original Claim No-Claim Suffix, Former Claim No-Claim Suffix -- in same feed

Error Code	Error Code
27	Metadata - No metadata file found or file is empty.
28	Metadata - MCE_Id incorrect for the plan.
29	Metadata - MCE_ID not found in metadata file.
30	Metadata - Date_Created not found in metadata file.
31	Metadata - Date_Created is not a valid date.
32	Metadata - Data_File_Name not found in metadata file.
33	Metadata - Data_File_Name does not exist or is not a regular file.
34	Metadata - Pro_file_Name not found in metadata file.
35	Metadata - Pro_file_Name does not exist or is not a regular file.
36	Metadata - Pro_Spec_Name not found in metadata file.
37	Metadata - Pro_Spec_Name does not exist or is not a regular file.
38	Metadata - Total_Records not found in metadata file.
39	Metadata - Total_Records does not match actual record count.
40	Metadata - Total_Net_Payments not found in metadata file.
41	Metadata - Total_Net_Payments does not match actual sum of dollar amount.
42	Metadata - Time_Period_From not found in metadata file.
43	Metadata - Time_Period_From is not a valid date.
44	Metadata - Time_Period_To not found in metadata file.
45	Metadata - Time_Period_To is not a valid date.
46	Metadata - Return_To not found in metadata file.
47	Metadata - Type_Of_Feed not found in metadata file.
48	Metadata - Type_Of_Feed contains invalid value. Refer to the spec for valid values.
49	Metadata - Metadata - Ref_Services_File_Name not found in metadata file.
50	Metadata - Ref_Services_File_Name does not exist or is not a regular file.
51	Metadata - ATHTYP_File_Name not found in metadata file.
52	Metadata - ATHTYP_File_Name does not exist or is not a regular file.
53	Metadata - GRPNUM_File_Name not found in metadata file.
54	Metadata - GRPNUM_File_Name does not exist or is not a regular file.
55	Metadata - SVCCLS_File_Name not found in metadata file.
56	Metadata - SVCCLS_File_Name does not exist or is not a regular file.
57	Metadata - CLATYP_File_Name not found in metadata file.
58	Metadata - CLATYP_File_Name does not exist or is not a regular file.
59	RefService not found.
60	If former claim number filled in, so must former_claim_suffix.
70	ICD Version Qualifier ICD9 used on a claim post ICD10 implementation (To Service Date >=10/01/2015)
71	ICD Version Qualifier ICD9 used on a claim post ICD10 implementation (Discharge Date>=10/01/2015)

Error Code	Error Code
72*	(Denial Code not in Denied_Claims file) Claim Number/Suffix in Denied_Claims_Reason_Code file not in Denied_Claims file
73*	Claim Number/Suffix in Denied_Claims file not in Denied_Claims_Reason_Code file
74	Correction to a claim that is not in MH DW
61	Missing Provider NPI – Not used at present
62	Metadata - Pro_MCEType_Name not found in metadata file.
63	Metadata - Pro_MCEType_Name does not exist or is not a regular file.
75	Codes on record are not in sequence

*Applies to the Denied Claims submissions only

All the MCEs including MBHP should resubmit correct records within 5 business days of receiving the error files from MassHealth. This process will be repeated until the number of validation errors is within a 3% threshold. Refer to the "Encounter Data" section of the MassHealth Contract for more details on the action required when data submission is not in compliance with Encounter Data requirements.

6.0 Media Requirements / Encounter Claims Files Submission Requirements

6.1 Format

File Type: PKZIP/WINZIP compressed plain text file

Character Set: ASCII

All submitted files should be **pipe-delimited**. Please compress the data file using PKZIP/WINZIP or compatible program. All records in the data file should follow the record layout specified in section 4.0 where the length represents the maximum length of each field. Padding fields with 0s or spaces is not required.

Note: Each record should end with the standard MS Windows text file end-of-line marker ("\r\n" - a carriage control followed by a new line).

6.2 Regular Monthly Encounter File Submission

Filename

The Zip file name should conform to the following naming convention

MCE_Claims_YYYYMMDD.zip

Example:

"BMC_Claims_20210701.zip", where YYYYMMDD -the date of file creation (4 digit year, 2 digit month, 2 digit day) and MCE identifies the Plan according to the following:

MCOs:

- BMC - Boston Medical Center HealthNet Plan
- CHA - Tufts Health Plan
- FLN - Fallon Community Health Plan
- MBH - Massachusetts Behavioral Health Partnership
- NHP - Allways Health Partners
- HNE - Health New England

SCOs:

- CCA - Commonwealth Care Alliance
- UHC – UnitedHealthCare
- NAV - Navicare
- SWH - Molina Healthcare (a.k.a. Senior Whole Health)
- TFT – Tufts Health Plan
- BHP – BMC HealthNet Plan

One Care (ICO):

- CCI - Commonwealth Care Alliance
- NWI – Tufts Health Unify
- UCC – UnitedHealthCare Connected

6.3 Project Related Filename

Names of the files submitted for the special projects should have an extension up to 6 characters after the date part of the name. For example, the files submitted for the J-Code project might have an extension “JCODE” in the name of the file.

Example:

“MCE_Claims_YYYYMMDD_JCODE.zip”

MH DW will give the MCEs specific instructions on the file naming standards related to specific projects.

6.4 The Manual Override File

A manual override file will override many of the claim line rejection edits intended to ensure quality data. Use with caution. Use only in limited circumstances when Plan is confident that the plan data is correct and the edit is wrong, e.g., a new NDC code is used which is not yet included in MassHealth’s reference table.

The manual override file should be named MCE_Claims_YYYYMMDD_MO. The “_MO” files should be sent only after the MCEs have corrected and re-submitted records rejected when the regular submission fie was processed. Corrections should be sent with “ENC” file.

Note: See description of “ENC” in Metadata file fie paragraph below.

The manual override file should have a file type of EMO in the metadata file.

6.5 Zip File

The Zip File should contain:

- The Encounter Data file
- The Provider data file
- The Provider specialty file
- The MCE Internal Provider Type file
- The Manual Override file (if applicable)
- The Service Reference file (MBHP Only)
- The Service Class Codes file (MBHP Only)
- The Authorization Type Codes file (MBHP Only)
- The Claim Type Codes file (MBHP Only)
- The Group Number Codes file (MBHP Only)
- Additional Documentation File or Metadata file

6.6 Metadata file

Please submit an additional file called **metadata.txt** which contains the following Key Value Pairs. A regular submission or error submission file should have a file type of ENC. The manual override file should have a file type of EMO in the metadata file.

	ENC/EMO
MCE_Id="Value" (MCO: FLN, NHP, BMC, CHA, MBH, HNE, CAR) (SCO: CCA, UHC, NAV, SWH, TFT, BHP) (One Care-ICO: CCI, NWI, FTC)	Mandatory
Date_Created=" YYYYMMDD"	Mandatory
Data_File_Name="Value"	Mandatory
Pro_File_Name="Value"	Mandatory
Pro_Spec_Name="Value"	Mandatory
Pro_MCEType_Name=”Value”	Mandatory
Total_Records="Value"	Mandatory
Total_Net_Payments="Value"	Mandatory
Time_Period_From="Value” (YYYYMMDD)	Mandatory
Time_Period_To="Value" (YYYYMMDD)	Mandatory
Return_To="email address"	Mandatory
Type_Of_Feed="Value" (ENC/EMO)	Mandatory
Ref_Services_File_Name ="Value"	Optional
SVCCLS_File_Name ="Value"	Optional
ATHTYP_File_Name ="Value"	Optional
CLATYP_File_Name ="Value"	Optional
GRPNUM_File_Name ="Value"	Optional

a) Names of the files in the metadata file must match the names of the actual files in submission
b) Send a zero byte None.txt for missing files - provider or specialty and set corresponding field value to "None.txt"
c) A file posted on SFTP server must have a unique name
d) Discrepancy between the actual feed and the values in Metadata file fields Total Net Payments and/or Total Records results in rejection of the entire feed.
e) The names of the fields in Metadata file should match the spelling suggested in the spec (Example: Total Net Payments)
f) From a processing perspective there is no difference between the original submission file, a correction file, and an Amendment file. All these types of submissions should have Type_ Of_ Feed = ”ENC” in metadata file

6.7 Secure FTP Server

MassHealth has set up a Secure FTP server for exchanging data with the MCEs. SFTP folder access is restricted to plan users that are approved by MassHealth. User can email EHS-DL-IT Requests for instructions.

Details of the server are below:

- *Server:* virtualgatewaydw.ehs.state.ma.us ID currently set up for MCOs: fln, nhp, bmc, cha, mbhp, gu02 (CAR), gu04 (HNE).
- *ID currently set up for SCOs:* swh, uhc, nav, cca, tft, bhp.
- *ID currently set up for One Care (ICOs):* cci, nwi, ftc.
- *Home directory :*/<mce>: example /nhp. Each home directory currently contains following sub directories
- *ehs_dw*: production folder for exchanging encounter data and error reports.
- *test_masshealth*: used by MassHealth for testing purpose.
- *test_mco*: available for mce to send any test files or ad hoc data to MassHealth.

6.8 Sending Encounter data

Transfer encounter data file in a format and content as described in sections above to the production folder on the server. After the data transfer is complete, include a zero-byte file called mce_done.txt.

- Refrain from sending several files with the same name.
- Only one submission of a kind (claims or member) can be placed on the server at any point of time. You may post the next file when the notification of the previous file load is received.
- If a second file is a project specific, please work with MH DW to follow the instructions on file submission related to the project

6.9 Receiving Error reports

After the data has been processed, an error zip file (beginning with err) will be posted to the production folder. A notification email will be sent to the email address provided in the Metadata feed. Note that error files are replaced with every new file load. The error file will be available on the server for a period of 30 days. MassHealth may need to revise the retention period in the future, based on available disk space on the server. If you post a file and do not receive email message about the error file back in 7 business days, please contact MassHealth. You will not receive a notice if a file could not be processed (errored out).

6.10 CMS Internet Security Policy [Removed]

7.0 Standard Data Values

This section contains tables that identify the standard coding structures for several of the encounter data fields.

NOTE: Tables F, J and L do not exist in these specifications.

Use of Standard Data Values

The tables list all of the standard data values for the fields, with descriptions.

Standard data values are given for the following tables:

- Table A Admit Type (UB)
- Table B Admit Source (UB)
- Table C Place of Service (CMS 1500)
- Table D Place of Service (from UB Type of Bill)
- Table E Discharge Status (UB Patient Status)
- Table G Servicing Provider Type
- Table H Servicing Provider Specialty (CMS 1500)
- Table I Service Category
  - I-A: MCO
  - I-B: SCO
  - I-C: One Care (ICO)
- Table K Bill Classifications – (UB Bill Classification, 3rd digit)
- Table M Present on Admission (UB)
- Table O UB-4 UNIT OF MEASURE

Note: The abbreviation "**NEC**" after a description stands for ***Not Elsewhere Classified***.

TABLE A – Type of Admission (UB)

Table A below represents the Type of Admission (UB):

Value	Definition
1	Emergency
2	Urgent
3	Elective
4	Newborn
5	Trauma Center
6-8	Reserved for National Assignment
9	Information not available

TABLE B – Source of Admission (UB)

Value	Description
1	Physician Referral
2	Clinic/Outpatient Referral
3	HMO Referral
4	Transfer from Hospital
5	Transfer from SNF
6	Transfer from another Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information not available
A	RESERVED FOR ASSIGNMENT BY THE NUBC (END 10/1/07)
B	TRANSFER FROM ANOTHER HOME HEALTH AGENCY
C	RESERVED FOR ASSIGNMENT BY THE NUBC (END 7/1/10)
D	TRANSFER FROM ONE UNIT TO ANOTHER - SAME HOSP
E	TRANSFER FROM AMBULATORY SURGICAL CENTER
F	TRANSFER FROM HOSPICE/ENROLLED IN HOSPICE PROGRAM
A	RESERVED FOR ASSIGNMENT BY THE NUBC (END 10/1/07)
B	TRANSFER FROM ANOTHER HOME HEALTH AGENCY

For Newborns

The following table represents the values for newborns:

Value	Description
1	Normal Delivery
2	Premature Delivery
3	Sick Baby
4	Extramural Birth

TABLE C – Place of Service (HCFA 1500)

Place of Service Codes for Professional Claims

CMS Database (as of 12/2021)

Value	Place of Service Name	Place of Service Description
01	Pharmacy**	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients (effective 10/1/05)
02	Telehealth Provided Other than in Patient's Home	The location where health services and health related services are provided or received, through a telecommunication system. (Effective January 1, 2017) The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology. (Effective January 1, 2017) (Description change effective January 1, 2022, and applicable for Medicare April 1, 2022)
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison-Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (effective 7/1/06)
10	Telehealth Provided in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology. This code is effective January 1, 2022, and available to Medicare April 1, 2022.

Value	Place of Service Name	Place of Service Description
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services. (effective 10/1/03)
14	Group Home*	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short-term accommodation such as a hotel, campground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.
17	Walk-in Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services. (This code is available for use immediately with a final effective date of May 1, 2010)
18	Place of Employment-Worksite	A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual. (This code is available for use effective January 1, 2013 but no later than May 1, 2013)
19	Off Campus-Outpatient Hospital	A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On Campus-Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Description change effective January 1, 2016)
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

Value	Place of Service Name	Place of Service Description
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance – Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (effective 10/1/03)
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

Value	Place of Service Name	Place of Service Description
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/ Individuals with Intellectual Disabilities	A facility which primarily provides health-related care and services above the level of custodial care to individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (effective: 10/1/03)
58	Non-residential Opioid Treatment Facility	A location that provides treatment for opioid use disorder on an ambulatory basis. Services include methadone and other forms of Medication Assisted Treatment (MAT). (Effective January 1, 2020)
59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician. (effective 10/1/03)

Value	Place of Service Name	Place of Service Description
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other place of service not identified above.

TABLE D – Type of Bill (from UB Bill Type – 1st & 2nd digits)

Type of Facility (1st digit)

Value	Description
1	Hospital
2	Skilled Nursing Facility (SNF)
3	Home Health Agency (HHA)
4	Christian Science (Hospital)
5	Christian Science (Extended Care)
6	Intermediate Care
7	Clinic (refer to Clinics Only for 2nd digit)
8	Substance Abuse or Specialty Facility
9	Halfway House

Bill Classifications – Facilities (2nd digit)

Value	Description
1	Inpatient (including Medicare Part A)
2	Inpatient (Medicare Part B only)
3	Outpatient
4	Other
5	Basic Care
6	Complementary Inpatient
7	Complementary Outpatient
8	Swing Beds
9	Halfway House

Bill Classifications – Clinics only (2nd digit)

Value	Description
1	Rural Health Clinic
2	Hospital-based or Freestanding End State Renal Dialysis Facility
3	Freestanding Clinic
4	Other Rehab Facility (ORF) or Community Mental Health Center
5	Comprehensive Outpatient Rehab Facility (CORF)
6-8	Reserved for national assignment
9	Other

Bill Classifications – Specialty Facility (2nd digit)

Value	Description
1	Hospice (non-hospital based)
2	Hospice (hospital based)
3	Ambulatory Surgery Center
4	Free Standing Birthing Center
5	Critical Access Hospital
6	Residential Facility
7-8	Reserved for national assignment
9	Other

TABLE E – Discharge Status (UB Patient Status)

Value	Description
01	Discharged alive to home / self-care (routine discharge)
02	Discharged/Transferred to short term general hospital
03	Discharged/Transferred to skilled nursing facility (SNF)
04	Discharged/Transferred to intermediate care facility (ICF)
05	Discharged/Transferred to other facility
06	Discharged/Transferred to home care
07	Left against medical advice
08	Discharged/Transferred to home under care of a home IV drug therapy provider
09	Admitted as an inpatient to this hospital
10 – 19	Discharged to be defined at State level if necessary
20	Expired (Did not recover – Christian Science Patient)
21 – 29	Expired to be defined at State level if necessary
30	Still a patient
31 – 39	Still a patient to be defined at State level if necessary
40	Expired at home (Hospice claims only)
41	Died in a medical facility (Hospice claims only)
42	Place of death unknown (Hospice claims only)
43 – 99	Reserved for National Assignment

TABLE G – Servicing Provider Type

Value	Description
00	Placeholder PCP or other Servicing Provider Type not listed
01	Acute Care Hospital-Inpatient
02	Acute Care Hospital-Outpatient
03	Chronic Hospital-Inpatient
04	Chronic Hospital-Outpatient
05	Ambulatory Surgery Centers
06	Trauma Center
10	Birthing Center
15	Treatment Center
20	Mental Health/Chemical Dep. (NEC)
21	Mental Health Facilities
22	Chemical Dependency Treatment Ctr.
23	Mental Health/Chem Dep Day Care
25	Rehabilitation Facilities
30	Long-Term Care (NEC)
31	Extended Care Facility
32	Geriatric Hospital
33	Convalescent Care Facility
34	Intermediate Care Facility
35	Residential Treatment Center
36	Cont. Care Retirement Community
37	Day/Night Care Center
38	Hospice
40	Facility (NEC)
41	Infirmary
42	Special Care Facility (NEC)
50	Physician
51	Medical Doctor MD
52	Osteopath DO
53	Allergy & Immunology
54	Anesthesiology
55	Colon & Rectal Surgery
56	Dermatology
57	Emergency Medicine
58	Family Practice
59	Geriatric Medicine
60	Internist (NEC)
61	Cardiovascular Diseases
62	Critical Care Medicine

Value	Description
63	Endocrinology/Metabolism
64	Gastroenterology
65	Hematology
66	Infectious Disease
67	Medical Oncology
68	Nephrology
69	Pulmonary Disease
70	Rheumatology
71	Neurological Surgery
72	Nuclear Medicine
73	Obstetrics/Gynecology
74	Ophthalmology
75	Orthopedic Surgery
76	Otolaryngology
77	Pathology
78	Pediatrician (NEC)
79	Pediatric Specialist
80	Physical Medicine and Rehabilitation
81	Plastic Surgery/Maxillofacial Surgery
82	Preventative Medicine
83	Psychiatry/Neurology
84	Radiology
85	Surgeon
86	Surgical Specialist
87	Thoracic Surgery
88	Urology
95	Dentist
96	Dental Specialist
99	Podiatry
100	Unknown Clinic
120	Chiropractor
125	Dental Health Specialists
130	Dietitian
135	Medical Technologists
140	Midwife
145	Nurse Practitioner
146	Nursing Services
150	Optometrist
155	Pharmacist
160	Physician’s Assistant

Value	Description
165	Therapy (physical)
170	Therapists (supportive)
171	Psychologist
175	Therapists (alternative)
180	Acupuncturist
185	Spiritual Healers
190	Health Educator
200	Transportation
205	Health Resort
210	Hearing Labs
215	Home Health Organization
220	Imaging Center
225	Laboratory
230	Pharmacy
235	Supply Center
240	Vision Center
245	Public Health Agency
246	Rehab Hospital-Inpatient
247	Rehab Hospital-Outpatient
248	Psychiatric Hospital-Inpatient
249	Psychiatric Hospital-Outpatient
250	Community Health Center
301	General Hospital
302	Certified Clinical Nurse Specialist
303	Infusion Therapy
304	Palliative Care Medicine
305	Adult Day Health
306	Adult Foster Care / Group Adult Foster Care
307	Fiscal Intermediary Services (FIS)
308	Personal Care Management Agency
309	Independent Living Centers
310	Day Habilitation
311	Durable Medical Equipment
312	Oxygen And Respiratory Therapy Equip
313	Prosthetics
314	Orthotics
315	Renal Dialysis Clinics
316	Respite Care
317	Intensive Residential Treatment Program (IRTP)
318	Complex Care Management

Value	Description
319	Special Programs
320	Recovery Learning Community (RLCs)
321	Certified Peer Specialist
322	Emergency Services Program (ESP)
323	Community Health Worker
324	Hospital Licensed Health Center
325	Aging Services Access Point (ASAP)
326	Geriatric Mental Health
327	Child Mental Health
328	Deaf and Hard of Hearing Independent Living Services Programs
329	Home Modification Service Providers
330	Transitional Assistance (across settings) Providers
331	Medication Management Providers
332	Substance Abuse Treatment Center
333	Magnetic Resonance Centers
334	Psych Day Treatment
335	QMB (Qualified Medicare Beneficiaries) Only Provider
336	Group Practice Physicians
337	School-Based Clinic or Health Center
338	Billing Agent

TABLE H – Servicing Provider Specialty (from CMS 1500)

Value	Description
01	General Practice
02	General Surgery
03	Allergy / Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative therapy
13	Neurology
14	Neurosurgery
15	Speech Language Pathologists
16	Obstetrics / Gynecology
17	Hospice and Palliative Care
18	Ophthalmology
19	Oral Surgery (Dentists Only)
20	Orthopedic Surgery
22	Pathology
23	Sports Medicine
24	Plastic & Reconstructive Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Geriatric Psychiatry
28	Colorectal Surgery
29	Pulmonary Disease
30	Diagnostic Radiology
31	Intensive Cardiac Rehabilitation
32	Anesthesiologist Assistant
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery
41	Optometrist

Value	Description
42	Certified Nurse Midwife
43	CRNA, Anesthesia Assistant
44	Infectious Diseases
45	Mammography Screening Center
46	Endocrinology
48	Podiatrist
49	Ambulatory Surgery Center
50	Nurse Practitioner
51	Med Supply Co w/Certified Orthotist
52	Med Supply Co w/Certified Prosthetist
53	Med Supply Co w/Certified Prosthetist/Orthotist
54	Med Supply Co not included in 51, 52 or 53
55	Individual Certified Orthotist
56	Individual Certified Prosthetist
57	Individual Certified Prosthetist/Orthotist
58	Individuals not included in 55, 56 or 57
59	Ambulance Service Supplier
60	Public Health or Welfare Agency (Federal, State & Local Govt)
61	Voluntary Health Agency (ex: Planned Parenthood)
62	Psychologist
63	Portable X-Ray Supplier
64	Audiologist
65	Physical Therapist
66	Rheumatology
67	Occupational Therapist
68	Clinical Psychologist
69	Clinical Laboratory
70	Multispecialty Clinic or Group Practice
71	Registered Dietician/Nutrition Professional
72	Pain Management
73	Mass Immunization Roster Biller
74	Radiation Therapy Centers
75	Slide Preparation Facilities
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
80	Licensed Clinical Social Worker
81	Critical Care (Intensivists)
82	Hematology

Value	Description
83	Hematology/Oncology
84	Preventive Medicine
85	Maxillofacial Surgery
86	Neuropsychiatry
87	All Other Suppliers (i.e.., Drug, & Department Stores)
88	Unknown Supplier/Provider Specialty
89	Certified Clinical Nurse Specialist
90	Medical Oncology
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Interventional Radiology
95	Independent Physiological Lab
96	Optician
97	Physician Assistant
98	Gynecologist/Oncologist
99	Unknown Physician Specialty
A0	Hospital
A1	SNF
A2	Intermediate Care Facility
A3	Nursing Facility, Other
A4	HHA
A5	Pharmacy
A6	Medical Supply Co w/Respiratory Therapist
A7	Department Store
A8	Grocery Store
A9	Dentist
B2	Pedorthic Personnel
B3	Medical Supply Company with Pedorthic Personnel
B4	Rehabilitation Agency
B5	Ocularist

TABLE I – A: Service Category (Using the 4B reporting groups)

Value	Description
1	Capitated Physician Services
2	Fee For Service Physician Services
3	Behavioral Health –Inpatient Services
4	Behavioral Health –Diversionary Services *
5	Behavioral Health –Emergency Services Program (ESP) Services
6	Behavioral Health –Mental Health Outpatient Services *
7	Behavioral Health –Substance Abuse Outpatient Services *
8	Behavioral Health –Other Outpatient Services *
9	Facility- Medical/Surgical
10	Facility- Pediatric/Sick Newborns
11	Facility- Obstetrics
12	Facility- Skilled Nursing Facility/Rehab
13	Facility- Other Inpatient
14	Facility- Emergency Room
15	Facility –Ambulatory Care
16	Prescription Drug
17	Laboratory
18	Radiology
19	Home Health
20	Durable Medical Equipment
21	Emergency Transportation
22	Therapies
23	Other (Please use this for Vision and Dental claims)
24	Other Alternative Care
25	Mental Health and Substance Abuse Outpatient Services (MBHP Only)*
26	Outpatient Day Services (MBHP Only) *
27	Non-ESP Emergency Services (MBHP Only) *
28	Behavioral Health –Diversionary Services – 24-Hour
29	Behavioral Health – Diversionary Services – Non-24-Hour
30	Behavioral Health –Standard Outpatient Services
31	Behavioral Health –Other Services
32	Behavioral Health – Intensive Home or Community Based Outpatient Services for Youth (Please note this new category is where all CBHI services, except youth mobile crisis intervention would be listed. Youth mobile crisis intervention would be considered part of the Emergency Services Program Services.)

*** Use these categories only for the claims with Dates of Service before 07/01/2010**.

TABLE I – B1: Service Category (Using the SCO reporting groups)

Note: For the Claims with Date of Service on or after October 1, 2016

Value	Description
301	Hospital Inpatient
302	Behavioral Health (BH) Hospital Inpatient
303	Hospital Outpatient
304	Behavioral Health (BH) Hospital Outpatient
305	Professional
306	Vision
307	Dental
308	Therapy
309	Pharmacy/Drugs
309B	Pharmacy/Drugs (non-Part D)
310	Laboratory, Radiology, Testing
311	Institutional Long-Term Care
312	Community Long Term Care
313	Home and Community Based Waiver
314	Transportation
315	Medical Equipment
316	Hospice
317	Case Management
318	Other Miscellaneous

TABLE I – B2: Service Category (Using the SCO reporting groups)

Note: For the Claims with Date of Service before October 1, 2016

Value	Description
101	Acute Inpatient
102	Chronic Inpatient
103	Outpatient Clinic
104	Mental Health/Substance Abuse
105	Physicians
106	Nonphysician Practitioners
107	Vision Care
108	Dental Care
109	Therapies
110	Pharmacy
111	Laboratory, radiology, testing

Value	Description
112	Institutional Long Term Care
113	Community Long Term Care
114	Waiver Services
115	Transportation
116	Supplies/ Durable Medical Equipment
117	Hospice
118	Care Management
119	Miscellaneous

TABLE I – C: Service Category (Using the One Care - ICO reporting groups)

Value	Description
201	Acute Inpatient
202	Inpatient – MH/SA
203	Hospital Outpatient
204	Outpatient – MH/SA
205	Professional
210	Pharmacy
212	Long-Term Care (LTC) Facility
213	Home and Community Based Services (HCBS)/Home Health
215	Transportation
216	Durable Medical Equipment (DME) and Supplies
217	*All Other

*Should follow the definition in the “Quarterly Financial Report” submitted to EOHHS Budget Unit

TABLE K – Bill Classifications - Frequency (3rd digit)

Value	Description
0	Nonpayment/Zero Claims
1	Admit thru discharge claim
2	Interim-first claim
3	Interim –continuing claim
4	Interim-last claim
5	Late charges only claim
6	Adjustment of prior claim
7	Replacement of prior claim
8	Void/back out of prior claim
9	Final claim for Home Health PPS episode
A	Admission/Election Notice
B	Hospice termination revocation notice
C	Hospice change of provider notice
D	Hospice Void/back out
E	Hospice change of ownership
F	Beneficiary Initiated adjustment claim-other
G	CWF Initiated adjustment claim-other
H	CMS Initiated adjustment claim-other
I	Intermediary adjustment claim (other than PRO or Provider)
J	Initiated adjustment claim-other
K	OIG initiated adjustment claim
L	Reserved for national assignment
M	MSP initiated adjustment claim
N	PRO adjustment Claim
O	Nonpayment/Zero Claims
P-W	Reserved for national assignment
X	Void/back out a prior abbreviated encounter submission
Y	Replacement of a prior abbreviated encounter submission
Z	New abbreviated encounter submission

TABLE M – Present on Admission (UB)

CMS POA Indicator Options and Definitions

Code	Reason for Code
Y	Diagnosis was present at time of inpatient admission
N	Diagnosis was not present at time of inpatient admission.
U	Documentation was insufficient to determine if the condition was present at the time of inpatient admission.
W	Clinically undetermined. Provider was unable to clinically determine whether the condition was present at the time of inpatient admission.
1	Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04, however; it was determined that blanks are undesirable when submitting this data via the 4010A.

CMS updated as of 12/21

TABLE O – UNIT OF MEASURE

#	Unit	Description	POPS Suggested Rules
1	F2	International Unit (for example, anti-hemophilia factor)	Physician Administered Drug claims only
2	GR	Gram (for creams, ointments, and bulk powder)	Physician Administered Drug claims only
3	ME	Milligrams (for creams, ointments, and bulk powder)	Physician Administered Drug claims only
4	UN	Unit (for tablets, capsules, suppositories, and powder filled vials)	Physician Administered Drug claims
5	ML	Milliliters (for liquids, suspensions, and lotions)	Physician Administered Drug claims **and** Pharmacy
6	EA	Each	Pharmacy claims only
7	GM	Gram	Pharmacy claims only

Unit of Measure Reference

Retail Pharmacy Type

- Source: NCPDP
- Unit of Measure (NCPDP 600-28)
- Valid values: EA, GM, ML

Medical Type:

- Source: CMS Guidance (https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/53111)
- Valid values: UN, GR, ML, F2, ME

#	Unit	Standard Referenced	Available Link
1	F2	ANSI 5010 837P and ANSI 5010 837I	
2	GR	ANSI 5010 837P and ANSI 5010 837I	
3	ME	ANSI 5010 837P and ANSI 5010 837I	
4	UN	ANSI 5010 837P and ANSI 5010 837I	https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/53111
5	ML	ANSI 5010 837P, ANSI 5010 837I, and NCPDP	NCPDP: http://www.ncpdp.org/NCPDP/media/pdf/BUS_fact_sheet.pdf
6	EA	NCPDP	NCPDP: http://www.ncpdp.org/NCPDP/media/pdf/BUS_fact_sheet.pdf
7	GM	NCPDP	NCPDP: http://www.ncpdp.org/NCPDP/media/pdf/BUS_fact_sheet.pdf

8.0 Quantity and Quality Edits, Reasonability and Validity Checks

Raw Data

- File layout format
- Length and data type of the fields
- Reasonability of data
- ICD Version Qualifier (field # 193) is populated on every encounter claim record that has either ICD diagnosis codes or ICD procedure codes.
- All ICD diagnosis and ICD procedure codes on a claim record are consistent with ICD Version Qualifier.

Data Quality

- Each field is checked for quantity and quality
- Distribution reports
- Percentage reports
- Valid value reports

Claims File

#	Field Name	MassHealth Standard
1	Org. Code	100% present and valid per field requirement.
2	Claim Category	100% present and valid, as found in Data Elements table.
3	Entity PIDSL	100% present on all encounters
4	Record Indicator	100% present and valid per field requirement.
5	Claim Number	100% present and valid per field requirement.
6	Claim Suffix	100% present and valid per field requirement.
7	Pricing Indicator	Directions will be provided later, validation standards TBD
8	Recipient DOB	100% present and valid, as compared to encounter service dates
9	Recipient Gender	100% present and valid, as found in Data Elements table
10	Recipient ZIP Code	100% present and valid per field requirement.
11	Medicare Code	Provide if applicable
12	Other Insurance Code	100% present and valid, as found in Data Elements table
13	Submission Clarification Code	Provide on Pharmacy and Provider-Administered Drug claims
14	Claim Type	100% present and valid for MBHP only
15	Admission Date	100% present and valid value on all Inpatient claims, Long Term Care claims and all hospital (institutional) claims with admission.
16	Discharge Date	100% present and valid value on all Inpatient claims, Long Term Care claims and all hospital (institutional) claims with admission.
17	From Service Date	100% present and valid date on all claims.
18	To Service Date	100% present and valid date on all claims.
19	Primary Diagnosis	100% present and valid ICD codes on all Professional, Institutional (including Long Term Care), Vision, and Transportation claims. See Diagnosis segment in Data Element Clarifications for additional requirements.
20	Secondary Diagnosis	60% present and valid ICD codes on inpatient facility and 20% present and valid on other records, excluding drug and vision. Not routinely coded on Dental records and LTC.

#	Field Name	MassHealth Standard
		Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
21	Tertiary Diagnosis	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
22	Diagnosis 4	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
23	Diagnosis 5	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
24	Type of Admission	100% present and valid value (Admit Type, Table A) on all inpatient claims, Long Term Care claims, and all hospital (institutional) claims with admission.
25	Source of Admission	100% present and valid value (Admit Source, Table B) on all inpatient claims, Long Term Care claims, and all hospital (institutional) claims with admission.
26	Procedure Code	98% present and valid in general but should be 100% present on all professional claims. Procedure Code Indicator match (i.e., if the code is a "CPT or HCPCS Level 1 Code" then the Procedure code indicator should be "2").
27	Procedure Modifier 1	Provide if available
28	Procedure Modifier 2	Provide if available
29	Procedure Modifier 3	Provide if available
30	Procedure Code Indicator	100% present and valid if Procedure Code field is filled
31	Revenue Code	98% present and valid on Hospital and Long-Term Care claims only and should be 100% present on all Inpatient claim detail lines
32	Place of Service	100% present and valid value on all professional claims.
33	Type Of Bill	100% present and valid on all Inpatient and Long-Term Care claims
34	Patient Discharge Status	100% present and valid value on all Inpatient claims, LTC claims, all hospital (institutional) claims with admission.
35	FILLER	
36	Quantity	100% present on all claim categories.
37	NDC Number	98% present and valid values on Pharmacy claims; and on Hospital and Professional claims when applicable
38	Metric Quantity	100% present and valid values, only on Pharmacy claims, reasonability of values (total number of units or volume) and on Hospital and Professional claims when applicable.
39	Days Supply	100% present and valid values, only on all prescription drug Pharmacy claims.
40	Refill Indicator	100% present and valid values, only on all prescription drug Pharmacy claims.
41	Dispense As Written Indicator	100% present and valid values, only on all prescription drug Pharmacy claims.
42	Dental Quadrant	100% present and valid values (1-4), only on dental claims, where applicable
43	Tooth Number	100% present, only on dental claims, where applicable
44	Tooth Surface	100% present, only on dental claims, where applicable
45	Paid Date	100% present and valid date, falls within submitted date range, falls after "Admit, Discharge, To, and From Dates"
46	Service Class	100% present and valid for MBHP only
47	PCP Provider ID	100% present should be an enrolled provider listed in provider enrollment file. Not applicable to MBHP.
48	PCP Provider ID Type	100% present and valid based on PCP Provider ID field. Not applicable to MBHP.

#	Field Name	MassHealth Standard
49	PCC Provider ID	Must match PCC Provider ID listed in provider enrollment file.
50	Servicing Provider ID	100% present and valid on all claims except Pharmacy. Should be an enrolled provider listed in provider enrollment file.
51	Servicing Provider ID Type	100% present and valid on all claims except Pharmacy, Based on Servicing Provider ID field
52	Referring Provider ID	If applicable, should be an enrolled provider listed in provider enrollment file.
53	Referring Provider ID Type	100% present and valid, only when Referring Provider ID is present
54	Servicing Provider Class	100% present and valid on all records, as found in the Data Elements table.
55	Servicing Provider Type	100% present and valid value (Servicing Provider Type, Table G)
56	Servicing Provider Specialty	100% present and valid value for Professional Claims (Servicing Provider Specialty, Table H)
57	Servicing Provider ZIP Code	100% present and valid
58	Billing Provider ID	100% present and valid on all claims; should be an enrolled provider listed in provider enrollment file.
59	Authorization Type	100% present and valid for MBHP only
60	Billed Charge	100% present financial field with implied 2 decimals, mathematical check with other dollar amounts
61	Gross Payment Amount	100% present financial field with implied 2 decimals, mathematical check with other dollar amounts
62	TPL Amount	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
63	Medicare Amount	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
64	Copay	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
65	Deductible	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
66	Ingredient Cost	100% present and valid on prescription drug records, financial field with implied 2 decimals, mathematical check with other dollar amounts only on Pharmacy claims
67	Dispensing Fee	100% present and valid on prescription drug records, financial field with implied 2 decimals, mathematical check with other dollar amounts only on Pharmacy claims
68	Net Payment	100% present financial field with implied 2 decimals, mathematical check with other dollar amounts
69	Withhold Amount	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
70	Record Type	100% present and valid on all records, as found in the Data Elements table, dollar amount checks
71	Group Number	100% present and valid
72	DRG	100% present and valid value (001 - 495), on Acute Inpatient Hospital claims, when collected by plan.
73	EPSDT Indicator	Not coded at the present time
74	Family Planning Indicator	Not coded at the present time
75	MSS/IS	Not coded at the present time

#	Field Name	MassHealth Standard
76	New Member ID (consistent with above data)	100% Present and valid on all claims; not allowed to be missed or invalid.
77	Former Claim Number	100% present and valid, only when Record Type is not O
78	Former Claim Suffix	100% present and valid, only when Record Type is not O
79	Record Creation Date	100% present and valid date
80	Service Category	100% present and valid (Service Category, Table I)
81	Prescribing Prov. ID	100% present and valid on Pharmacy claims. Should be an enrolled provider listed in provider enrollment file.
82	Date Script Written	100% present and valid on Pharmacy claims.
83	Compound Indicator	100% present and valid on prescription drug records
84	Rebate Indicator	100% present and valid on prescription drug records
85	Admitting Diagnosis	100% present and valid value on all Inpatient claims, Long Term Care claims, and all hospital (institutional) claim with admission.
86	Allowable Amount	100% present and valid, financial field with implied 2 decimals, mathematical check with other dollar amounts
87	Attending Prov. ID	100% present should be an enrolled provider listed in provider enrollment file. Inpatient Claims only.
88	Non-covered Days	Provide if applicable
89	External Injury Diagnosis 1	Provide if available. Consistent with ICD Version Qualifier.
90	Claim Received Date	100% present and valid date
91	Frequency	100% present and valid on Inpatient claims.
92	PCC Provider ID Type	100% present and valid, when PCC Provider ID is present
93	Billing Provider ID _Type	100% present, and valid on all claims.
94	Prescribing Prov. ID _Type	100% present and valid on Pharmacy claims.
95	Attending Prov. ID _Type	100% present, and valid
96	Admission Time	100% present and valid value on Hospital and Long Term Care claims
97	Discharge Time	100% present and valid value on Hospital and Long Term Care claims
98	Diagnosis 6	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
99	Diagnosis 7	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
100	Diagnosis 8	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
101	Diagnosis 9	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
102	Diagnosis 10	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
103	Surgical Procedure code 1	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.

#	Field Name	MassHealth Standard
104	Surgical Procedure code 2	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
105	Surgical Procedure code 3	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
106	Surgical Procedure code 4	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
107	Surgical Procedure code 5	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
108	Surgical Procedure code 6	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
109	Surgical Procedure code 7	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
110	Surgical Procedure code 8	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
111	Surgical Procedure code 9	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
112	Employment	Provide if available
113	Auto Accident	Provide if available
114	Other Accident	Provide if available
115	Total Charges	Provide if available
116	Non-Covered charges	Provide if available
117	Coinsurance	Provide if available
118	Void Reason Code	100% present on all claims with Record Type “V”
119	DRG Description	Provide if applicable
120	DRG Type	Provide if applicable
121	DRG Version	Provide if applicable
122	DRG Severity of Illness Level	Provide if applicable
123	DRG Risk of Mortality Level	Provide if applicable
124	Patient Pay Amount	Provide if applicable
125	Patient Reason for Visit Diagnosis 1	Provide if applicable. Consistent with ICD Version Qualifier.
126	Patient Reason for Visit Diagnosis 2	Provide if applicable. Consistent with ICD Version Qualifier.
127	Patient Reason for Visit Diagnosis 3	Provide if applicable. Consistent with ICD Version Qualifier.
128	Present on Admission (POA) 1	100% present on Hospital and Long-Term Care claims
129	Present on Admission (POA) 2	Provide if Diagnosis 2 is available on Hospital and Long-Term Care claims
130	Present on Admission (POA) 3	Provide if Diagnosis 3 is available on Hospital and Long-Term Care claims
131	Present on Admission (POA) 4	Provide if Diagnosis 4 is available on Hospital and Long-Term Care claims
132	Present on Admission (POA) 5	Provide if Diagnosis 5 is available on Hospital and Long-Term Care claims

#	Field Name	MassHealth Standard
133	Present on Admission (POA) 6	Provide if Diagnosis 6 is available on Hospital and Long-Term Care claims
134	Present on Admission (POA) 7	Provide if Diagnosis 7 is available on Hospital and Long-Term Care claims
135	Present on Admission (POA) 8	Provide if Diagnosis 8 is available on Hospital and Long-Term Care claims
136	Present on Admission (POA) 9	Provide if Diagnosis 9 is available on Hospital and Long-Term Care claims
137	Present on Admission (POA) 10	Provide if Diagnosis 10 is available on Hospital and Long-Term Care claims
138	Diagnosis 11	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
139	Present on Admission (POA) 11	Provide if Diagnosis 11 is available on Hospital and Long-Term Care claims
140	Diagnosis 12	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
141	Present on Admission (POA) 12	Provide if Diagnosis 12 is available on Hospital and Long-Term Care claims
142	Diagnosis 13	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
143	Present on Admission (POA) 13	Provide if Diagnosis 13 is available on Hospital and Long-Term Care claims
144	Diagnosis 14	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
145	Present on Admission (POA) 14	Provide if Diagnosis 14 is available on Hospital and Long-Term Care claims
146	Diagnosis 15	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
147	Present on Admission (POA) 15	Provide if Diagnosis 15 is available on Hospital and Long-Term Care claims
148	Diagnosis 16	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
149	Present on Admission (POA) 16	Provide if Diagnosis 16 is available on Hospital and Long-Term Care claims
150	Diagnosis 17	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
151	Present on Admission (POA) 17	Provide if Diagnosis 17 is available on Hospital and Long-Term Care claims
152	Diagnosis 18	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
153	Present on Admission (POA) 18	Provide if Diagnosis 18 is available on Hospital and Long-Term Care claims
154	Diagnosis 19	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
155	Present on Admission (POA) 19	Provide if Diagnosis 19 is available on Hospital and Long-Term Care claims
156	Diagnosis 20	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.

#	Field Name	MassHealth Standard
157	Present on Admission (POA) 20	Provide if Diagnosis 20 is available on Hospital and Long-Term Care claims
158	Diagnosis 21	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
159	Present on Admission (POA) 21	Provide if Diagnosis 21 is available on Hospital and LTC claims
160	Diagnosis 22	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
161	Present on Admission (POA) 22	Provide if Diagnosis 22 is available on Hospital and Long-Term Care claims
162	Diagnosis 23	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
163	Present on Admission (POA) 23	Provide if Diagnosis 23 is available on Hospital and Long-Term Care claims
164	Diagnosis 24	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
165	Present on Admission (POA) 24	Provide if Diagnosis 24 is available on Hospital and Long-Term Care claims
166	Diagnosis 25	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
167	Present on Admission (POA) 25	Provide if Diagnosis 25 is available on Hospital and Long-Term Care claims
168	Diagnosis 26	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
169	Present on Admission (POA) 26	Provide if Diagnosis 26 is available on Hospital and Long-Term Care claims
170	Present on Admission (POA) EI 1	Provide if External Injury Diagnosis 1 is available on Hospital and Long-Term Care claims
171	External Injury Diagnosis 2	Provide if available. Consistent with ICD Version Qualifier.
172	Present on Admission (POA) EI 2	Provide if External Injury Diagnosis 2 is available on Hospital and Long-Term Care claims
173	External Injury Diagnosis 3	Provide if available. Consistent with ICD Version Qualifier.
174	Present on Admission (POA) EI 3	Provide if External Injury Diagnosis 3 is available on Hospital and Long-Term Care claims
175	External Injury Diagnosis 4	Provide if available. Consistent with ICD Version Qualifier.
176	Present on Admission (POA) EI 4	Provide if External Injury Diagnosis 4 is available on Hospital and Long-Term Care claims
177	External Injury Diagnosis 5	Provide if available. Consistent with ICD Version Qualifier.
178	Present on Admission (POA) EI 5	Provide if External Injury Diagnosis 5 is available on Hospital and Long-Term Care claims
179	External Injury Diagnosis 6	Provide if available. Consistent with ICD Version Qualifier.
180	Present on Admission (POA) EI 6	Provide if External Injury Diagnosis 6 is available on Hospital and Long-Term Care claims

#	Field Name	MassHealth Standard
181	External Injury Diagnosis 7	Provide if available. Consistent with ICD Version Qualifier.
182	Present on Admission (POA) EI 7	Provide if External Injury Diagnosis 7 is available on Hospital and Long-Term Care claims
183	External Injury Diagnosis 8	Provide if available. Consistent with ICD Version Qualifier.
184	Present on Admission (POA) EI 8	Provide if External Injury Diagnosis 8 is available on Hospital and Long-Term Care claims
185	External Injury Diagnosis 9	Provide if available. Consistent with ICD Version Qualifier.
186	Present on Admission (POA) EI 9	Provide if External Injury Diagnosis 9 is available on Hospital and Long-Term Care claims
187	External Injury Diagnosis 10	Provide if available. Consistent with ICD Version Qualifier.
188	Present on Admission (POA) EI 10	Provide if External Injury Diagnosis 10 is available on Hospital and Long-Term Care claims
189	External Injury Diagnosis 11	Provide if available. Consistent with ICD Version Qualifier.
190	Present on Admission (POA) EI 11	Provide if External Injury Diagnosis 11 is available on Hospital and Long-Term Care claims
191	External Injury Diagnosis 12	Provide if available. Consistent with ICD Version Qualifier.
192	Present on Admission (POA) EI 12	Provide if External Injury Diagnosis 12 is available on Hospital and Long-Term Care claims
193	ICD Version Qualifier	100 % Present on all Professional and Institutional claims. 100% required on all other claims when at least one ICD diagnosis code or ICD surgical procedure code is submitted.
194	Procedure Modifier 4	Provide if available
195	Service Category Type	100% present and valid
196	Ambulance Patient Count	Provide if applicable
197	Obstetric Unit Anesthesia Count	Provide if applicable
198	Prescription Number	100% present on Pharmacy claims
199	Taxonomy Code	Provide if available
200	Rate Increase Indicator	Provide if applicable
201	Bundle Indicator	Provide if available. Follow instructions in Section 2.0 - Data Element Clarifications
202	Bundle Claim Number	100% present if Bundle Indicator=” Y”.
203	Bundle Claim Suffix	100% present if Bundle Indicator=” Y.
204	Value Code	Provide on the new-born claim lines
205	Value Amount	Provide when Value Code is present in field # 203
206	Surgical Procedure Code 10	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
207	Surgical Procedure Code 11	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
208	Surgical Procedure Code 12	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.

#	Field Name	MassHealth Standard
209	Surgical Procedure Code 13	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
210	Surgical Procedure Code 14	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
211	Surgical Procedure Code 15	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
212	Surgical Procedure Code 16	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
213	Surgical Procedure Code 17	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
214	Surgical Procedure Code 18	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
215	Surgical Procedure Code 19	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
216	Surgical Procedure Code 20	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
217	Surgical Procedure Code 21	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
218	Surgical Procedure Code 22	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
219	Surgical Procedure Code 23	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
220	Surgical Procedure Code 24	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
221	Surgical Procedure Code 25	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
222	Attending Prov. ID Address Location Code	Provide when Attending Prov. ID is present
223	Billing Provider ID Address Location Code	Provide when Billing Provider ID is present
224	Prescribing Prov. ID Address Location Code	Provide when Prescribing Prov. ID is present
225	PCP Provider ID Address Location Code	Provide when PCP Provider ID is present
226	Referring Provider ID Address Location Code	Provide when Referring Provider ID is present
227	Servicing Provider ID Address Location Code	Provide when Servicing Provider ID is present
228	PCC Provider ID Address Location Code	Provide when PCC Provider ID is present
229	Submission Clarification Code 2	Provide on Pharmacy and Provider-Administered Drug claims
230	Submission Clarification Code 3	Provide on Pharmacy and Provider-Administered Drug claims
231	Unit of Measure	100 % present and valid on Pharmacy and/or Physician-Administered Drug claims
232	Provider Payment	Provide when available
233	Filler	

9.0 Appendices

Appendix C – Member File and Member Enrollment File Specifications

Overview

MCEs are required to submit member enrollment data on a monthly basis along with Encounter data submission. Member level enrollment data are needed for multiple EHS projects.

For example, the updated Member Enrollment File captures member enrollment with a PCP and member demographics.

Member File Layout

#	Field	Description	Length	Type	Required	Comments
1	Org. Code	Unique ID assigned by MH DW to each submitting organization. Code that identifies your Organization: MCO / ACPP 465 Fallon Community Health Plan 469 Allways Health Partners (a.k.a. Neighborhood Health Plan) 997 Boston Medical Center HealthNet Plan 998 Tufts Health Plan (a.k.a. Network Health) 999 Massachusetts Behavioral Health Partnership 470 CeltiCare - Retired 471 Health New England SCO 501 Commonwealth Care Alliance 502 United HealthCare (a.k.a. Evercare) 503 NaviCare 504 Molina Healthcare (a.k.a. Senior Whole Health) 505 Tufts Health Plan Senior Care Options 506 Boston Medical Center HealthNet Plan Senior Care Options One Care 601 Commonwealth Care Alliance 602 Tufts Health Unify (a.k.a., Network Health) 603 Fallon Total – Retired 604 United HealthCare Connected (new)	3	N	Required	
2	Member ID	The MassHealth ID for the member	12	C	Required	
3	Active Status Indicator	Y/N indicates whether the member has a current “Active” enrollment status with the MCE	1	C	Required	
4	Member Birth Date	Member Date of Birth	8	Date YYYY MMDD	Required	

#	Field	Description	Length	Type	Required	Comments
5	Member Death Date	Member Date of Death	8	Date YYYY MMD D	Required	
6	Member First Name	Member first name	100	C	Required	
7	Member Last Name	Member last name	100	C	Required	
8	Member Middle Initial	Member Middle Initial	1	C	Required	
9	Member Gender	The gender of the member: "Male" ; "Female", or “Other” These values should be spelled out and should not be abbreviated	8	C	Required	
10	Member Ethnicity	Please follow the US Office of Management and Budget (OMB) standards for Classification of Race and Ethnicity	75	C	Provide if available	Values should have descriptions and not codes
11	Member Race	Please follow the US Office of Management and Budget (OMB) standards for Classification of Race and Ethnicity	75	C	Provide if available	Values should have descriptions and not codes
12	Member Primary Language	The Primary Language of the Member	75	C	Provide if available	Values should have descriptions and not codes
13	Member Address 1	Member Street Address 1	100	C	Required	
14	Member Address 2	Member Street Address 2	100	C	Provider if applicable	
15	Member City	Member City	40	C	Required	
16	Member State	Member State	2	C	Required	
17	Member Zip Code	Member Zip Code	5	C	Required	
18	Homeless Indicator	Y/N. Indicates if the member is homeless	1	C	Provide if available	
19	Communication Access Needs Indicator	Y/N. Indicates if the member has special needs for communicator	1	C	Provide if available	
20	Disability Indicator	Y/N. Indicates if the member has a disability	1	C	Provide if available	
21	Disability Type	Identifies the disability type for a member. This is a place holder until the disability types are clearly defined. Values TBD	30	C	Provide if available	

Member Enrollment File Layout

#	Field	Description	Length	Type	Required	Comments
1	Org. Code	Unique ID assigned by MH DW to each submitting organization. This code identifies your Organization: MCO / ACPP 465 Fallon Community Health Plan 469 Allways Health Partners (a.k.a. Neighborhood Health Plan) 997 Boston Medical Center HealthNet Plan 998 Tufts Health Plan (a.k.a. Network Health) 999 Massachusetts Behavioral Health Partnership 470 CeltiCare - Retired 471 Health New England SCO 501 Commonwealth Care Alliance 502 United HealthCare (a.k.a. Evercare) 503 NaviCare 504 Molina Healthcare (a.k.a. Senior Whole Health) 505 Tufts Health Plan Senior Care Options 506 Boston Medical Center HealthNet Plan Senior Care Options One Care 601 Commonwealth Care Alliance 602 Tufts Health Unify (a.k.a., Network Health) 603 Fallon Total – Retired 604 United HealthCare Connected (new)	3	N	Required	
2	Member ID	The MassHealth ID for the member	12	C	Required	
3	Provider Enroll Type	This field indicates the Type of Provider a member is enrolled with. It should reflect the information entered in the Provider ID and ID Type. For example, if Provider Enroll Type is entered as '02' then the Provider ID and ID Type should be for the "Geriatric Coordinator" the member is enrolled with. The values are as follows: 01 = PCP 02 = Geriatric Coordinator 03 = LTSS Coordinator 04 = Care Coordinator 05 = Care Coordination Program (if no assigned care coordinator but member is enrolled in a care coordination program) 06 = Care Manager 07 = Care Management Program (if no assigned care manager but member is enrolled in a care management program)	2	C	Required	This is a key field and it indicates whether the provider fields are for a PCP or CM providers.

#	Field	Description	Length	Type	Required	Comments
4	Provider Enroll Type Description	The Description of the Provider Enroll Type. The description should be consistent with the value selected in Provider Enroll Type. If the value entered in Provider Enroll Type is **" 01"** the description should be "PCP" If the value entered in Provider Enroll Type is **"02"** the description should be " Geriatric Coordinator" and so on.	40	C	Required	
5	Care Level	This field is required with all CM Providers to indicate whether the Provider ID submitted is at the MCE or Practice/Provider level. If the Provider is a PCP, value "NA" **must** be entered in this field. Values are: "MCE" "PRV" "NA" for "Not Applicable"	3	C	Required	
6	Begin Enrollment Date	This is the beginning enrollment date with a PCP or CM Providers	8	Date YYYY MMD D	Required	
7	End Enrollment Date	This is the end enrollment date with a PCP or CM Providers	8	Date YYYY MMD D	Required	This value should be "99991231" for "active" enrollment which represents End of Time (EOT).
8	Provider ID	Provider ID	15	C	Required	This ID should be consistent with the ID submitted in the Encounter Provider File for a provider. Information provided in this field should be consistent with the information submitted in the "Provider Enroll Type" field above. For example, if the Provider Enroll Type was submitted on a record as "01" then the Provider ID for that record would be for a PCP. This applies to all other values in the Provider Enroll Type.
9	Provider ID Type	Provider ID Type is required when the provider is part of prior and current provider files submitted in the encounter data.	1	C	Required	This ID Type should be consistent with the ID Type submitted in the

#	Field	Description	Length	Type	Required	Comments
		The values are: 1 for NPI 6 for MCE Internal ID				Encounter Provider File for a provider. Information provided in this field should be consistent with the information submitted in the "Provider Enroll Type" field above. For example, if the Provider Enroll Type was submitted on a record as "01" then the Provider ID Type for that record would be the ID Type associated with a PCP. This applies to all other values in the Provider Enroll Type.
10	Practice ID	Practice ID.	15	C	Highly important so please provide if available	This ID should be consistent with the ID submitted in the Encounter Provider File for a Practice
11	Practice ID Type	Practice ID Type. The values are: 1 for NPI 6 for MCE Internal ID	1	C	Highly important so please provide if available	This ID Type should be consistent with the ID Type submitted in the Encounter Provider File for a Practice
12	Provider ID Address Location Code	Code to identify address location of Provider ID in Field #8	15	C		
13	Practice ID Address Location Code	Code to identify address location of Practice ID in Field #10.	15	C		
14	Entity PIDSL	ACO PIDSL for the ACO claims and MCO PIDSL for the MCO claims SCO PIDSL on SCO claims One Care PIDSL on One Care claims Example: 999999999A	10	C	Required on all records	Should be consistent with ACO PIDSL submitted in the encounter provider file

Technical Specifications

MCEs should submit a full refresh of the Member and the Member Enrollment files on a monthly basis:

Member File

1. Each MCE should submit a full refresh of Member File of all MassHealth and CommCare members who have been enrolled with the MCE on or after 1/1/2010 including members who ended their enrollment after 1/1/2010.
2. The Member File contains the **member** MassHealth ID and demographic information.
3. The Member File is a snapshot as of the end of the month prior to the submission date. For example, the "as of" date for data submitted end of September 2013 is August 31, 2013.
4. The Member File always contains the most current member demographic information.
5. Member records submitted by the MCEs stay in EHS DW unless the MCE sends a "delete" file with the member records that have to be removed from EHS DW system. ***This file will only be sent when the MCE determines that the member should never have been part of EOHHS population and had been erroneously sent to MassHealth***. In this case, the member in the delete file will be deleted from both the Member File and the Member Enrollment File (See section 3 –Submission Process).

Member Enrollment File

1. Each MCE should submit a full refresh of all MassHealth and CommCare members who have been enrolled with a PCP on or after 1/1/2010 including members who ended their enrollment after 1/1/2010.
2. The file should include all enrollments since 1/1/2010. For example, if a member had three PCP enrollments during this period, then all three enrollments will be reported in the file.
3. Begin and End Enrollment dates must reflect changes in member ***enrollment*** with a PCP and changes in Practice affiliation.
4. Members who are enrolled with an MCE and are in the Member File, but do not have PCP enrollment should ***not*** be included in Member Enrollment file.
5. All members included in the Member Enrollment File should also be included in the Member File.
6. Any member enrollment record that existed in prior files and is not submitted in current files get "soft" deleted from MassHealth system.

Member Enrollment File Providers and Practices

1. PCPs are considered "Providers", and their IDs should be submitted in the Provider ID field.
2. The Practice that the above providers are associated with is referred to as "Practice", and the Practice Provider ID should be submitted in the Practice ID field.
3. If one Practice location cannot be identified for the member enrollment with a PCP then MCEs should provide the ID for the PCP's head contracting entity in the Practice ID field.
4. A "Provider Enroll Type" field indicates that the Provider ID is for a PCP.
5. A "Care Level" field indicates whether the CM Provider IDs are submitted at the MCE or Practice/Provider level.
6. The only information required in the Member Enrollment File for a Provider and Practice is Provider ID/Provider ID Type and Practice ID/Practice ID Type.
7. Every Provider ID for a PCP and every Practice ID must exist in the Provider File submitted in the Encounter file.

8. Any change in ***Provider or Practice*** demographic information would not require the submission of any new records in the Member Enrollment File. Demographic information will be maintained in the Encounter Provider File

Member Enrollment File Begin and End Enrollment Dates

1. The Member Enrollment File will have “Begin” and “End” Enrollment Dates to identify all enrollments with a PCP.
2. Any change in the member enrollment with a provider would require additional records with new “Begin” and “End” Enrollment dates.
3. “Begin” and “End” enrollment dates must be submitted with each record. End Enrollment Date for “active” enrollments with a provider will be submitted as “End of Time” (EOT – 99991231)

Submission Process

1. Member ZIP File must be named “MCE_MEMBER_YYYYMMDD.zip” (e.g., BMC_MEMBER_20130831.zip).
2. Member ZIP File must include Member File, Member Enrollment File, and Member Metadata File.
3. Member File and Member Enrollment File must be submitted as “Pipe” delimited text files.
4. The member metadata file in the Member ZIP File must be named MEM_metadata.txt.
5. Member ZIP File must be submitted at the same time the Encounter data is submitted. It should be placed on SFTP server after the claims zip file is posted.
6. A zero-byte file "mem_mce_done.txt" must be placed on SFTP server along with the Member Zip file. The file “mem_mce_done.txt” is only needed when the Member Zip file is submitted.

Member Metadata File

Metadata Field	Submission
MCE_Id="Value"	Mandatory
Date_Created=" YYYYMMDD"	Mandatory
Member_File_Name="Value"	Mandatory
MemEnroll_File_Name="Value"	Mandatory
CareMgmt_File_Name="Value"	Mandatory
Total_Member_Records="Value"	Mandatory
Total_MemEnroll_Records="Value"	Mandatory
Total_CareMgmt_Records="Value"	Mandatory
Time_MemEnroll_From="Value" (YYYYMMDD)	Mandatory
Return_To=”Email Address”	Mandatory

Notes:

i. Total_Member_Records is the total number of records in the Member File
ii. Total_MemEnroll_Records is the total number of records in the Member Enrollment File.

iii. Time_MemEnroll_From is the earliest "Begin" Enrollment Date in the Member Enrollment File.

iv. Total_CareMgmt_Records is the total number of records in the Care Management Provider File.

v. For files missing from a submission set corresponding field value to "none.txt"

Member Delete File

1. Member Delete File has the same format as Member File but will only have the member records that need to be deleted from our system. This file will only be sent when the MCE determines that the member should never have been part of EOHHS population and had been erroneously sent to MassHealth.
2. The member in the delete file will be deleted from both the Member File and the Member Enrollment File.
3. Member Delete File will be submitted independently from the Member Zip file and will be named MCE_DELETE_MEM_YYYYMMDD.txt (e.g., BMC_DELETE_MEM_20210930.txt).
4. The Member Delete File can be submitted any time; however, the MCE must send an email to MassHealth Data Warehouse to notify them about the submission of a delete file.

Validation Rules

Member File

1. All Member IDs submitted in the Member File should exist in MMIS.
2. In the following scenarios, all records for that Member ID will be rejected:
    a) Member ID is missing
    b) Member ID is invalid
    c) Org. Code is missing
    d) Org. Code is not meeting MassHealth Standards
    e) Entity Identifier is not meeting MassHealth Standards
3. Member File data are not used in the claims validation process. Rejected Member File records do not affect encounter claims data load.
4. It is expected that values be collected and submitted for all fields. For example, Member Ethnicity (field #10), Member Race (field #11), and Member Primary Language (field #12) are fields that are not currently validated but that are nevertheless expected and important for determining new policies that improve care to Members.

Member Enrollment File

1) All Member IDs submitted in the Member Enrollment File must exist in MMIS
2) All Member IDs submitted in the Member Enrollment File must exist in Member File
3) The records get rejected if:
    a) Member ID is missing or invalid
    ~~b)~~ Provider ID is missing or invalid (not found in MCE Provider Files)
    c) Provider ID Type is missing or invalid (not found in MCE Provider Files)
    d) Provider ID address location code is missing or invalid (not found in MCE Provider Files)
    e) Practice ID Type or Practice ID Address Location Code is missing when Practice ID is provided
    f) Practice ID Type not found in MCE Provider File
    g) Provider Enroll Type is missing
    h) Provider Enroll Type is not valid as per specification
    i) Care Level is missing or is not valid as per specification
    j) Begin Enrollment Date is missing or invalid
    k) End Enrollment Date is missing or invalid
    l) Org. Code is missing or invalid

4) Member Enrollment File data are not used in claims validation process.
5) Rejected Member Enrollment File records do not affect encounter claims data load.
6) Records are currently not rejected if the values in other fields are missing or invalid (e.g., Entity PIDSL is missing or doesn't match MMIS). However, these fields are nevertheless very important for reporting and decisions. MassHealth reserves the right to introduce additional completeness validation rules.

Member and Member Enrollment Error Files:

1. All records in the Member File, Member Enrollment File not meeting validation rules described in Section 4 will be rejected.
2. An error file for the Member File will be posted on the FTP server and will be named "ERR_MCE_MEMBER_YYYYMMDD.txt". (e.g., ERR_BMC_MEMBER_20130930.txt)
3. An error file for the Member Enrollment File will be posted on the FTP server and will be named "ERR_MCE_MEMENROLL_YYYYMMDD.txt". (e.g., ERR_BMC_MEMENROLL_20130930.txt)
4. Records that get rejected must be corrected and sent back to MassHealth to get into the system.
5. Member and Member Enrollment correction files should follow the same format as the original files
6. Member and Member Enrollment correction files must be submitted with the Encounter correction/manual override file or must be corrected in the following month's member files submission.
7. Corrected records in Member File, Member Enrollment File that still have errors will never go into MassHealth system and will not be overridden even when submitted along with the Manual Override Encounter file.

Appendix Q - EOHHS Accountable Care Organization Quality Appendix

This Appendix details how EOHHS will calculate the Contractor's Quality Score and DSRIP Accountability Score as described in the Contract. EOHHS reserves the right to modify the methodology set forth herein prior to execution of the Contract. EOHHS may modify the methodology set forth herein after the execution of the Contract by written amendment. EOHHS anticipates ongoing evaluation of this methodology, including but not limited to the list of Quality Measures, during the Contract Term. EOHHS anticipates engaging the Contractor and other ACOs as well as other stakeholders in this evaluation process. The following information is included. **For the purposes of this document, "Budget Period (BP)" is used interchangeably with "Performance Year (PY)".**

1 Overview of Quality Score and DSRIP Accountability Score

The Contractor shall receive, for each Performance Year, a Quality Score and a DSRIP Accountability Score, which may be two different values. The Contractor's Quality Score shall modify the Contractor's risk corridor payments, as described in Section 4 and Appendix D of the Contract. The Contractor's DSRIP Accountability Score shall be used to determine the proportion of the Contractor's withheld DSRIP payments the Contractor receives, as described in Section 5 of the Contract.

The Contractor's Quality Score and DSRIP Accountability Score shall be calculated as described in this Appendix and as further specified by EOHHS. Section 2 of this Appendix describes how the Contractor's Quality Score is calculated. Section 3 of this Appendix describes how the Contractor's DSRIP Accountability Score is calculated.

2 Methodology to Calculate Quality Score

The Contractor's Quality Score is based on a weighted average of the Contractor's scores across a set of individual measures that are grouped into domains. This Section of the Appendix describes the individual measures, the methodology EOHHS will use to calculate the Contractor's score for each measure, and the methodology EOHHS will use to calculate and average domain scores to produce the Contractor's Quality Score.

2.1 List of Quality Measures

Quality Measures include claims-based measures, Clinical Quality Measures, and member care experience surveys across the following four domains:

- Prevention & Wellness
- Care Integration
- Patient Experience Survey: Overall Rating and Care Delivery
- Patient Experience Survey: Person-centered Integrated Care

In calculating the Contractor's Quality Score, EOHHS will apply a weight to each domain. The Quality Measures Domain Weights are presented in Exhibit 1.

EXHIBIT 1 – Quality Domain Weights

ACO Quality Domain Weights					
Quality Domain		Domain Weight: PY 1	Domain Weight: PY 2	Domain Weight: PY 3	Domain Weight: PY 4-5
Clinical Quality Measures					
1	Prevention & Wellness	100% (P4R only)	85%	65%	45%
2	Care Integration		--	20%	40%
Patient Experience Surveys					
3	Overall Rating and Care Delivery	--	15%	15%	7.5%
4	Person-centered Integrated Care	--	--	--	7.5%

In Performance Year 1, quality is "pay-for-reporting" – i.e., the Contractor will be required to report all Hybrid Quality Measures satisfactorily (i.e., measures requiring submission of record based data) to achieve a full score. Beginning in Performance Year 2, a subset of Quality Measures will be pay-for-performance (P4P) – i.e., the Contractor's score will be based on the Contractor's performance. For Performance Year 3, the State has proposed reweighting as illustrated in the table above to account for the impact of the public health emergency on measurement and accountability in 2020. For Performance Years 4-5, all Quality Measures will be pay-for-performance (P4P).

If the Contractor has an insufficient number of Enrollees (as determined by EOHHS) for a Measure, then EOHHS will exempt the Contractor from that particular Measure. As such, the weight assigned to the Measure within the Measure's domain will be redistributed equally among all other measures within that domain. Thus, the overall domain weights will not increase or decrease as a result of measure ineligibility.

Please see Exhibit 2 for the list of Quality Measures. EOHHS reserves the right to modify this list as deemed necessary and determined by EOHHS.

EXHIBIT 2 – ACO Quality Measures

#	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.
1	Childhood Immunization Status	Percentage of members who received all recommended immunizations by their 2nd birthday	Hybrid	NCQA	0038
2	Immunizations for Adolescents	Percentage of members 13 years of age who received all recommended vaccines, including the HPV series	Hybrid	NCQA	1407
3	Timeliness of Prenatal Care	Percentage of deliveries in which the member received a prenatal care visit in the first trimester or within 42 days of enrollment	Hybrid	NCQA	1517
4	Oral Health Evaluation	Percentage of members under age 21 years who received a comprehensive or periodic oral evaluation within the year	Claims	ADA DQA	2517
5	Screening for Depression and Follow Up Plan	Percentage of members 12 to 64 years of age screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen	Hybrid	CMS	0418
6	Asthma Medication Ratio	Percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater	Claims	NCQA	1800
7	Controlling High Blood Pressure	Percentage of members 18 to 64 years of age with hypertension and whose blood pressure was adequately controlled	Hybrid	NCQA	0018
8	Comprehensive Diabetes Care: A1c Poor Control	Percentage of members 18 to 64 years of age with diabetes whose most recent HbA1c level demonstrated poor control (> 9.0%)	Hybrid	NCQA	0059

#	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.
9	Depression Remission or Response	Percentage of members 12 to 64 years of age with a diagnosis of depression and elevated PHQ-9 score, who receive follow-up PHQ-9 and experienced remission or response within 4 to 8 months of the initial elevated score	Hybrid	NCQA	N/A
10	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Percentage of members 1 to 17 years of age who had two or more antipsychotic prescriptions and received metabolic testing	Claims	NCQA	2800
11	Emergency Department Visits for Individuals with Mental Illness, Addiction, or Co-occurring Conditions	Risk adjusted ratio (obs/exp) of ED visits for members 18 to 64 years of age identified with a diagnosis of serious mental illness, substance addiction, or co-occurring conditions	Claims	EOHHS	N/A
12	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	Percentage of ED visits for members 6 to 64 years of age with a principal diagnosis of mental illness, where the member received follow-up care within 7 days of ED discharge	Claims	NCQA	2605
13	Follow-Up After Hospitalization for Mental Illness (7 days)	Percentage of discharges for members 6 to 64 years of age, hospitalized for mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge	Claims	NCQA	0576
14	Hospital Readmissions (Adult)	Case-mix adjusted rate of acute unplanned hospital readmissions within 30 days of discharge for members 18 to 64 years of age	Claims	NCQA	1768
15	Health-Related Social Needs Screening	Percentage of members 0 to 64 years of age who were screened for health-related social needs in the measurement year	Hybrid	EOHHS	N/A
16	Behavioral Health Community Partner Engagement	Percentage of members 18 to 64 years of age who engaged with a BH Community Partner and received a treatment plan within 4 months (122 days) of Community Partner assignment	Claims	EOHHS	N/A

#	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.
17	Long-Term Services and Supports Community Partner Engagement	Percentage of members 3 to 64 years of age who engaged with an LTSS Community Partner and received a care plan within 4 months (122 days) of Community Partner assignment	Claims	EOHHS	N/A
18	Community Tenure	The percentage of eligible days that ACO members 18-64 with bipolar disorder, schizophrenia, or psychosis (BSP) diagnoses, and separately, for other members 18-64 who have at least 3 consecutive months of LTSS utilization reside in their home or in a community setting without utilizing acute, chronic, or post-acute institutional health care services during the measurement year	Claims	EOHHS	N/A
19	Initiation and Engagement of Alcohol, or Other Drug Abuse or Dependence Treatment	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiate treatment within 14 days of diagnosis and who receive at ≥2 additional services within 30 days of the initiation visit	Claims	NCQA	0004
20	Overall Rating and Care Delivery	Composites related to communications and willingness to recommend	Survey	AHRQ	0005
21	Person-Centered Integrated Care	Composites related to care planning, self-management, and integration of care	Survey	TBD	N/A

2.2 Member Experience Survey

EOHHS will use survey instruments to evaluate the Enrollee experience for its ACO program. Where available, EOHHS will use nationally validated surveys, such as the CAHPS Clinician and Group Survey. EOHHS will include survey questions related to EOHHS' delivery system reform priorities, such as a Patient-Centered Medical Home supplement and specific questions related to the integration of physical health, Behavioral Health, Long Term Services and Supports, and health-related social needs. EOHHS intends to phase in new approaches to evaluating Enrollee experience over time, including survey instruments that evaluate Enrollee experience with the services provided by Behavioral Health and Long Term Services and Support providers.

2.3 Quality Measure Scoring Methodology for All Measures (Budget Periods 2, 4, and 5)

The Contractor may receive "achievement points" and "improvement points" for each Quality Measure.

2.3.1 Achievement Points

The Contractor may receive up to a maximum of ten (10) achievement points for each Quality Measure, as follows:

1. EOHHS will establish an "attainment threshold" and a "goal benchmark" for each Quality Measure
    a. "Attainment threshold" sets the minimum level of performance at which the contractor can earn achievement points
    b. "Goal benchmark" is a high performance standard above which the Contractor earns the maximum number of achievement points (i.e., 10 points)
2. EOHHS will calculate the Contractor's performance score on the Quality Measure based on the measure specifications
3. EOHHS will award the Contractor between zero (0) and ten (10) achievement points as follows:
    a. If the Contractor's performance score is less than the attainment threshold: 0 achievement points
    b. If the Contractor's performance score is greater than or equal to the goal benchmark: 10 achievement points
    c. If the performance score is between the attainment threshold and goal benchmark: achievement points earned are determined by the formula:
        i. 10*((Performance Score – Attainment Threshold) / (Goal Benchmark – Attainment Threshold))

EXHIBIT 3 – Example Calculation of Achievement Points for Measure A

Measure A attainment threshold = 45% (e.g., corresponding to 25th percentile of HEDIS benchmarks)
Measure A goal benchmark = 80% (e.g., corresponding to 90th percentile of HEDIS benchmarks)

Scenario 1:

- Measure A performance score = 25%
- Achievement points earned = 0 points

Scenario 2:

- Measure A performance score = 90%
- Achievement points earned = 10 points

Scenario 3:

- Measure A performance score = 60%
- Achievement points earned = 10*((60% - 45%) / (80% - 45%)) = 4.29 points

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2.3.2 Improvement Points

In addition to receiving achievement points based on performance (on a 0 to 10 scale), the Contractor may earn improvement points for reaching established improvement targets for each Quality Measure. Improvement points will be calculated as follows:

1. EOHHS will calculate the Contractor's performance score on each Quality Measure based on the measure specifications. Each Quality Measure's specifications will describe the detailed methodology by which this performance score is calculated.

2. EOHHS will compare the Contractor's performance score on each Quality Measure to the Contractor's performance score on that same Quality Measure from the highest scoring previous Performance Year (excluding BP3 due to a state of emergency declared by the federal or state government).

3. EOHHS will calculate an Improvement Target for each Quality Measure using the following formula (unless otherwise communicated by EOHHS). The Improvement Target is based on at least a 20% improvement each year in the gap between Goal Benchmark and the Attainment Threshold of each ACO measure.

    a. Improvement Target formula = [(Goal Benchmark –Attainment Threshold) /5]

For example, for Measure A, if the Attainment Threshold is 50% and the Goal Benchmark is 60%, the Improvement Target is 2% [(60 – 50)/5)]

    b. For the purposes of calculating the Improvement Target, the result is rounded to the nearest tenth (i.e., one decimal point).

For example, for Measure B, if the Attainment Threshold is 80% and the Goal Benchmark is 90.2%, the Improvement Target is calculated to 2.04% [(90.2 – 80)/5)] which rounds to 2.0%.

c. Starting in PY2, the Contractor may earn up to five (5) improvement points per measure per year for increases in measure score which meet or exceed the improvement target.

For example, for Measure B, the Improvement Target is 2.0%. If Contractor performance in PY4 is 54.0% and if Contractor performance in PY5 is 60.0%, the Contractor improvement from PY4 to PY5 is 6.0% [(60.0-54.0)] and the Contractor is awarded 5 improvement points. No points above 5 are awarded for increases in excess of the improvement target.

d. For the purposes of calculating the difference in Contractor quality performance over a previous year, the results are rounded to the nearest tenth (i.e., one decimal point). Rounding takes place after the calculation.

For example, for Measure B, if Contractor performance in PY4 is 54.54% and if Contractor performance in PY5 is 60.17%, the Contractor improvement from PY4 to PY5 is 5.63% [(60.17-54.54)], and the Contractor improvement will be rounded to the nearest tenth (i.e., one decimal point) to 5.6%.

e. The Improvement Target is based on the ***higher*** of the original baseline (PY1) or any year's performance prior to the current PY. This is intended to avoid rewarding regression in performance.

For example, for Measure B, assume Contractor performance in PY1 is 90.0% and the Improvement Target is 2.0%. If in PY4 the performance for the Contractor decreases to 89.0%, in PY5 the Contractor would need to reach 92.0% to reach the Improvement Target.

f. There are several special circumstances:
   i. *At or Above Goal:* If the Contractor has prior PY performance scores equal to or greater than the Goal Benchmark then the Contractor may still earn up to five (5) improvement points in each PY if improvement from the highest prior PY (excluding PY3 due to a state of emergency declared by the federal or state government) is greater than or equal to the Improvement Target.

   ii. *At or Below Attainment:* If the Contractor has prior PY performance scores less than the Attainment Threshold then the Contractor may still earn up to five (5) improvement points each PY if improvement from the highest prior PY (excluding PY3 due to a state of emergency declared by the federal or state government) is greater than or equal to the Improvement Target, and performance in the current PY does not equal or exceed the Attainment Threshold. Additionally, if the Contractor has prior PY performance scores less than the Attainment Threshold and current PY performance scores equal to or above the Attainment Threshold then the Contractor may still earn up to five (5) improvement points if the improvement is greater than or equal to the Improvement Target.

EXHIBIT 4 – Example Calculation of Improvement Points for Measure B

Measure B Attainment = 48.9% | Goal = 59.4% | Improvement Target = 2.1%

	PY4 Score	PY5 Score	Improvement	Improvement Target Met	Improvement Points Earned
Scenario 1:	50.0%	52.1%	2.1%	Yes	5
Scenario 2:	50.0%	56.7%	6.7%	Yes	5
Scenario 3:	59.5%	63.0%	3.5%	Yes; above Goal Benchmark	5
Scenario 4	45.0%	48.0%	3.0%	Yes; below Attainment Threshold	5
Scenario 5:	46.0%	49.0%	3.0 %	Yes; crossing Attainment	5
Scenario 6:	45.0%	46.0%	1.0%	No	0

2.4 Domain Scoring Methodology for All Measures (Budget Periods 2, 4, and 5)

Domain-based scoring does not apply in PY 1, as only P4R results factor into Quality Score calculation. In PY2, PY4 and PY5, EOHHS will sum the Contractor's achievement and improvement points for all Quality Measures within each Quality Domain. Improvement points earned in one Quality Domain may only be summed with achievement points from the same Quality Domain. The total number of points earned by the Contractor in each domain cannot exceed the maximum number of achievement points available in the domain. The maximum number of achievement points in the domain is calculated by multiplying the number of Pay-for-Performance (P4P) measures in the domain, in the given PY, by the number of available achievement points per measure.

For example, if in PY4, there are ten (10) clinical quality measures in Domain X in Pay-for-Performance, and each measure is worth ten (10) achievement points, the maximum number of achievement points in Domain X would be 100. Assume that in PY5 there are now twelve (12) clinical quality measures in Domain X in Pay-for-Performance, and that each measure is worth ten (10) achievement points, the maximum number of achievement points in Domain X would be 120.

Cumulative Example:
Total number of measures in domain: 2
Maximum number of achievement points in the domain = 20
Measure Attainment = 48.9% | Goal = 59.4%
Improvement Target = [(Goal Benchmark –Attainment Level) /5] = [59.4-48.9]/5 = 2.1

For example, for Measure A, if Contractor performance in PY4 is 54.54% and if Contractor performance in PY5 is 58.17% the Contractor will earn 8.8 Achievement Points [10 * (58.17 – 48.9)/(59.4 – 48.9)]. The Contractor has improved from PY4 to PY5 by 3.63% [(58.17 - 54.54)] which will be rounded to the nearest tenth (e.g., one decimal point) to 3.6% which exceeds the Improvement Target of 2.1%. Thus the Contractor will earn five (5) improvement points. No points above 5 are awarded for increases in excess of the improvement target.

In this scenario the Contractor would earn 13.8 points.

If there is only one (1) additional measure in the Domain and the Contractor earned 9 total points for this measure; the total score for the Contractor would be 20.0 (out of 20) given that domain scores are capped at the maximum number of achievement points (20) in the domain.

Once the total number of points has been calculated, EOHHS will divide the resulting sum by the maximum number of achievement points that the Contractor is eligible for in the domain to produce the Contractor's Domain Score. Domain Scores are a value between zero (0) and one (1) expressed as a percentage (i.e., 0% to 100%). In PY4 and PY5, EOHHS will score the Contractor on each P4P Quality Measure unless the Contractor does not meet eligibility requirements for a specific measure (e.g., it does not meet the minimum denominator requirement). In cases like this, the measure is not factored into the denominator. Reporting measures do not factor into the Domain Score. Additionally, improvement points do not count towards the denominator; they are therefore "bonus" points. Domain Scores are each capped at a maximum value of 100%.

Exhibit 5 below shows an example calculation of an unweighted Domain Score for a Quality Domain.

EXHIBIT 5 – Example Calculations of Unweighted Domain Score

Example Calculations of Unweighted Domain Score		
Example 1	Domain only has two Quality Measures (Measure A and Measure B)	
	Therefore, maximum number of achievement points is 2x10 = 20 points	
	Measure A:	Achievement points: 1.5
		Improvement Points: 0
	Measure B:	Achievement points: 0
		Improvement Points: 5
	Total achievement points: 1.5 + 0 = 1.5 points	
	Total improvement points: 0 + 5 = 5 points	
	Sum of achievement and improvement points: 1.5 + 5 = 6.5 points	
	Unweighted domain score = 6.5/20 * 100 = 32.5%	
Example 2	Domain only has two Quality Measures (Measure A and Measure B)	
	Therefore, maximum number of achievement points is 2x10 = 20 points	
	Measure A:	Achievement points: 8
		Improvement Points: 5
	Measure B:	Achievement points: 9.3
		Improvement Points: 0
	Total achievement points: 8 + 9.3 = 17.3	
	Total improvement points: 5 points	
	Sum of achievement and improvement points: 17.3 + 5 = 22.3 points	
	However, total number of points cannot exceed maximum number of achievement points (20)	
	Therefore, total domain points = 20	

	Unweighted domain score = 20/20 * 100 = 100%

2.5 Quality Measure Scoring Methodology (Budget Period 3)

In order to address the impact of the state of emergency declared by the federal or state government on ACO quality performance, domain scores for budget period 3 (BP3) are calculated using the following methodology.

2.5.1 Achievement Points

For each measure in pay-for-performance status in BP3 the State will decide whether to set the individual ACOs' BP3 measure performance rates to 1) the higher of the ACOs' BP3 or budget period 2 (BP2) actual measure rates, or 2) the higher of the ACO's BP2 actual rates or the statewide median rates (i.e., measure level median performance among all ACOs) in BP2.

If the State determines BP3 measure performance rates by comparing the individual ACOs' BP2 actual rates to BP3 actual rates, then ACOs earn achievement points following the scoring approach set forth in Section 2.3.1. If the State determines BP3 measure performance rates by comparing individual ACOs' BP2 actual rates to the BP2 statewide median rates, then:

- For measures where an ACO demonstrates a higher BP2 rate than the BP2 statewide median, the ACO earns achievement points based on its own rate, following the scoring approach set forth in Section 2.3.1
- For measures where the statewide median demonstrates a higher rate than the ACO's own rate, the ACO earns achievement points based on the statewide median, following the scoring approach set forth in Section 2.3.1
- In order to prevent such cases where an ACO's measure performance rate would improve excessively through the use of the statewide median, the number of raw (i.e., percentage) points an ACO may earn when replacing an ACO actual measure rate with that of the statewide median rate is capped at 10 raw points

EXHIBIT 6 - BP3 Measure Rate Calculation with Raw Point Cap = 10.0

Measure	ACO BP2 Rate	BP2 Statewide Median	Performance Rate Used For BP3	Raw Point Cap
A	73.0%	74.0%	74.0%	No
B	73.0%	70.0%	73.0%	No
C	73.0%	80.0%	80.0%	No
D	73.0%	84.0%	83.0%*	Yes

*BP3 Performance Rate 'capped' at 83.0% (i.e., 73.0% + maximum allowance of 10.0 raw points, using BP2 state median)

Results from the 'Performance Rate Used for BP3' column are then compared to measure benchmarks for the calculation of Achievements Points, following the scoring approach described in Section 2.3.1

2.5.2 Improvement Points

If the State sets individual ACOs' BP3 measure performance rates to be the ACOs' actual BP3 measure rates, then the improvement point calculation process will follow the process used for budget period 2 (BP2), budget period 4 (BP4), and budget period 5 (BP5), as described above in Section 2.3.2. If the State sets individual ACOs' BP3 measure performance rates as either individual ACOs' BP2 rates or the BP2 statewide median rates (capped or uncapped), then improvement point calculation for BP3 is determined by the following methodology:

Step 1: ACO Improvement

a. For each applicable measure, ACO BP2 actual rates are compared to ACO BP1 actual rates
    i. For measures where an ACO demonstrates improvement (i.e., reaches the predetermined improvement targets), the ACO earns improvement points
    ii. For measures where an ACO fails to demonstrate improvement, then Step 2 is implemented

Step 2: Statewide Median Improvement

a. For each applicable measure (i.e., from Step 1.a.ii), the statewide median for BP1 is compared to the statewide median for BP2
    i. For measures where the State demonstrates improvement (i.e., reaches the predetermined improvement targets), the ACO earns improvement points

Note: The number of measures by which an ACO may use Step 2.a.i to earn improvement points is capped at a number to be determined by the State, thereby preventing an unintended inflation of ACO scores (see example in Exhibit 7)

    ii. For measures where the State fails to demonstrate improvement, the ACO does not earn improvement points

Note: For purposes of simplicity, this example assumes each measure has the same Improvement Target across measures A-G

Measure Improvement Target = 2.1

State Improvement Median = 2.1

Measure	ACO BP1 Actual Rate	ACO BP2 Actual Rate	ACO Improvement	Improvement Used	Improvement Points Received (Source)
A	50.0%	53.1%	3.1	ACO = 3.1	YES (Step 1)
B	40.0%	49.1%%	9.1	ACO = 9.1	YES (Step 1)
C	59.0%	58.0%	-1.0	State Med = 2.1	YES (Step 2) cap count 1/3
D	65.0%	65.0%	0.0	State Med = 2.1	YES (Step 2) cap count 2/3
E	20.0%	22.0%	2.0	State Med = 2.1	YES (Step 2) cap count 3/3
F	25.0%	26.0%	1.0	State Med = 2.1	NO cap reached*
G	20.0%	30.0%	10.0	ACO = 10.0	YES (Step 1)

*In this example, this ACO used the state median improvement (2.1) for measures C, D, E, thereby reaching the cap of using the state median 3 times. As such, this ACO may not utilize the state median for measure F.

EXHIBIT 7 - Example of Improvement Point Calculation with Cap = 3 Measures

Note: Use of the state median only 'counts' toward the cap in such measures where its usage results in the allocation of improvement points. In other words, in such cases where the state median is higher than ACO improvement, but does not reach the Improvement Target, then use of the state median does not count toward the cap.

2.6 Domain Scoring Methodology for Member Experience Quality Domains (Budget Periods 2 and 3)

In order to address the impact of the state of emergency declared by the federal or state government on ACO quality performance, member experience domain scores for BP2 and BP3 are calculated using the following methodology.

2.6.1 Achievement Points

For each composite in the Overall Care Delivery domain, the State will decide whether to set the individual ACOs' BP3 performance rates to 1) the higher of their BP1 or BP2 actual rates, or 2) the higher of their

BP2 or BP3 actual rates. Regardless of which comparison the State decides to use, the rate selected will be used not just for the BP3 performance rates, but also the BP2 performance rates, given that the timing of BP2 data collection (i.e., January through May of 2020) could lead to BP2 actual rates being variably impacted across ACOs as a result of the state of emergency declared by the federal or state government. Upon determination of the ACOs' BP2 and BP3 performance rates, achievements points will be determined following the process set forth in Section 2.3.1.

EXHIBIT 8 Example of Member Experience Calculation When Deciding Between BP1 and BP2 Actual Rates

Composite (Willingness to recommend - Adult)	ACO BP1 Actual Rate	ACO BP2 Actual Rate	Performance Rate Used for Scoring BP 2 and BP3
ACO A	85%	87.0 %	87.0%
ACO B	9%	87.0%	89.0%

2.6.2 Improvement Points

Improvement point calculation for BP2 and BP3 is determined by the following methodology:

Step 1: ACO Improvement

a. For each composite within a domain, compare ACO BP1 actual rates to BP2 performance rates
    i. For composites where an ACO demonstrates improvement (i.e., reaches the improvement target), the ACO earns improvement points
    ii. For composites where an ACO fails to demonstrate improvement, then Step 2 is implemented

Step 2: Statewide Improvement

a. If the State sets individual ACOs' BP2 and BP3 performance rates to be the higher of their actual BP1 or BP2 rates, then for each composite within a domain, compare BP1 statewide median rates to BP2 statewide median rates. If the State sets ACOs' BP2 and BP3 performance rates to be the higher of their BP2 or BP3 actual rates, then for each composite within a domain, compare BP1 statewide median rates to the higher of BP2 statewide median rates or BP3 statewide median rates.
    i. For composites where the State demonstrates improvement (i.e., reaches the improvement target), the ACO earns improvement points
    ii. For composites where the State fails to demonstrate targeted improvement, the ACO does not earn improvement points

Note: In order to prevent such cases where an ACO's performance would improve excessively through the use of the statewide median, the number of composites by which an ACO may use Step 2.a.i to earn improvement points is capped at one

EXHIBIT 9 - Example of Improvement Point Calculation with Cap = 1 Composite

Note: This example assumes each composite has the same Improvement Target across composites A-D, and that the State is comparing BP1 rates to BP2 rates.

Measure Improvement Target = 1.0

State Improvement Median = 1.0

Composite - Example	ACO BP1 Actual Rate	ACO BP2 Performance Rate	ACO Improvement	Improvement Used	Improvement Points Received (Source)
A – Willingness to Recommend (Adult Survey)	75.1%	75.9%	0.8 (target not met by ACO)	State Med = 1.0	YES (Step 2 applied)
B - Willingness to Recommend (Child Survey)	85.1%	87.0%	1.9 (target met by ACO)	ACO = 1.9	YES (Step 2 not needed)
C - Communications (Adult Survey)	89.5	88.7%	-0.8 (target not met by ACO)	State Med = 1.0	NO (Capped at 1: Composite A already received points)
D - Communications (Child Survey)	78.1%	78.5%	0.4 (target not met by ACO)	State Med = 0.8 (target not met by State)	NO

2.7 Methodology for Establishing Performance Benchmarks for Quality Measures

EOHHS will establish the attainment threshold and goal benchmark for each Quality Measure. EOHHS anticipates establishing these performance benchmarks as follows:

- For Quality Measures based on NCQA HEDIS measures, EOHHS anticipates using NCQA Quality Compass percentile benchmarks where possible

- For non-HEDIS claims-based Quality Measures, EOHHS anticipates using existing MassHealth data sources such as MassHealth historical claims or encounter data
- For non-HEDIS Clinical Quality Measures, or other Quality Measures where EOHHS does not have access to applicable data, EOHHS anticipates using MassHealth benchmarks based on the ACO-attributed population

2.8 Methodology to Calculate Quality Score

EOHHS will calculate the Contractor's Quality Score by multiplying the unweighted domain scores for each domain by the domain weights detailed in Exhibit 1, and then summing the resulting weighted domain scores together. The Contractor's Quality Score will be a number between zero (0) and one (1), inclusive.

3 Methodology to Calculate DSRIP Accountability Score

3.1 Overall Approach

The amount of at-risk DSRIP funds a Contractor earns will be determined by its DSRIP Accountability Score. The Contractor's DSRIP Accountability Score will be based on the ACO's TCOC achievement, as well as their quality performance on the same four (4) Quality Measure domains used for the Contractor's Quality Score. The Contractor's TCOC achievement will be calculated as described in Section 3.2 below; the Contractor's quality performance will be calculated as described in Section 3.3 below. The relative contributions of the Contractor's TCOC achievement and quality performance are detailed in Exhibit 10:

EXHIBIT 10 – ACO DSRIP Accountability Domains

DSRIP Accountability Domain	% Contribution to DSRIP Accountability Score		
	Performance Year (PY) 0	PY 1-2	PY 3-5
Total Cost of Care achievement	NA	NA	25%
Quality performance	NA	100%	75%

3.2 Total Cost of Care Performance

This domain reflects a Contractor's TCOC performance for its Enrollees, relative to the Medical Component of the Risk Adjusted Capitation Payment as described in Section 4 of the Contract. The Contractor's TCOC component of its DSRIP Accountability Score will be calculated in the following manner:

- If the Contractor has any Gain (and no Loss) after risk sharing on the Medical Component of the Risk Adjusted Capitation Payment, as described in Appendix D of the Contract, the Contractor's TCOC component of its DSRIP Accountability Score equals 100%
- If the Contractor's Loss after risk sharing on the Medical Component of the Risk Adjusted Capitation Payment exceeds 5% of the Medical Component of the Risk Adjusted Capitation

Payment, as described in Appendix D of the Contract, the Contractor's TCOC component of its DSRIP Accountability Score equals 0%

- If the Contractor's Loss after risk sharing on the Medical Component of the Risk Adjusted Capitation Payment is less than 5% of the Medical Component of the Risk Adjusted Capitation Payment, the Contractor's TCOC component of its DSRIP Accountability Score equals: one (1) minus (the Contractor's Loss) / (5% of the Medical Component of the Risk Adjusted Capitation Payment)

3.3 Quality Performance

The Contractor's quality component of the DSRIP Accountability Score will be the exact same number as the Contractor's Quality Score, as described in Section 2.

3.4 DSRIP Accountability Score

EOHHS will calculate the Contractor's DSRIP Accountability Score by multiplying the Contractor's TCOC component of its DSRIP Accountability Score (as calculated in Section 3.2 above) and the Contractor's quality component of its DSRIP Accountability Score (as described in Section 3.3 above) by the domain weights in Exhibit 10 above, and summing the resulting amounts together. The resulting number is the Contractor's DSRIP Accountability Score, which will be a number between zero (0) and one (1), inclusive.

Appendix T: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

APPENDIX T - Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Exhibit 1 -- Rate Floors 1/1/2022 - 6/30/22				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90791	UG - Doctoral Level (Child Psychiatrist)	Psychiatric Diagnostic Evaluation	$ 189.34
MH and SA OP Services	90791	U6 - Doctoral Level (MD / DO)	Psychiatric Diagnostic Evaluation	$ 151.95
MH and SA OP Services	90791	AH - Doctoral Level (PhD, PsyD, EdD)	Psychiatric Diagnostic Evaluation	$ 130.44
MH and SA OP Services	90791	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychiatric Diagnostic Evaluation	$ 131.51
MH and SA OP Services	90791	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Psychiatric Diagnostic Evaluation	$ 117.41
MH and SA OP Services	90791	U3 - Intern (PhD, PsyD, EdD) / or MAT	Psychiatric Diagnostic Evaluation	$ 65.22
MH and SA OP Services	90791	U4 - Intern (Master's)	Psychiatric Diagnostic Evaluation	$ 58.71
MH and SA OP Services	90791	HA-CANS; UG-Doctoral Level (Child Psychiatrist)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 204.34
MH and SA OP Services	90791	HA-CANS; U6-Doctoral Level (MD / DO)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 166.95
MH and SA OP Services	90791	HA-CANS; AH-Doctoral Level (PhD, PsyD, EdD)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 145.44
MH and SA OP Services	90791	HA-CANS; SA, UF -Nurse Practitioner/Board Certified RNCS and APRN-BC	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 146.51
MH and SA OP Services	90791	HA-CANS; HO-Master's Level	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 132.41
MH and SA OP Services	90791	HA-CANS; U3-Intern (PhD, PsyD, EdD)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 80.22
MH and SA OP Services	90791	HA-CANS; U4-Intern (Master's)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 73.71
MH and SA OP Services	90792	UG - Doctoral Level (Child Psychiatrist)	Psychiatric Diagnostic Evaluation with Medical Services	$ 119.82
MH and SA OP Services	90792	U6-Doctoral Level (MD / DO)	Psychiatric Diagnostic Evaluation with Medical Services	$ 103.92
MH and SA OP Services	90792	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychiatric Diagnostic Evaluation with Medical Services	$ 95.06
MH and SA OP Services	90832	UG-Doctoral Level (Child Psychiatrist)	Individual Psychotherapy, approximately 20-30 minutes	$ 52.60
MH and SA OP Services	90832	U6-Doctoral Level (MD / DO)	Individual Psychotherapy, approximately 20-30 minutes	$ 45.54
MH and SA OP Services	90832	AH-Doctoral Level (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 20-30 minutes	$ 44.22

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90832	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Individual Psychotherapy, approximately 20-30 minutes	$ 42.96
MH and SA OP Services	90832	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Individual Psychotherapy, approximately 20-30 minutes	$ 42.96
MH and SA OP Services	90832	U7-Certified Addiction Counselor / Certified Alcohol & Drug Abuse Counselor	Individual Psychotherapy, approximately 20-30 minutes	$ 29.94
MH and SA OP Services	90832	U3-Intern (PhD, PsyD, EdD) / or MAT	Individual Psychotherapy, approximately 20-30 minutes	$ 22.11
MH and SA OP Services	90832	U4-Intern (Master's)	Individual Psychotherapy, approximately 20-30 minutes	$ 21.44
MH and SA OP Services	90833	U6-Doctoral Level (MD / DO)	Add-On Code; Psychotherapy, 30 minutes, when Performed with an Evaluation and Management Service	$ 31.77
MH and SA OP Services	90833	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Add-On Code; Psychotherapy, 30 minutes, when Performed with an Evaluation and Management Service	$ 31.77
MH and SA OP Services	90834	UG-Doctoral Level (Child Psychiatrist)	Individual Psychotherapy, approximately 45 minutes	$ 105.18
MH and SA OP Services	90834	U6-Doctoral Level (MD / DO)	Individual Psychotherapy, approximately 45 minutes	$ 92.42
MH and SA OP Services	90834	AH-Doctoral Level (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 45 minutes	$ 87.17
MH and SA OP Services	90834	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Individual Psychotherapy, approximately 45 minutes	$ 85.91
MH and SA OP Services	90834	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Individual Psychotherapy, approximately 45 minutes	$ 85.91
MH and SA OP Services	90834	U3-Intern (PhD, PsyD, EdD) / or MAT	Individual Psychotherapy, approximately 45 minutes	$ 43.62
MH and SA OP Services	90834	U4-Intern (Master's)	Individual Psychotherapy, approximately 45 minutes	$ 42.96
MH and SA OP Services	90836	U6-Doctoral Level (MD / DO)	Add-On Code; Psychotherapy, 45 minutes, when Performed with an Evaluation and Management Service	$ 51.58
MH and SA OP Services	90836	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Add-On Code; Psychotherapy, 45 minutes, when Performed with an Evaluation and Management Service	$ 51.58
MH and SA OP Services	90837	UG-Doctoral Level (Child Psychiatrist)	Psychotherapy, 60 minutes	$ 105.18

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90837	U6-Doctoral Level (MD / DO)	Psychotherapy, 60 minutes	$ 92.42
MH and SA OP Services	90837	AH-Doctoral Level (PhD, PsyD, EdD)	Psychotherapy, 60 minutes	$115.94
MH and SA OP Services	90837	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 60 minutes	$114.26
MH and SA OP Services	90837	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Psychotherapy, 60 minutes	$114.26
MH and SA OP Services	90837	U3-Intern (PhD, PsyD, EdD) / or MAT	Psychotherapy, 60 minutes	$ 43.62
MH and SA OP Services	90837	U4-Intern (Master's)	Psychotherapy, 60 minutes	$ 42.96
MH and SA OP Services	90838	U6-Doctoral Level (MD / DO)	Add-On Code; Psychotherapy, 60 minutes, when Performed with an Evaluation and Management Service	$ 83.11
MH and SA OP Services	90838	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Add-On Code; Psychotherapy, 60 minutes, when Performed with an Evaluation and Management Service	$ 83.11
MH and SA OP Services	90846	UG-Doctor Level (Child Psychiatrist)	Family Psychotherapy (without patient present)	$ 128.56
MH and SA OP Services	90846	U6-Doctor Level (MD/DO)	Family Psychotherapy (without patient present)	$ 97.84
MH and SA OP Services	90846	AH-Doctoral Level (PhD, PsyD, EdD)	Family Psychotherapy (without patient present)	$ 91.34
MH and SA OP Services	90846	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Family Psychotherapy (without patient present)	$ 88.68
MH and SA OP Services	90846	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Family Psychotherapy (without patient present)	$ 88.68
MH and SA OP Services	90846	U3-Intern (PhD, PsyD, EdD) / or MAT	Family Psychotherapy (without patient present)	$ 45.66
MH and SA OP Services	90846	U4-Intern (Master's)	Family Psychotherapy (without patient present)	$ 44.34
MH and SA OP Services	90847	UG-Doctoral Level (Child Psychiatrist)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 128.56
MH and SA OP Services	90847	U6-Doctoral Level (MD / DO)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 97.84

Appendix T: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

APPENDIX T - Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Exhibit 1 -- Rate Floors 1/1/2022 - 6/30/22				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90847	AH-Doctoral Level (PhD, PsyD, EdD)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 91.34
MH and SA OP Services	90847	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 88.68
MH and SA OP Services	90847	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 88.68
MH and SA OP Services	90847	U3-Intern (PhD, PsyD, EdD) / or MAT	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 45.66
MH and SA OP Services	90847	U4-Intern (Master's)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 44.34
MH and SA OP Services	90849	UG-Doctor Level (Child Psychiatrist)	Multi-family group psychotherapy	$ 42.08
MH and SA OP Services	90849	U6-Doctor Level (MD/DO)	Multi-family group psychotherapy	$ 35.31
MH and SA OP Services	90849	AH-Doctoral Level (PhD, PsyD, EdD)	Multi-family group psychotherapy	$ 32.60
MH and SA OP Services	90849	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Multi-family group psychotherapy	$ 30.00
MH and SA OP Services	90849	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Multi-family group psychotherapy	$ 22.17
MH and SA OP Services	90849	U3-Intern (PhD, PsyD, EdD) / or MAT	Multi-family group psychotherapy	$ 16.33
MH and SA OP Services	90849	U4-Intern (Master's)	Multi-family group psychotherapy	$ 15.00
MH and SA OP Services	90853	UG-Doctoral Level (Child Psychiatrist)	Group psychotherapy (other than of a multiple-family group)	$ 42.08
MH and SA OP Services	90853	U6-Doctoral Level (MD / DO)	Group psychotherapy (other than of a multiple-family group)	$ 35.31
MH and SA OP Services	90853	AH-Doctoral Level (PhD, PsyD, EdD)	Group psychotherapy (other than of a multiple-family group)	$ 32.60
MH and SA OP Services	90853	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Group psychotherapy (other than of a multiple-family group)	$ 30.00
MH and SA OP Services	90853	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Group psychotherapy (other than of a multiple-family group)	$ 30.00

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90853	U3-Intern (PhD, PsyD, EdD) / or MAT	Group psychotherapy (other than of a multiple-family group)	$ 16.33
MH and SA OP Services	90853	U4-Intern (Master's)	Group psychotherapy (other than of a multiple-family group)	$ 15.00
MH and SA OP Services	90882	UG-Doctoral Level (Child Psychiatrist)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 46.46
MH and SA OP Services	90882	U6-Doctoral Level (MD / DO)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 40.30
MH and SA OP Services	90882	AH-Doctoral Level (PhD, PsyD, EdD)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 21.79
MH and SA OP Services	90882	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 34.87
MH and SA OP Services	90882	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 21.48
MH and SA OP Services	90882	U3-Intern (PhD, PsyD, EdD) / or MAT	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 10.91
MH and SA OP Services	90882	U4-Intern (Master's)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 10.74
MH and SA OP Services	90887	UG-Doctoral Level (Child Psychiatrist)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 46.46
MH and SA OP Services	90887	U6-Doctoral Level (MD / DO)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 40.30
MH and SA OP Services	90887	AH-Doctoral Level (PhD, PsyD, EdD)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 21.79
MH and SA OP Services	90887	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 34.87

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90887	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 21.48
MH and SA OP Services	90887	U3-Intern (PhD, PsyD, EdD) / or MAT	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 10.91
MH and SA OP Services	90887	U4-Intern (Master's)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 10.74
MH and SA OP Services	96372	U6 - Doctoral Level (MD / DO)	Therapeutic, Prophylactic or Diagnostic Injection; subcutaneous or intramuscular	$ 28.41
MH and SA OP Services	96372	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Therapeutic, Prophylactic or Diagnostic Injection; subcutaneous or intramuscular	$ 21.11
MH and SA OP Services	97810	*N/A*	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-to-one contact	$ 19.84
MH and SA OP Services	97811	*N/A*	Add-On Code; Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-to-one contact with re-insertion of needle(s).	$ 19.84
MH and SA OP Services	99202	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 15-29 minutes	$ 68.41
MH and SA OP Services	99202	U6-Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 15-29 minutes	$ 59.33
MH and SA OP Services	99202	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 15-29 minutes	$ 55.25
MH and SA OP Services	99203	UG- Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 30-44 minutes	$ 98.68
MH and SA OP Services	99203	U6-Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 30-44 minutes	$ 85.58
MH and SA OP Services	99203	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 30-44 minutes	$ 79.46
MH and SA OP Services	99204	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 45-59 minutes	$ 149.09
MH and SA OP Services	99204	U6-Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 45-59 minutes	$ 129.30
MH and SA OP Services	99204	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 45-59 minutes	$ 121.14
MH and SA OP Services	99205	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 60-74 minutes	$ 185.17

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99205	U6-Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 60-74 minutes	$ 160.59
MH and SA OP Services	99205	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 60-74 minutes	$ 150.39
MH and SA OP Services	99211	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 5 minutes	$ 19.88
MH and SA OP Services	99211	U6-Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 5 minutes	$ 17.24
MH and SA OP Services	99211	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 5 minutes	$ 15.71
MH and SA OP Services	99212	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 10-19 minutes	$ 40.99
MH and SA OP Services	99212	U6-Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 10-19 minutes	$ 35.55
MH and SA OP Services	99212	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 10-19 minutes	$ 32.49
MH and SA OP Services	99213	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 20-29 minutes	$ 73.98
MH and SA OP Services	99213	U6-Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 20-29 minutes	$ 63.15
MH and SA OP Services	99213	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 20-29 minutes	$ 54.84
MH and SA OP Services	99214	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 30-39 minutes	$ 130.89
MH and SA OP Services	99214	U6-Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 30-39 minutes	$ 86.37
MH and SA OP Services	99214	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 30-39 minutes	$ 77.46
MH and SA OP Services	99215	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 40-54 minutes	$ 130.89
MH and SA OP Services	99215	U6-Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 40-54 minutes	$ 113.52
MH and SA OP Services	99215	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 40-54 minutes	$ 103.84
MH and SA OP Services	99231	UG-Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 70.97
MH and SA OP Services	99231	U6-Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 53.88
MH and SA OP Services	99231	AH-Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 51.72
MH and SA OP Services	99231	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 43.15
MH and SA OP Services	99232	UG-Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 106.46
MH and SA OP Services	99232	U6-Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 80.17
MH and SA OP Services	99232	AH-Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 76.96

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99232	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 64.21
MH and SA OP Services	99233	UG-Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 141.96
MH and SA OP Services	99233	U6-Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 106.90
MH and SA OP Services	99233	AH-Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 102.62
MH and SA OP Services	99233	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 85.62
MH and SA OP Services	99251	UG-Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 20 minutes	$ 95.22
MH and SA OP Services	99251	U6-Doctoral Level (MD / DO)	Initial Inpatient Consultation, 20 minutes	$ 72.27
MH and SA OP Services	99251	AH-Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 20 minutes	$ 69.38
MH and SA OP Services	99251	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 40 minutes	$ 57.88
MH and SA OP Services	99252	UG-Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 40 minutes	$ 142.83
MH and SA OP Services	99252	U6-Doctoral Level (MD / DO)	Initial Inpatient Consultation, 40 minutes	$ 107.56
MH and SA OP Services	99252	AH-Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 40 minutes	$ 103.25
MH and SA OP Services	99252	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 40 minutes	$ 86.15
UG-MH and SA OP Services	99253	UG-Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 55 minutes	$ 190.43
MH and SA OP Services	99253	U6-Doctoral Level (MD / DO)	Initial Inpatient Consultation, 55 minutes	$ 143.40
MH and SA OP Services	99253	AH-Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 55 minutes	$ 137.67
MH and SA OP Services	99253	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 55 minutes	$ 114.86
MH and SA OP Services	99254	UG-Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 80 minutes	$ 255.41
MH and SA OP Services	99254	U6-Doctoral Level (MD / DO)	Initial Inpatient Consultation, 80 minutes	$ 191.80
MH and SA OP Services	99254	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 80 minutes	$ 153.64
MH and SA OP Services	99255	UG-Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation - Comprehensive, 110 minutes	$ 336.47
MH and SA OP Services	99255	U6-Doctoral Level (MD / DO)	Initial Inpatient Consultation - Comprehensive, 110 minutes	$ 252.34
MH and SA OP Services	99255	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation - Comprehensive, 110 minutes	$ 202.12

Appendix T: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

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Unique Code/Modifier Combinations				
Exhibit 1 -- Rate Floors 1/1/2022 - 6/30/22				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99281	U6-Doctoral Level (MD/DO)	Emergency Department visit for the evaluation and management of a patient, which requires 3 key components: A problem-focused history; A problem-focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.	$ 18.31
MH and SA OP Services	99282	UG-Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem-focused history; An expanded problem-focused examination; and Medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	$ 32.15
MH and SA OP Services	99282	U6-Doctoral Level (MD/DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	$ 30.62
MH and SA OP Services	99282	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	$ 29.73
MH and SA OP Services	99283	UG-Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	$ 48.65

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99283	U6-Doctoral Level (MD/DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	$ 46.34
MH and SA OP Services	99283	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	$ 44.99
MH and SA OP Services	99284	UG-Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	$ 91.44
MH and SA OP Services	99284	U6-Doctoral Level (MD/DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	$ 87.09

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99284	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	$ 84.55
MH and SA OP Services	99285	UG-Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$ 135.25
MH and SA OP Services	99285	U6-Doctoral Level (MD/DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$ 128.81
MH and SA OP Services	99285	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$ 123.91
MH and SA OP Services	99402	AH-Doctoral Level (PhD, PsyD, EdD)	Preventative Medicine Counseling , 30 minutes (Psychological Testing)	$ 40.98
MH and SA OP Services	99402	U3-Intern (PhD, PsyD, EdD) / or MAT	Preventative Medicine Counseling, 30 minutes (Psychological Testing)	$ 20.50

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99404	U6-Doctoral Level (MD / DO)	Preventative Medicine Counseling, 60 minutes (Counseling and/or Risk Factor Reduction Intervention)	$ 177.11
MH and SA OP Services	99404	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Preventative Medicine Counseling, 60 minutes (Counseling and/or Risk Factor Reduction Intervention)	$ 153.27
MH and SA OP Services	99417	U6-Doctoral Level (MD / DO)	Add-On Code; Prolonged office or other outpatient evaluation and management service, requiring total time with or without direct patient contact beyond usual service, on the date of the primary service (e.g., 99205 or 99215), each 15 minutes	$ 26.08
MH and SA OP Services	99417	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Add-On Code; Prolonged office or other outpatient evaluation and management service, requiring total time with or without direct patient contact beyond usual service, on the date of the primary service (e.g., 99205 or 99215), each 15 minutes	$ 26.08
Diversionary Services	H0015	*N/A*	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan) including assessment, counseling; crisis intervention, and activity therapies or education. (Enhanced Structured Outpatient Addiction Program - SOAP with Motivational Interviewing Counseling)	$ 80.30
Diversionary Services	H0015	*N/A*	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan) including assessment, counseling; crisis intervention, and activity therapies or education. (Structured Outpatient Addiction Program - SOAP with Motivational Interviewing)	$ 71.59
Diversionary Services	H0037	*N/A*	Community Psychiatric Supportive Treatment Program, per diem (Community Based Acute Treatment - CBAT)	$ 654.13
Diversionary Services	H0038	HF-Substance Abuse Program	Recovery Coaching – A non-clinical service provided (in 15 minutes increments) by a trained recovery advocate who provides guidance and coaching for individuals to meet their recovery goals	101 CMR 346
Diversionary Services	H2012	*N/A*	Behavioral Health Day Treatment, per hour (Psychiatric Day Treatment)	101 CMR 307.00
Diversionary Services	H2012	*N/A*	Behavioral Health Day Treatment, per hour (Enhanced Psychiatric Day Treatment)	101 CMR 307.00
Diversionary Services	H2015	*N/A*	Comprehensive community support services, per 15 minutes (Community Support Program)	$ 13.97
Diversionary Services	H2015	HF-Substance Abuse Program	Recovery Support Navigator – Self-help/peer service by a recovery advocate trained in Recovery Coaching. Rate is in 15-minutes increments.	101 CMR 444.00

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APPENDIX T - Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Exhibit 1 -- Rate Floors 1/1/2022 - 6/30/22				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Diversionary Services	H2016	HE-Mental Health Program	When directed by EOHHS, Comprehensive community support services, per diem (Community Support Program (CSP) for members residing in DHCD-funded new temporary shelters)	$ 17.30
Diversionary Services	H2016	HH-Integrated Mental Health/Substance Abuse Program	Effective on the later of October 1, 2021 or the date on which CMS approves these services, comprehensive community support program, per diem (Enrolled Client Day) (behavioral health service by a navigator trained to support members with justice	$17.23
Diversionary Services	H2016	HM-Less than bachelor degree level	Comprehensive community support program, per diem (Enrolled Client Day) (recovery support service by a recovery advocate trained in Recovery Coaching)	101 CMR 346.00
Diversionary Services	H2020	*N/A*	Therapeutic behavioral services, per diem (Dialectical Behavior Therapy)	$ 26.50
Diversionary Services	H2022	HE-Mental Health Program	Intensive Hospital Diversion Services for Children, per diem	$ 175.19
Diversionary Services	S9484	*N/A*	Crisis intervention mental health services, per hour (Urgent Outpatient Services)	$ 147.57
MH and SA OP Services	H0014	*N/A*	Alcohol and/or drug services; ambulatory detoxification (Adult or Adolescent)	$ 227.65
MH and SA OP Services	H0020	*N/A*	Alcohol and/or drug services; methadone administration and/or service (Dosing)	$ 11.43
MH and SA OP Services	H0020/T1006	*N/A*	Alcohol and/or drug services; methadone administration and/or service (Family/couple counseling); 1 unit = 60 minutes	$ 84.79
MH and SA OP Services	H0020/H0005	*N/A*	Alcohol and/or drug services; methadone administration and/or service (Group counseling); 1 unit = 60 to 90 minutes	$ 28.68
MH and SA OP Services	H0020	*N/A*	Alcohol and/or drug services; methadone administration and/or service (Individual counseling); 1 unit = 30 minutes	$ 41.16
MH and SA OP Services	H0004	*N/A*	Alcohol and/or drug services; methadone administration and/or service (Individual counseling); 1 unit = 15 minutes	$ 20.58
Adult ESP Services	S9485	U1-ESP - Mobile Non-Emergency Department / or MAT	Crisis intervention mental health services, per diem (Emergency Service Program Mobile Non-Emergency Department)	$ 819.64
Adult ESP Services	S9485	U1-ESP - Mobile Non-Emergency Department / or MAT	Crisis intervention mental health service, per diem (Emergency Service Program Mobile Non-Emergency Department - Uninsured)	$ 505.85
Adult ESP Services	S9485	HE-Mental Health Program	Crisis intervention mental health services, per diem (Emergency Service Program Community Based)	$ 744.23
Adult ESP Services	S9485	HE-Mental Health Program	Crisis intervention mental health services, per diem (Emergency Service Program Community Based - Uninsured)	$ 505.85
Adult ESP Services	S9485	HB-Adult Program, non-geriatric	Crisis intervention mental health services, per diem (Emergency Service Program Hospital Emergency Room)	$ 505.85

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Adult ESP Services	S9485	ET-Emergency Services	Crisis intervention mental health services, per diem (Emergency Service Program's Adult Community Crisis Stabilization Day 1)	$ 505.53
Adult ESP Services	S9485	TF-Intermediate level of care	Crisis intervention mental health services, per diem (Emergency Service Program's Adult Community Crisis Stabilization Day 2-5)	$ 505.53
Adult ESP Services	S9485	TG-Complex level of care	Crisis intervention mental health services, per diem (Emergency Service Program's Adult Community Crisis Stabilization Day 6 and After)	$ 505.53
Other Outpatient	90870	*N/A*	Electroconvulsive therapy (includes necessary monitoring)	$ 630.95
Other Outpatient	96112	AH-Doctoral Level (PhD, PsyD, EdD)	Developmental Testing administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour (Learning Disorders)	$ 180.72
Other Outpatient	96113	AH-Doctoral Level (PhD, PsyD, EdD)	Add-On Code; Each additional 30 minutes (List separately in addition to code for primary procedure) (Developmental/Behavioral Screening and Testing)	$ 90.36
Other Outpatient	96116	AH-Doctoral Level (PhD, PsyD, EdD)	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician o rother qualified health professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour	$ 120.46
Other Outpatient	96121	AH-Doctoral Level (PhD, PsyD, EdD)	Add-On Code; Each additional hour (List separately in addition to code for primary procedure)	$ 120.46
Other Outpatient	96130	AH-Doctoral Level (PhD, PsyD, EdD)	Psychological testing evaluation services by physician or other qualified health care professional, including integrating of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	$ 91.39
Other Outpatient	96131	AH-Doctoral Level (PhD, PsyD, EdD)	Add-On Code; Each additional hour (List separately in addition to code for primary procedure)	$ 91.39
Other Outpatient	96132	AH-Doctoral Level (PhD, PsyD, EdD)	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	$ 91.39

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Other Outpatient	96133	AH-Doctoral Level (PhD, PsyD, EdD)	Add-On Code; Each additional hour (List separately in addition to code for primary procedure)	$ 91.39
Other Outpatient	96136	AH-Doctoral Level (PhD, PsyD, EdD)	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes (Test administration and scoring by professional)	$ 45.70
Other Outpatient	96137	Doctoral Level (PhD, PsyD, EdD)	Add-On Code; Each additional 30 minutes (List separately in addition to code for primary procedure) (Test administration and scoring by professional)	$ 45.70
Other Outpatient	96138	*N/A*	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	$ 22.85
Other Outpatient	96139	*N/A*	Add-On Code; Each additional 30 minutes (List separately in addition to code for primary procedure) (Test administration and scoring by technician)	$ 22.85
Other Outpatient	H0032	HO-HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Mental health service plan development by a nonphysician (Bridge consultation inpatient/outpatient)	$ 166.67
Other Outpatient	H0046	UG-Doctoral Level (Child Psychiatrist)	Mental health services, not otherwise specified (Collateral Contact)	$ 46.46
Other Outpatient	H0046	U6-Doctoral Level (MD/DO)	Mental health services, not otherwise specified (Collateral Contact)	$ 40.30
Other Outpatient	H0046	AH-Doctoral Level (PhD, PsyD, EdD)	Mental health services, not otherwise specified (Collateral Contact)	$ 21.79
Other Outpatient	H0046	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Mental health services, not otherwise specified (Collateral Contact)	$ 34.87
Other Outpatient	H0046	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Mental health services, not otherwise specified (Collateral Contact)	$ 21.48
Other Outpatient	H0046	U7-Certified Addiction Counselor / Certified Alcohol & Drug Abuse Counselor	Mental health services, not otherwise specified (Collateral Contact)	$ 21.48
Other Outpatient	H0046	U3-Intern (PhD, PsyD, EdD) / or MAT	Mental health services, not otherwise specified (Collateral Contact)	$ 10.91
Other Outpatient	H0046	U4-Intern (Master's)	Mental health services, not otherwise specified (Collateral Contact)	$ 10.74
Other Outpatient	H2028	*N/A*	Sexual offender treatment service, per 15 minutes (ASAP - Assessment for Safe and Appropriate Placement)	$ 22.79

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	H0001	U1-ESP - Mobile Non-Emergency Department / or MAT	MAT - Alcohol and/or drug assessment (buprenorphine and naltrexone medication evaluation by physician and/or midlevel practitioner)	$ 146.93
MH and SA OP Services	H0033	*N/A*	MAT-Oral medication administration, with extended direct observation up to 2.5 hours (buprenorphine and associated drug screens, to be billed once during induction); may not be combined with H0033-U2	$ 38.54
MH and SA OP Services	H0033	U3-Intern (PhD, PsyD, EdD) / or MAT	MAT-Oral medication administration, direct observation (oral naltrexone dosing)	$ 9.45
MH and SA OP Services	H0047	*N/A*	MAT-Alcohol and/or other drug abuse services, not otherwise specified; oral medication preparation and administration (buprenorphine and associated drug screens); may not be combined with H0033; may be billed once per each day a member receives medication	$ 10.36
MH and SA OP Services	J0571	N/A	MAT-Buprenorphine, oral, 1 mg (maximum 32 mg per day) (prior authorization required)	$ 0.80
MH and SA OP Services	J0572	N/A	MAT-Buprenorphine/naloxone, oral, less than or equal to 3 mg (maximum of one unit per day; may be combined with J0573 as medically necessary)	$ 4.34
MH and SA OP Services	J0573		MAT-Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg; (may be billed in sufficient increments to achieve appropriate dose, may be combined with one unit of J0572 as medically necessary)	$ 7.76
MH and SA OP Services	J2315		MAT-Injection, naltrexone, depot form, 1 mg (maximum of 380 mg. per month)	$ 2.83
MH and SA OP Services	J3490		MAT-Unclassified drugs (Naltrexone, oral)	$ 1.20

Appendix T: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

APPENDIX T - Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Exhibit 2 -- Rate Floors 7/1/2022 - 12/31/22				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90791	UG - Doctoral Level (Child Psychiatrist)	Psychiatric Diagnostic Evaluation	$ 189.34
MH and SA OP Services	90791	U6 - Doctoral Level (MD / DO)	Psychiatric Diagnostic Evaluation	$ 151.95
MH and SA OP Services	90791	AH - Doctoral Level (PhD, PsyD, EdD)	Psychiatric Diagnostic Evaluation	$ 130.44
MH and SA OP Services	90791	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychiatric Diagnostic Evaluation	$ 131.51
MH and SA OP Services	90791	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Psychiatric Diagnostic Evaluation	$ 117.41
MH and SA OP Services	90791	U3 - Intern (PhD, PsyD, EdD) / or MAT	Psychiatric Diagnostic Evaluation	$ 65.22
MH and SA OP Services	90791	U4 - Intern (Master's)	Psychiatric Diagnostic Evaluation	$ 58.71
MH and SA OP Services	90791	HA-CANS; UG-Doctoral Level (Child Psychiatrist)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 204.34
MH and SA OP Services	90791	HA-CANS; U6-Doctoral Level (MD / DO)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 166.95
MH and SA OP Services	90791	HA-CANS; AH-Doctoral Level (PhD, PsyD, EdD)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 145.44
MH and SA OP Services	90791	HA-CANS; SA, UF -Nurse Practitioner/Board Certified RNCS and APRN-BC	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 146.51
MH and SA OP Services	90791	HA-CANS; HO-Master's Level	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 132.41
MH and SA OP Services	90791	HA-CANS; U3-Intern (PhD, PsyD, EdD)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 80.22
MH and SA OP Services	90791	HA-CANS; U4-Intern (Master's)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 73.71
MH and SA OP Services	90792	UG - Doctoral Level (Child Psychiatrist)	Psychiatric Diagnostic Evaluation with Medical Services	$ 119.82
MH and SA OP Services	90792	U6-Doctoral Level (MD / DO)	Psychiatric Diagnostic Evaluation with Medical Services	$ 103.92
MH and SA OP Services	90792	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychiatric Diagnostic Evaluation with Medical Services	$ 95.06
MH and SA OP Services	90832	UG-Doctoral Level (Child Psychiatrist)	Individual Psychotherapy, approximately 20-30 minutes	$ 52.60
MH and SA OP Services	90832	U6-Doctoral Level (MD / DO)	Individual Psychotherapy, approximately 20-30 minutes	$ 45.54
MH and SA OP Services	90832	AH-Doctoral Level (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 20-30 minutes	$ 44.22

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90832	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Individual Psychotherapy, approximately 20-30 minutes	$ 42.96
MH and SA OP Services	90832	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Individual Psychotherapy, approximately 20-30 minutes	$ 42.96
MH and SA OP Services	90832	U7-Certified Addiction Counselor / Certified Alcohol & Drug Abuse Counselor	Individual Psychotherapy, approximately 20-30 minutes	$ 29.94
MH and SA OP Services	90832	U3-Intern (PhD, PsyD, EdD) / or MAT	Individual Psychotherapy, approximately 20-30 minutes	$ 22.11
MH and SA OP Services	90832	U4-Intern (Master's)	Individual Psychotherapy, approximately 20-30 minutes	$ 21.44
MH and SA OP Services	90833	U6-Doctoral Level (MD / DO)	Add-On Code; Psychotherapy, 30 minutes, when Performed with an Evaluation and Management Service	$ 31.77
MH and SA OP Services	90833	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Add-On Code; Psychotherapy, 30 minutes, when Performed with an Evaluation and Management Service	$ 31.77
MH and SA OP Services	90834	UG-Doctoral Level (Child Psychiatrist)	Individual Psychotherapy, approximately 45 minutes	$ 105.18
MH and SA OP Services	90834	U6-Doctoral Level (MD / DO)	Individual Psychotherapy, approximately 45 minutes	$ 92.42
MH and SA OP Services	90834	AH-Doctoral Level (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 45 minutes	$ 87.17
MH and SA OP Services	90834	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Individual Psychotherapy, approximately 45 minutes	$ 85.91
MH and SA OP Services	90834	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Individual Psychotherapy, approximately 45 minutes	$ 85.91
MH and SA OP Services	90834	U3-Intern (PhD, PsyD, EdD) / or MAT	Individual Psychotherapy, approximately 45 minutes	$ 43.62
MH and SA OP Services	90834	U4-Intern (Master's)	Individual Psychotherapy, approximately 45 minutes	$ 42.96
MH and SA OP Services	90836	U6-Doctoral Level (MD / DO)	Add-On Code; Psychotherapy, 45 minutes, when Performed with an Evaluation and Management Service	$ 51.58
MH and SA OP Services	90836	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Add-On Code; Psychotherapy, 45 minutes, when Performed with an Evaluation and Management Service	$ 51.58
MH and SA OP Services	90837	UG-Doctoral Level (Child Psychiatrist)	Psychotherapy, 60 minutes	$ 105.18

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90837	U6-Doctoral Level (MD / DO)	Psychotherapy, 60 minutes	$ 92.42
MH and SA OP Services	90837	AH-Doctoral Level (PhD, PsyD, EdD)	Psychotherapy, 60 minutes	$115.94
MH and SA OP Services	90837	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 60 minutes	$114.26
MH and SA OP Services	90837	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Psychotherapy, 60 minutes	$114.26
MH and SA OP Services	90837	U3-Intern (PhD, PsyD, EdD) / or MAT	Psychotherapy, 60 minutes	$ 43.62
MH and SA OP Services	90837	U4-Intern (Master's)	Psychotherapy, 60 minutes	$ 42.96
MH and SA OP Services	90838	U6-Doctoral Level (MD / DO)	Add-On Code; Psychotherapy, 60 minutes, when Performed with an Evaluation and Management Service	$ 83.11
MH and SA OP Services	90838	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Add-On Code; Psychotherapy, 60 minutes, when Performed with an Evaluation and Management Service	$ 83.11
MH and SA OP Services	90846	UG-Doctor Level (Child Psychiatrist)	Family Psychotherapy (without patient present)	$ 128.56
MH and SA OP Services	90846	U6-Doctor Level (MD/DO)	Family Psychotherapy (without patient present)	$ 97.84
MH and SA OP Services	90846	AH-Doctoral Level (PhD, PsyD, EdD)	Family Psychotherapy (without patient present)	$ 91.34
MH and SA OP Services	90846	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Family Psychotherapy (without patient present)	$ 88.68
MH and SA OP Services	90846	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Family Psychotherapy (without patient present)	$ 88.68
MH and SA OP Services	90846	U3-Intern (PhD, PsyD, EdD) / or MAT	Family Psychotherapy (without patient present)	$ 45.66
MH and SA OP Services	90846	U4-Intern (Master's)	Family Psychotherapy (without patient present)	$ 44.34
MH and SA OP Services	90847	UG-Doctoral Level (Child Psychiatrist)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 128.56
MH and SA OP Services	90847	U6-Doctoral Level (MD / DO)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 97.84

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90847	AH-Doctoral Level (PhD, PsyD, EdD)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 91.34
MH and SA OP Services	90847	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 88.68
MH and SA OP Services	90847	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 88.68
MH and SA OP Services	90847	U3-Intern (PhD, PsyD, EdD) / or MAT	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 45.66
MH and SA OP Services	90847	U4-Intern (Master's)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 44.34
MH and SA OP Services	90849	UG-Doctor Level (Child Psychiatrist)	Multi-family group psychotherapy	42.08
MH and SA OP Services	90849	U6-Doctor Level (MD/DO)	Multi-family group psychotherapy	35.31
MH and SA OP Services	90849	AH-Doctoral Level (PhD, PsyD, EdD)	Multi-family group psychotherapy	32.60
MH and SA OP Services	90849	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Multi-family group psychotherapy	30.00
MH and SA OP Services	90849	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Multi-family group psychotherapy	22.17
MH and SA OP Services	90849	U3-Intern (PhD, PsyD, EdD) / or MAT	Multi-family group psychotherapy	16.33
MH and SA OP Services	90849	U4-Intern (Master's)	Multi-family group psychotherapy	15.00
MH and SA OP Services	90853	UG-Doctoral Level (Child Psychiatrist)	Group psychotherapy (other than of a multiple-family group)	$ 42.08
MH and SA OP Services	90853	U6-Doctoral Level (MD / DO)	Group psychotherapy (other than of a multiple-family group)	$ 35.31
MH and SA OP Services	90853	AH-Doctoral Level (PhD, PsyD, EdD)	Group psychotherapy (other than of a multiple-family group)	$ 32.60
MH and SA OP Services	90853	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Group psychotherapy (other than of a multiple-family group)	$ 30.00
MH and SA OP Services	90853	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Group psychotherapy (other than of a multiple-family group)	$ 30.00

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90853	U3-Intern (PhD, PsyD, EdD) / or MAT	Group psychotherapy (other than of a multiple-family group)	$ 16.33
MH and SA OP Services	90853	U4-Intern (Master's)	Group psychotherapy (other than of a multiple-family group)	$ 15.00
MH and SA OP Services	90882	UG-Doctoral Level (Child Psychiatrist)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 46.46
MH and SA OP Services	90882	U6-Doctoral Level (MD / DO)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 40.30
MH and SA OP Services	90882	AH-Doctoral Level (PhD, PsyD, EdD)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 21.79
MH and SA OP Services	90882	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 34.87
MH and SA OP Services	90882	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 21.48
MH and SA OP Services	90882	U3-Intern (PhD, PsyD, EdD) / or MAT	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 10.91
MH and SA OP Services	90882	U4-Intern (Master's)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 10.74
MH and SA OP Services	90887	UG-Doctoral Level (Child Psychiatrist)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 46.46
MH and SA OP Services	90887	U6-Doctoral Level (MD / DO)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 40.30
MH and SA OP Services	90887	AH-Doctoral Level (PhD, PsyD, EdD)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 21.79
MH and SA OP Services	90887	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 34.87

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90887	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 21.48
MH and SA OP Services	90887	U3-Intern (PhD, PsyD, EdD) / or MAT	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 10.91
MH and SA OP Services	90887	U4-Intern (Master's)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 10.74
MH and SA OP Services	96372	U6 - Doctoral Level (MD / DO)	Therapeutic, Prophylactic or Diagnostic Injection; subcutaneous or intramuscular	$ 28.41
MH and SA OP Services	96372	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Therapeutic, Prophylactic or Diagnostic Injection; subcutaneous or intramuscular	$ 21.11
MH and SA OP Services	97810	*N/A*	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-to-one contact	$ 19.84
MH and SA OP Services	97811	*N/A*	Add-On Code; Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-to-one contact with re-insertion of needle(s).	$ 19.84
MH and SA OP Services	99202	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 15-29 minutes	$ 68.41
MH and SA OP Services	99202	U6-Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 15-29 minutes	$ 59.33
MH and SA OP Services	99202	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 15-29 minutes	$ 55.25
MH and SA OP Services	99203	UG- Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 30-44 minutes	$ 98.68
MH and SA OP Services	99203	U6-Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 30-44 minutes	$ 85.58
MH and SA OP Services	99203	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 30-44 minutes	$ 79.46
MH and SA OP Services	99204	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 45-59 minutes	$ 149.09
MH and SA OP Services	99204	U6-Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 45-59 minutes	$ 129.30
MH and SA OP Services	99204	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 45-59 minutes	$ 121.14
MH and SA OP Services	99205	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 60-74 minutes	$ 185.17

Appendix T: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

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Unique Code/Modifier Combinations				
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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99205	U6-Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 60-74 minutes	$ 160.59
MH and SA OP Services	99205	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 60-74 minutes	$ 150.39
MH and SA OP Services	99211	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 5 minutes	$ 19.88
MH and SA OP Services	99211	U6-Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 5 minutes	$ 17.24
MH and SA OP Services	99211	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 5 minutes	$ 15.71
MH and SA OP Services	99212	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 10-19 minutes	$ 40.99
MH and SA OP Services	99212	U6-Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 10-19 minutes	$ 35.55
MH and SA OP Services	99212	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 10-19 minutes	$ 32.49
MH and SA OP Services	99213	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 20-29 minutes	$ 73.98
MH and SA OP Services	99213	U6-Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 20-29 minutes	$ 63.15
MH and SA OP Services	99213	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 20-29 minutes	$ 54.84
MH and SA OP Services	99214	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 30-39 minutes	$ 130.89
MH and SA OP Services	99214	U6-Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 30-39 minutes	$ 86.37
MH and SA OP Services	99214	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 30-39 minutes	$ 77.46
MH and SA OP Services	99215	UG-Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 40-54 minutes	$ 130.89
MH and SA OP Services	99215	U6-Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 40-54 minutes	$ 113.52
MH and SA OP Services	99215	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 40-54 minutes	$ 103.84
MH and SA OP Services	99231	UG-Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 70.97
MH and SA OP Services	99231	U6-Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 53.88
MH and SA OP Services	99231	AH-Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 51.72
MH and SA OP Services	99231	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 43.15
MH and SA OP Services	99232	UG-Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 106.46
MH and SA OP Services	99232	U6-Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 80.17
MH and SA OP Services	99232	AH-Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 76.96

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99232	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 64.21
MH and SA OP Services	99233	UG-Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 141.96
MH and SA OP Services	99233	U6-Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 106.90
MH and SA OP Services	99233	AH-Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 102.62
MH and SA OP Services	99233	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 85.62
MH and SA OP Services	99251	UG-Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 20 minutes	$ 95.22
MH and SA OP Services	99251	U6-Doctoral Level (MD / DO)	Initial Inpatient Consultation, 20 minutes	$ 72.27
MH and SA OP Services	99251	AH-Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 20 minutes	$ 69.38
MH and SA OP Services	99251	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 40 minutes	$ 57.88
MH and SA OP Services	99252	UG-Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 40 minutes	$ 142.83
MH and SA OP Services	99252	U6-Doctoral Level (MD / DO)	Initial Inpatient Consultation, 40 minutes	$ 107.56
MH and SA OP Services	99252	AH-Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 40 minutes	$ 103.25
MH and SA OP Services	99252	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 40 minutes	$ 86.15
UG-MH and SA OP Services	99253	UG-Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 55 minutes	$ 190.43
MH and SA OP Services	99253	U6-Doctoral Level (MD / DO)	Initial Inpatient Consultation, 55 minutes	$ 143.40
MH and SA OP Services	99253	AH-Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 55 minutes	$ 137.67
MH and SA OP Services	99253	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 55 minutes	$ 114.86
MH and SA OP Services	99254	UG-Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 80 minutes	$ 255.41
MH and SA OP Services	99254	U6-Doctoral Level (MD / DO)	Initial Inpatient Consultation, 80 minutes	$ 191.80
MH and SA OP Services	99254	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 80 minutes	$ 153.64
MH and SA OP Services	99255	UG-Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation - Comprehensive, 110 minutes	$ 336.47
MH and SA OP Services	99255	U6-Doctoral Level (MD / DO)	Initial Inpatient Consultation - Comprehensive, 110 minutes	$ 252.34
MH and SA OP Services	99255	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation - Comprehensive, 110 minutes	$ 202.12

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99281	U6-Doctoral Level (MD/DO)	Emergency Department visit for the evaluation and management of a patient, which requires 3 key components: A problem-focused history; A problem-focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.	$ 18.31
MH and SA OP Services	99282	UG-Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem-focused history; An expanded problem-focused examination; and Medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	$ 32.15
MH and SA OP Services	99282	U6-Doctoral Level (MD/DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	$ 30.62
MH and SA OP Services	99282	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	$ 29.73
MH and SA OP Services	99283	UG-Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	$ 48.65

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99283	U6-Doctoral Level (MD/DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	$ 46.34
MH and SA OP Services	99283	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	$ 44.99
MH and SA OP Services	99284	UG-Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	$ 91.44
MH and SA OP Services	99284	U6-Doctoral Level (MD/DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	$ 87.09

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99284	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	$ 84.55
MH and SA OP Services	99285	UG-Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$ 135.25
MH and SA OP Services	99285	U6-Doctoral Level (MD/DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$ 128.81
MH and SA OP Services	99285	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$ 123.91
MH and SA OP Services	99402	AH-Doctoral Level (PhD, PsyD, EdD)	Preventative Medicine Counseling , 30 minutes (Psychological Testing)	$ 40.98
MH and SA OP Services	99402	U3-Intern (PhD, PsyD, EdD) / or MAT	Preventative Medicine Counseling, 30 minutes (Psychological Testing)	$ 20.50

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99404	U6-Doctoral Level (MD / DO)	Preventative Medicine Counseling, 60 minutes (Counseling and/or Risk Factor Reduction Intervention)	$ 177.11
MH and SA OP Services	99404	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Preventative Medicine Counseling, 60 minutes (Counseling and/or Risk Factor Reduction Intervention)	$ 153.27
MH and SA OP Services	99417	U6-Doctoral Level (MD / DO)	Add-On Code; Prolonged office or other outpatient evaluation and management service, requiring total time with or without direct patient contact beyond usual service, on the date of the primary service (e.g., 99205 or 99215), each 15 minutes	$ 26.08
MH and SA OP Services	99417	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Add-On Code; Prolonged office or other outpatient evaluation and management service, requiring total time with or without direct patient contact beyond usual service, on the date of the primary service (e.g., 99205 or 99215), each 15 minutes	$ 26.08
Diversionary Services	H0015	*N/A*	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan) including assessment, counseling; crisis intervention, and activity therapies or education. (Enhanced Structured Outpatient Addiction Program - SOAP with Motivational Interviewing Counseling)	$ 80.30
Diversionary Services	H0015	*N/A*	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan) including assessment, counseling; crisis intervention, and activity therapies or education. (Structured Outpatient Addiction Program - SOAP with Motivational Interviewing)	$ 71.59
Diversionary Services	H0037	*N/A*	Community Psychiatric Supportive Treatment Program, per diem (Community Based Acute Treatment - CBAT)	$ 654.13
Diversionary Services	H0038	HF-Substance Abuse Program	Recovery Coaching – A non-clinical service provided (in 15 minutes increments) by a trained recovery advocate who provides guidance and coaching for individuals to meet their recovery goals	101 CMR 346
Diversionary Services	H2012	*N/A*	Behavioral Health Day Treatment, per hour (Psychiatric Day Treatment)	101 CMR 307.00
Diversionary Services	H2012	*N/A*	Behavioral Health Day Treatment, per hour (Enhanced Psychiatric Day Treatment)	101 CMR 307.00
Diversionary Services	H2015	*N/A*	Comprehensive community support services, per 15 minutes (Community Support Program)	$ 13.97
Diversionary Services	H2015	HF-Substance Abuse Program	Recovery Support Navigator – Self-help/peer service by a recovery advocate trained in Recovery Coaching. Rate is in 15-minutes increments.	101 CMR 444.00

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Diversionary Services	H2016	HE-Mental Health Program	When directed by EOHHS, Comprehensive community support services, per diem (Community Support Program (CSP) for members residing in DHCD-funded new temporary shelters)	$ 17.30
Diversionary Services	H2016	HH-Integrated Mental Health/Substance Abuse Program	Effective September 1, 2022, comprehensive community support program, per diem (Enrolled Client Day) (behavioral health service by a navigator trained to support members with justice involvement) (CSP-JI)	$17.23
Diversionary Services	H2016	HM-Less than bachelor degree level	Comprehensive community support program, per diem (Enrolled Client Day) (recovery support service by a recovery advocate trained in Recovery Coaching)	101 CMR 346.00
Diversionary Services	H2020	*N/A*	Therapeutic behavioral services, per diem (Dialectical Behavior Therapy)	$ 26.50
Diversionary Services	H2022	HE-Mental Health Program	Intensive Hospital Diversion Services for Children, per diem	$ 175.19
Diversionary Services	S9484	*N/A*	Crisis intervention mental health services, per hour (Urgent Outpatient Services)	$ 147.57
MH and SA OP Services	H0014	*N/A*	Alcohol and/or drug services; ambulatory detoxification (Adult or Adolescent)	$ 227.65
MH and SA OP Services	H0020	*N/A*	Alcohol and/or drug services; methadone administration and/or service (Dosing)	$13.72
MH and SA OP Services	H0020/T1006	*N/A*	Alcohol and/or drug services; methadone administration and/or service (Family/couple counseling); 1 unit = 60 minutes	$101.75
MH and SA OP Services	H0020/H0005	*N/A*	Alcohol and/or drug services; methadone administration and/or service (Group counseling); 1 unit = 60 to 90 minutes	$34.42
MH and SA OP Services	H0020	*N/A*	Alcohol and/or drug services; methadone administration and/or service (Individual counseling); 1 unit = 30 minutes	$49.39
MH and SA OP Services	H0004	*N/A*	Alcohol and/or drug services; methadone administration and/or service (Individual counseling); 1 unit = 15 minutes	$24.70
Adult ESP Services	S9485	U1-ESP - Mobile Non-Emergency Department / or MAT	Crisis intervention mental health services, per diem (Emergency Service Program Mobile Non-Emergency Department)	$ 819.64
Adult ESP Services	S9485	U1-ESP - Mobile Non-Emergency Department / or MAT	Crisis intervention mental health service, per diem (Emergency Service Program Mobile Non-Emergency Department - Uninsured)	$ 505.85
Adult ESP Services	S9485	HE-Mental Health Program	Crisis intervention mental health services, per diem (Emergency Service Program Community Based)	$ 744.23
Adult ESP Services	S9485	HE-Mental Health Program	Crisis intervention mental health services, per diem (Emergency Service Program Community Based - Uninsured)	$ 505.85

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Adult ESP Services	S9485	HB-Adult Program, non-geriatric	Crisis intervention mental health services, per diem (Emergency Service Program Hospital Emergency Room)	$ 505.85
Adult ESP Services	S9485	ET-Emergency Services	Crisis intervention mental health services, per diem (Emergency Service Program's Adult Community Crisis Stabilization Day 1)	$ 505.53
Adult ESP Services	S9485	TF-Intermediate level of care	Crisis intervention mental health services, per diem (Emergency Service Program's Adult Community Crisis Stabilization Day 2-5)	$ 505.53
Adult ESP Services	S9485	TG-Complex level of care	Crisis intervention mental health services, per diem (Emergency Service Program's Adult Community Crisis Stabilization Day 6 and After)	$ 505.53
Other Outpatient	90870	*N/A*	Electroconvulsive therapy (includes necessary monitoring)	$ 630.95
Other Outpatient	96112	AH-Doctoral Level (PhD, PsyD, EdD)	Developmental Testing administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour (Learning Disorders)	$ 180.72
Other Outpatient	96113	AH-Doctoral Level (PhD, PsyD, EdD)	Add-On Code; Each additional 30 minutes (List separately in addition to code for primary procedure) (Developmental/Behavioral Screening and Testing)	$ 90.36
Other Outpatient	96116	AH-Doctoral Level (PhD, PsyD, EdD)	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician o rother qualified health professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour	$ 120.46
Other Outpatient	96121	AH-Doctoral Level (PhD, PsyD, EdD)	Add-On Code; Each additional hour (List separately in addition to code for primary procedure)	$ 120.46
Other Outpatient	96130	AH-Doctoral Level (PhD, PsyD, EdD)	Psychological testing evaluation services by physician or other qualified health care professional, including integrating of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	$ 91.39
Other Outpatient	96131	AH-Doctoral Level (PhD, PsyD, EdD)	Add-On Code; Each additional hour (List separately in addition to code for primary procedure)	$ 91.39

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Other Outpatient	96132	AH-Doctoral Level (PhD, PsyD, EdD)	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	$ 91.39
Other Outpatient	96133	AH-Doctoral Level (PhD, PsyD, EdD)	Add-On Code; Each additional hour (List separately in addition to code for primary procedure)	$ 91.39
Other Outpatient	96136	AH-Doctoral Level (PhD, PsyD, EdD)	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes (Test administration and scoring by professional)	$ 45.70
Other Outpatient	96137	Doctoral Level (PhD, PsyD, EdD)	Add-On Code; Each additional 30 minutes (List separately in addition to code for primary procedure) (Test administration and scoring by professional)	$ 45.70
Other Outpatient	96138	*N/A*	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	$ 22.85
Other Outpatient	96139	*N/A*	Add-On Code; Each additional 30 minutes (List separately in addition to code for primary procedure) (Test administration and scoring by technician)	$ 22.85
Other Outpatient	H0032	HO-HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Mental health service plan development by a nonphysician (Bridge consultation inpatient/outpatient)	$ 166.67
Other Outpatient	H0046	UG-Doctoral Level (Child Psychiatrist)	Mental health services, not otherwise specified (Collateral Contact)	$ 46.46
Other Outpatient	H0046	U6-Doctoral Level (MD/DO)	Mental health services, not otherwise specified (Collateral Contact)	$ 40.30
Other Outpatient	H0046	AH-Doctoral Level (PhD, PsyD, EdD)	Mental health services, not otherwise specified (Collateral Contact)	$ 21.79
Other Outpatient	H0046	SA-Nurse Practitioner/Board Certified RNCS and APRN-BC	Mental health services, not otherwise specified (Collateral Contact)	$ 34.87
Other Outpatient	H0046	HO-Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Mental health services, not otherwise specified (Collateral Contact)	$ 21.48
Other Outpatient	H0046	U7-Certified Addiction Counselor / Certified Alcohol & Drug Abuse Counselor	Mental health services, not otherwise specified (Collateral Contact)	$ 21.48

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Other Outpatient	H0046	U3-Intern (PhD, PsyD, EdD) / or MAT	Mental health services, not otherwise specified (Collateral Contact)	$ 10.91
Other Outpatient	H0046	U4-Intern (Master's)	Mental health services, not otherwise specified (Collateral Contact)	$ 10.74
Other Outpatient	H2028	*N/A*	Sexual offender treatment service, per 15 minutes (ASAP - Assessment for Safe and Appropriate Placement)	$ 22.79
MH and SA OP Services	H0001	U1-ESP - Mobile Non-Emergency Department / or MAT	MAT - Alcohol and/or drug assessment (buprenorphine and naltrexone medication evaluation by physician and/or midlevel practitioner)	$ 146.93
MH and SA OP Services	H0033	*N/A*	MAT-Oral medication administration, with extended direct observation up to 2.5 hours (buprenorphine and associated drug screens, to be billed once during induction); may not be combined with H0033-U2	$46.25
MH and SA OP Services	H0033	U3-Intern (PhD, PsyD, EdD) / or MAT	MAT-Oral medication administration, direct observation (oral naltrexone dosing)	$11.34
MH and SA OP Services	H0047	*N/A*	MAT-Alcohol and/or other drug abuse services, not otherwise specified; oral medication preparation and administration (buprenorphine and associated drug screens); may not be combined with H0033; may be billed once per each day a member receives medication	$12.43
MH and SA OP Services	J0571	N/A	MAT-Buprenorphine, oral, 1 mg (maximum 32 mg per day) (prior authorization required)	$ 0.80
MH and SA OP Services	J0572	N/A	MAT-Buprenorphine/naloxone, oral, less than or equal to 3 mg (maximum of one unit per day; may be combined with J0573 as medically necessary)	$ 4.34
MH and SA OP Services	J0573		MAT-Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg; (may be billed in sufficient increments to achieve appropriate dose, may be combined with one unit of J0572 as medically necessary)	$ 7.76
MH and SA OP Services	J2315		MAT-Injection, naltrexone, depot form, 1 mg (maximum of 380 mg. per month)	$ 2.83
MH and SA OP Services	J3490		MAT-Unclassified drugs (Naltrexone, oral)	$ 1.20

List of Modifier Groups
UG-Doctoral Level (Child Psychiatrist)
U6-Doctoral Level (MD / DO)
AH-Doctoral Level (PhD, PsyD, EdD)
SA-Nurse Practitioner/Board Certified RNCS and APRN-BC
HO-Master's Level
U3-Intern (PhD, PsyD, EdD)
U4-Intern (Master's)
U7-CAC/CADAC

Appendix AA

Directed Payments Related to Certain ACO Covered Services

Exhibit 1: HCBS Temporary Rate Increases by Service

Exhibit 1A Summary of HCBS Rate Increases

Covered Service	Increase	Rate Increase Effective Date	Rate Increase End Date
Nursing	10%	1/1/2022	12/31/2022
Children's Behavioral Health Initiative (CBHI)	EOHHS has increased its state plan rates for CBHI services. The Contractor shall pay CBHI providers at or above the MassHealth state plan rate. See Exhibit 1B below. See Exhibit 2 below for rate increase for In Home Therapy applicable for 7/1/2022 through 12/31/2022.	1/1/2022	6/30/2022
Home Health Services	10%	1/1/2022	12/31/2022
Durable Medical Equipment	10%	1/1/2022	6/30/2022

The Contractor shall refer to the following MassHealth Provider Manual sections for additional detail on applicable codes for each service:

- https://www.mass.gov/doc/independent-nurse-in-subchapter-6-0/download
- https://www.mass.gov/doc/home-health-agency-hha-subchapter-6/download
- https://www.mass.gov/doc/durable-medical-equipment-dme-subchapter-6/download
- www.mass.gov/doc/continuous-skilled-nursing-agency-csn-subchapter-6-0/download
- www.mass.gov/doc/oxygen-and-respiratory-therapy-equipment-oxy-subchapter-6-0/download

Exhibit 1B Children's Behavioral Health Initiative (CBHI) Rate Increase by Services

The table below details the revised state plan rates for CBHI services (see also 101 CMR 447) for the rate increases effective from January 1, 2022, to June 30, 2022.

Service Description	Code	Unit	Rate	Add-on	Total
Self-help/peer services, per 15 minutes (parent-caregiver peer-to-peer support service provided by a family partner)	H0038	15 minutes	$18.58	$1.86	$20.44
Crisis intervention service, per 15 minutes (mobile crisis intervention service provided by a paraprofessional)	H2011-HN	15 minutes	$30.57	$3.06	$33.63

Service Description	Code	Unit	Rate	Add-on	Total
Crisis intervention service, per 15 minutes (mobile crisis intervention service provided by a master-level clinician)	H2011-HO	15 minutes	$39.70	$3.97	$43.67
Skills training and development, per 15 minutes (behavior management monitoring provided by a bachelor-level clinician)	H2014-HN	15 minutes	$15.02	$1.50	$16.52
Skills training and development, per 15 minutes (behavior management therapy provided by a master-level clinician)	H2014-HO	15 minutes	$28.48	$2.85	$31.33
Therapeutic behavioral services, per 15 minutes (therapeutic training and support services provided by a bachelor-level clinician)	H2019-HN	15 minutes	$16.79	$1.68	$18.47
Therapeutic behavioral services, each 15 minutes (in-home therapy provided by a master-level clinician)	H2019-HO	15 minutes	$23.95	$2.40	$26.35
Family training and counseling for child development, per 15 minutes (therapeutic mentoring service)	T1027-EP	15 minutes	$15.64	$1.56	$17.20
Behavioral Health Outreach Service (Targeted Case Management) (multi-disciplinary team) that includes family support and training and intensive care coordination per day	H0023-HT	Per Day	$51.93	$5.19	$57.12

Managed care plans are required to pay providers at least the rates listed below for dates of service on or after April 1, 2022, through June 30, 2022.

Crisis intervention service, per 15 minutes (mobile crisis intervention service provided by a paraprofessional, community-based site of service. Must use place of service code "- 15")	H2011-HN	15 minutes	$33.94	$3.39	$37.33
Crisis intervention service- per 15 minutes (mobile crisis intervention service provided by a master-level clinician, community-based site of service. Must use place of service code "- 15")	H2011-HO	15 minutes	$44.33	$4.43	$48.76

Exhibit 2: Summary of Behavioral Health Services Rate Increases by Service

Covered Service*	Increase	Rate Increase Effective Date	Rate Increase End Date
Acute Treatment Services (ATS) for Substance Use Disorders and Clinical Support Services for Substance Use Disorders (including Individualized Treatment Services)	10%	1/1/2022	12/31/2022
Applied Behavioral Analysis for members under 21 years of age (ABA Services)	10%	1/1/2022	9/30/2022
Children's Behavioral Health Initiative (CBHI), In Home Therapy	10%	7/1/2022	12/31/2022
Community-Based Acute Treatment for Children and Adolescents (CBAT)	10%	1/1/2022	12/31/2022
Community Support Program (CSP)	10%	1/1/2022	12/31/2022
Early intervention	10%	1/1/2022	6/30/2022
Early Intensive Behavioral Intervention	10%	1/1/2022	9/30/2022
Emergency Service Program (ESP) and Community Crisis Stabilization (CCS)	10%	1/1/2022	12/31/2022
Intensive Hospital Diversion	10%	1/1/2022	6/30/2022
Intensive Outpatient Program (IOP)	10%	1/1/2022	12/31/2022
Outpatient mental health services: • Couples/Family Treatment • Diagnostic Evaluation • Dialectical Behavioral Therapy (DBT) • Family Consultation • Group Treatment • Individual Treatment • Medication visit • Psychological Testing • Special Education Psychological Testing • Electro-Convulsive Therapy (ECT) • Case consultation • Collateral Contact	10%	1/1/2022	12/31/2022
Partial Hospitalization (PHP)	10%	1/1/2022	12/31/2022
Program of Assertive Community Treatment (PACT)	10%	1/1/2022	12/31/2022
Psych Day Treatment	10%	1/1/2022	12/31/2022
SUD Clinic Services: • Acupuncture Treatment • Ambulatory Withdrawal Management • Medication Visit • including counseling services	10%	1/1/2022	12/31/2022
SUD Clinic Services: Opioid Treatment Services	10%	1/1/2022	6/30/2022

Covered Service*	Increase	Rate Increase Effective Date	Rate Increase End Date
Residential Rehabilitation Services for Substance Use Disorders, including Transitional Age Youth and Young Adult Residential, Youth Residential, and Pregnancy Enhanced Residential	10%	1/1/2022	12/31/2022
Residential Rehabilitation Services for Substance Use Disorders - Co-occurring Enhanced RRS	10%	1/1/2022	6/30/2022
Structured Outpatient Addiction Program (SOAP)	10%	1/1/2022	12/31/2022
Recovery Support Navigators (RSN)	10%	1/1/2022	12/31/2022
Recovery Coaching	10%	1/1/2022	12/31/2022
Transitional Care Unit (TCU)	10%	1/1/2022	12/31/2022

*Such covered services include the services set forth in Appendix T except as set forth below as well as the following services:

CBAT – Community Based Acute Treatment (Rev Code 1001), TCU – Transitional Care Unit (Rev codes 0100, 0114, 0124, 0134, 0144, 0154), ABA – Applied Behavior Analysis (H2012, H0032, H0031, H2019, 97156, ITS H2036), IOP – Intensive Outpatient Psychiatric (Rev Code 0905, 0906 CPT 90834), Early Intervention (96153, 96164, 96165, H2015, T1015, T1027, T1023, T1024), PACT – Program of Assertive Community Treatment (H0040, ATS H0011 or rev code 1002 for MBHP), RSS and COE RRS (H0019 or H0019-HH), CSS (H0010 or rev code 907 for MBHP), CSP-SIF – Community Support Program - Social Innovation Financing for Chronic Homelessness Program (H2016 SE), CSP-CHI – Community Support Program for Chronically Homeless Individuals (H2016 HK)

Such covered services do not include the following services set forth in Appendix T:

Certain Consult codes and E&M codes (99231, 99232, 99233, 99251, 99252, 99253, 99254, 99255, 99281, 99282, 99283, 99284, 99285), Specialing (T1004), ASAP (H2028), SUD medication (J0571, J0572, J0573, J2315, J3490)