



The Commonwealth of Massachusetts

HEALTH POLICY COMMISSION

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Chapter 52 of Acts of 2016 Claim Denial Reporting Requirements (“Data Guidelines”) For Reports Due on or before July 1, 2025 (reporting on Calendar Year 2024)

I. Purpose:

The Office of Patient Protection (“OPP”) is issuing these data guidelines pursuant to of 958 CMR 3.00 Health Insurance Consumer Protection to all Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc. and Health Maintenance Organizations (hereinafter referred to as “Carriers”) and which offer health insurance coverage in the Commonwealth of Massachusetts and which must comply with the amended regulation as set forth.

This reporting aims to provide greater transparency on claim denials based on diagnosis types related to Medical/Surgical, Mental Health and Substance use disorder (SUD).

II. Data Collection:

The OPP, the Division of Insurance (“DOI”), Carriers and Representatives have developed a pre-defined excel workbook with the intent for it to be used as the data collection tool and repository for all required data related to this reporting.

Please note that for all data to be included in the template, as further detailed below, the **report is due to OPP and DOI on or before July 1, 2025** and must include claims data on the latest version of all fully adjudicated claims with a **date of service in Calendar Year 2024**. Carriers will submit the latest version of a fully adjudicated claim as of March 31, 2025. See Sections V and VI for additional reporting information.

The workbook includes five (5) tabs that shall be used by Carriers in conjunction with the below guidelines.

Tab Name	Description
Overview	Describes the reporting template and each tab associated with it.
Reporting Dashboard	Reporting elements to be submitted by Carriers pursuant to 958 CMR 3.00. This is the spreadsheet carriers are required to populate and report to OPP and DOI.
ASC X12 EDI 835 Crosswalk	The mapping guidance of 835 transaction codes to be used as a crosswalk to populate elements of the reporting dashboard.
Appendix A Mental Health ICD10	All ICD-10/diagnostic codes to be used to define and populate all "mental health" and "behavioral health" claim denial reporting categories.
Appendix B SUD ICD10	All ICD-10/diagnostic codes used to define and populate all "substance use disorder (SUD) disorder" claim denial

III. Data Reporting:

- A. Carriers shall **include** the following as part of the data used to populate the reporting template:
- i. Insured lines of business only (includes both on-exchange and off-Exchange plans).
 - ii. Vision and Dental claims data that was paid and/or denied under a medical policy.
 - iii. Claims to be entered into the following Reporting Tables in the Reporting Template:
 1. Table 1: Professional and Related, Non-Independent Clinical Laboratory Claims (line level);
 2. Table 2: Institutional Outpatient and Related, Non-Independent Clinical Laboratory Claims (line level);
 3. Table 3: Institutional Inpatient and Related, Non-Independent Clinical Laboratory Claims (header level); and
 4. Table 4: Claims Related to Services performed at an Independent Lab (line level).
- B. Carriers shall not report claims data in multiple reporting tables (i.e., no duplicate data). Claims reported in each table shall not be duplicative of claims in any other table. Where a claim is denied for two or more reasons and one of the reasons corresponds with denial reasons A-C, please report A, B, or C as the denial reason. Do not count the claim in multiple denial categories.
- C. Carriers shall work closely with entities of which they have carve outs and/or vendor contracts (where applicable) to obtain the necessary data to populate the template.
- D. Carriers shall **exclude** the following in the data used to populate the reporting template:
- i. Government health programs (e.g., Medicare, Medicare Supplement Plan, or MassHealth).
 - ii. Self-funded employment-sponsored health plans.
 - iii. Group Insurance Commission health plans.
 - iv. Group Health plans covering Massachusetts residents with a contractual situs outside of the Commonwealth.
 - v. Durable Medical Equipment (DME) and other Supplies
 1. If a claim is received and has 1 line that has been denied and that line is related to DME or other Supplies, the claim should not be counted.
 2. If the claim is received and denied and has 2 lines, (1) line is related to DME (2) line is related to a service (e.g., Evaluation), the claim should be counted 1 time for each type of relevant diagnosis.
 3. If the claim is received and denied and has 1 claim bundled with both DME and a service (e.g., Evaluation) on 1 claim line, the claim should be counted 1 time for each type of relevant diagnosis.
 - vi. Vision and Dental claims that were paid and/or denied under a standalone vision and dental policy and not under a medical policy.

**It is recommended that the Carriers refer to the most recent Healthcare Common Procedure Coding System (HCPCS) list provided by the Center for Medicare and Medicaid Services (CMS) to assist with excluding DME and other supplies from the claims data being reported (as appropriate).*

IV. Reporting Template:

The below provides guidance of each element on the reporting dashboard template. Carriers shall use this guidance to collect and report the data. The guidance also includes detail on what data Carriers shall include and exclude in addition to the above references in this document.

Template Cell Description	Guideline
General Carrier Information	
Name of Carrier	Carriers shall insert their full legal name of the Entity of which the data is relevant.
NAIC Number	Carriers shall insert their unique identifier provided by National Association of Insurance Commissioners (NAIC).
Contact Information of Individual Reporting	
Contact Name	Carriers shall insert the name of the person within their organization that may be contacted to answer any questions related to the data and reporting. This person may be different than the actual submitter of the data.
Contact Title	Carriers shall insert the title of the person (listed in the above contact name field).
Contact Email Address	Carriers shall insert the email address of the person (listed in the above contact name field).
Contact Phone Number	Carriers shall insert the phone number of the person (listed in the above contact name field).
Data Detail	
Date of Report	Carriers shall insert the date the report has been finalized.
Report Data Range	Carriers shall insert the date range of the report.
Total # of Professional and Related, Non-Independent Lab Claims at Line-level Submitted and Fully Adjudicated (Both Paid and Denied)	Carriers shall insert the Total # of Professional Claims (at the line level) submitted and fully adjudicated both paid and denied which includes Med/Surg, mental health and SUD.

Template Cell Description	Guideline
Data Detail CONTINUED	
Total # of Institutional Outpatient and Related, Non-Independent Lab Claims Adjudicated at Line Level; Submitted and Fully Adjudicated (Both Paid and Denied)	Carriers shall insert the Total # of Institutional Outpatient Claims (at the line level) submitted and fully adjudicated both paid and denied which includes Med/Surg, mental health and SUD.
Total # of Institutional Inpatient and Related, Non-Independent Lab Claims Adjudicated at Header Level; Submitted and Fully Adjudicated (Both Paid and Denied)	Carriers shall insert the Total # of Institutional Inpatient Claims (at the header level) submitted and fully adjudicated both paid and denied which includes Med/Surg, mental health and SUD.
Total # of Independent Lab Claims at Line Level Submitted and Fully Adjudicated (Both Paid and Denied)	Carriers shall insert the Total # of Lab Claims (at the line level) submitted and fully adjudicated both paid and denied for labs performed at a stand-alone lab facility which includes Med/Surg, mental health and SUD.
Health Plan Submission Comments	
Please explain how CY2024 claims data compares to CY2023 data submitted to OPP/DOI and provide a brief explanation as to any notable changes in the data reported year over year.	Carriers shall provide comments in this field to describe year over year changes in data (e.g., provide supporting information on membership and/or utilization changes).
Notes field for any additional information, caveats, exceptions, etc.	Carriers may use this field to document any comments related to the data.
Table 1: Professional and Related, Non-Independent Lab Claims (Line Level)	
Types of Diagnosis Category	<ul style="list-style-type: none"> • Med/Surg as it relates to this reporting shall be defined as all non-MH/SUD treatments and services. • Mental Health as it relates to this reporting shall be defined as a person's condition with regard to their psychological and emotional well-being. • SUD as it relates to this reporting shall be defined as an overindulgence in or dependence on an addictive substance, especially alcohol or drugs.
Total # of Adjudicated Claims at Line Level (Both Paid and Denied)	Using the primary diagnosis pointer on each claim line, Carriers shall count the total # of claim lines both paid and denied, fully adjudicated and received during reporting period based on type of each diagnosis category (Med/Surg, Mental Health, and SUD).

Template Cell Description	Guideline
Table 1: Professional and Related, Non-Independent Lab Claims (Line Level) CONTINUED	
<p># of Adjudicated Denied Claims at Line Level by Denial Reason (Listed below)</p> <ul style="list-style-type: none"> A. No Prior Authorization or Referral by Insured B. Medical Necessity C. Experimental or Investigational D. Member not covered or eligible at the time services were rendered E. Service/Provider Not Covered <ul style="list-style-type: none"> 1. Service Not Covered - Benefit Limit 2. Service Not Covered – Benefit Exclusions 3. Provider Not Covered – OON F. Duplicate Claim or Coverage (e.g. subro, Wcomp, auto, etc.) G. Incomplete Claims H. Coding Errors I. Other Administrative Denials 	<p>Using the primary diagnosis pointer on each claim line, Carriers shall submit the # of adjudicated denied claim lines for each specified denial reason listed on the reporting dashboard of the template.</p> <p>Carriers shall refer to the following tabs in the excel workbook to populate the data on the reporting dashboard:</p> <ol style="list-style-type: none"> 1. ASC X12 EDI 835 Crosswalk AND 2. Appendix A Mental Health ICD10 AND 3. Appendix B SUD ICD10 <p>Carriers shall not use any other additional diagnosis codes to populate the Mental Health and SUD cells within the reporting dashboard.</p> <p>For Med/Surg data collection, Carriers are to use any other diagnosis codes that are not already accounted for on the Appendix A Mental Health ICD10 and/or Appendix B SUD ICD10 predefined tabs in the excel workbook.</p> <p>Carriers may need to remove the decimal points on Appendix A and Appendix B in order to allow compatibility with internal systems.</p>
Total # of Claims (Line level) Denied	Data should equal the sum of all cells under the # of Adjudicated Denied Claims at Line Level by Denial Reason (Listed below) section of the template.
Total # of Claims (Line Level) Paid	Data should equal Total # of Adjudicated Claims at Line Level (Both Paid and Denied) minus the Total # of Claims (Line level) Denied.

Template Cell Description	Guideline
Table 2: Institutional Outpatient and Related, Non-Independent Lab Claims (Line Level)	
Types of Diagnosis Category	<ul style="list-style-type: none"> • Med/Surg as it relates to this reporting shall be defined as all non-MH/SUD treatments and services. • Mental Health as it relates to this reporting shall be defined as a person's condition with regard to their psychological and emotional well-being. • SUD as it relates to this reporting shall be defined as an overindulgence in or dependence on an addictive substance, especially alcohol or drugs.
Total # of Adjudicated Claims at Line Level (Both Paid and Denied)	Using the primary diagnosis pointer on each claim line, Carriers shall count the total # of claims (line level) both paid and denied, fully adjudicated and received during reporting period based on type of each diagnosis category (Med/Surg, Mental Health, and SUD).
<p># of Adjudicated Denied Claims at the Line Level by Denial Reason (Listed below)</p> <p>A. No Prior Authorization or Referral by Insured</p> <p>B. Medical Necessity</p> <p>C. Experimental or Investigational</p> <p>D. Member not covered or eligible at the time services were rendered</p>	<p>Using the primary diagnosis pointer on each claim line, Carriers shall submit the # of adjudicated denied claims at the line level by each specified denial reason listed on the reporting dashboard of the template.</p> <p>Carriers shall refer to the following tabs in the excel workbook to populate the data on the reporting dashboard:</p> <ol style="list-style-type: none"> 1. ASC X12 EDI 835 Crosswalk AND 2. Appendix A Mental Health ICD10 AND 3. Appendix B SUD ICD10 <p>Carriers shall not use any other additional diagnosis codes to populate the Mental Health and SUD cells within the reporting dashboard.</p>

Template Cell Description	Guideline
Table 2: Institutional Outpatient and Related, Non-Independent Lab Claims (Line Level) CONTINUED	
<ul style="list-style-type: none"> E. Service/Provider Not Covered <ul style="list-style-type: none"> 1. Service Not Covered - Benefit Limit 2. Service Not Covered – Benefit Exclusion 3. Provider Not Covered / OON F. Duplicate Claim or Coverage (e.g. subro Wcomp, auto, etc.) G. Incomplete Claims H. Coding Errors I. Other Administrative Denials 	<p>For Med/Surg data collection, Carriers are to use any other diagnosis codes that are not already accounted for on the Appendix A Mental Health ICD10 and/or Appendix B SUD ICD10 predefined tabs in the excel workbook.</p> <p>Carriers may need to remove the decimal points on Appendix A and Appendix B in order to allow compatibility with internal systems.</p>
Total # of Claims (Line Level) Denied	Data should equal the sum of all cells under the # of Adjudicated Denied Claims at the Line Level by Denial Reason (Listed below) section of the template.
Total # of Claims (Line Level) Paid	Data should equal Total # of Adjudicated Claims at Line Level (Both Paid and Denied) minus the Total # of Claims (Line Level) Denied.

Template Cell Description	Guideline
Table 3: Institutional Inpatient and Related, Non-Independent Lab Claims (Header Level)	
Types of Diagnosis Category	<ul style="list-style-type: none"> • Med/Surg as it relates to this reporting shall be defined as all non-MH/SUD treatments and services. • Mental Health as it relates to this reporting shall be defined as a person’s condition with regard to their psychological and emotional well-being. • SUD as it relates to this reporting shall be defined as an overindulgence in or dependence on an addictive substance, especially alcohol or drugs.
Total # of Claims Adjudicated at Header Level (Both Paid and Denied)	Using the principal diagnosis on the claim, Carrier shall count the total # of claims (header level) both paid and denied, fully adjudicated at the header level and received during reporting period based on type of each diagnosis category (Med/Surg, Mental Health, and SUD).
<p># of Denied Claims Adjudicated at the Header Level by Denial Reason (Listed below)</p> <p>A. No Prior Authorization or Referral by Insured</p> <p>B. Medical Necessity</p> <p>C. Experimental or Investigational</p> <p>D. Member not covered or eligible at the time services were rendered</p>	<p>Using the principal diagnosis on the claim, as applicable, Carriers shall submit the # of denied claims adjudicated at the header level by each specified denial reason listed on the reporting dashboard of the template.</p> <p>Carriers shall refer to the following tabs in the excel workbook to populate the data on the reporting dashboard:</p> <ol style="list-style-type: none"> 1. ASC X12 EDI 835 Crosswalk AND 2. Appendix A Mental Health ICD10 AND 3. Appendix B SUD ICD10 <p>Carriers shall not use any other additional diagnosis codes to populate the Mental Health and SUD cells within the reporting dashboard.</p>

Template Cell Description	Guideline
Table 3: Institutional Inpatient and Related, Non-Independent Lab Claims (Header Level) CONTINUED	
<p>E. Service/Provider Not Covered</p> <ol style="list-style-type: none"> 1. Service Not Covered - Benefit Limit 2. Service Not Covered – Benefit Exclusion 3. Provider Not Covered / OON <p>F. Duplicate Claim or Coverage (e.g. subro Wcomp, auto, etc.)</p> <p>G. Incomplete Claims</p> <p>H. Coding Errors</p> <p>I. Other Administrative Denials</p>	<p>For Med/Surg data collection, Carriers are to use any other diagnosis codes that are not already accounted for on the Appendix A Mental Health ICD10 and/or Appendix B SUD ICD10 predefined tabs in the excel workbook.</p> <p>Carriers may need to remove the decimal points on Appendix A and Appendix B in order to allow compatibility with internal systems.</p>
<p>Total # of Claims (Header Level) Denied</p>	<p>Data should equal the sum of all cells under the # of Adjudicated Denied Claims at the Header by Denial Reason (Listed below) section of the template.</p>
<p>Total # of Claims (Header Level) Paid</p>	<p>Data should equal Total # of Adjudicated Claims at Header Level (Both Paid and Denied) minus the Total # of Claims (Header Level) Denied.</p>

Template Cell Description	Guideline
Table 4: Lab Claims Received by Independent Laboratories (Line Level)	
	<i>NOTES: Lab claims reported in Table 4 should not be duplicative of any claims reported in Tables 1, 2, or 3.</i>
Types of Diagnosis Category	<ul style="list-style-type: none"> • Med/Surg as it relates to this reporting shall be defined as all non-MH/SUD treatments and services. • Mental Health as it relates to this reporting shall be defined as a person’s condition with regard to their psychological and emotional well-being. • SUD as it relates to this reporting shall be defined as an overindulgence in or dependence on an addictive substance, especially alcohol or drugs.
Total # of Adjudicated Claims at Line Level (Both Paid and Denied)	Using the primary diagnosis pointer on each claim line, Carriers shall count the total # of claim lines both paid and denied, fully adjudicated and received during reporting period based on type of each diagnosis category (Med/Surg, Mental Health, and SUD). This will include all claims received by laboratory providers including clinical laboratories, physiological laboratories, medical laboratories, and military clinical laboratories.
# of Adjudicated Denied Claims at the Line Level by Denial Reason (Listed below) A. No Prior Authorization or Referral by Insured B. Medical Necessity C. Experimental or Investigational D. Member not covered or eligible at the time services were rendered	Using the diagnosis pointer or diagnosis code on each claim line (see attachment A for reference), Carriers shall submit the # of adjudicated denied claim lines at the line level for each specified denial reason listed on the reporting dashboard of the template. Carriers shall refer to the following tabs in the excel workbook to populate the data on the reporting dashboard: 1. ASC X12 EDI 835 Crosswalk AND 2. Appendix A Mental Health ICD10 AND 3. Appendix B SUD ICD10 Carriers shall not use any other additional diagnosis codes to populate the Mental Health and SUD cells within the reporting dashboard.

Template Cell Description	Guideline
Table 4: Lab Claims Received by Independent Laboratories (Line Level) CONTINUED	
E. Service/Benefit Not Covered <ol style="list-style-type: none"> 1. Service Not Covered – Benefit Limit 2. Service Not Covered – Benefit Exclusion 3. Provider Not Covered / OON F. Duplicate Claim or Coverage (e.g. subro Wcomp, auto, etc.) G. Incomplete Claims H. Coding Errors I. Other Administrative Denials	For Med/Surg data collection, Carriers are to use any other diagnosis codes that are not already accounted for on the Appendix A Mental Health ICD10 and/or Appendix B SUD ICD10 predefined tabs in the excel workbook. Carriers may need to remove the decimal points on Appendix A and Appendix B in order to allow compatibility with internal systems.
Total # of Claims (Line Level) Denied	Data should equal the sum of all cells under the # of Adjudicated Denied Claims at the Line Level by Denial Reason (Listed below) section of the template.
Total # of Claims (Line Level) Paid	Data should equal Total # of Adjudicated Claims at Line Level (Both Paid and Denied) minus the Total # of Claims (Line Level) Denied.

V. Report Due Date and Pertinent Data Range:

Report Due Date	Data Range
Report Due: July 1, 2025	Report should reflect the latest version of all fully adjudicated claims with a date of service in Calendar Year 2024. Carriers will submit the latest version of a fully adjudicated claim as of March 31, 2025.

VI. Report Submission Requirements:

Carriers shall concurrently submit the “Reporting Dashboard” to OPP and DOI no later than the due dates specified in section *V. Report Due Date and Pertinent Data Range* of this document.

- Send to OPP via e-mail to Nancy.K.Ryan@mass.gov or, in the alternative, via postal mail on a USB or other electronic media storage mode at Health Policy Commission, Office of Patient Protection, 50 Milk Street, 8th Floor, Boston, MA 02109 **AND**
- Send to DOI via e-mail to Kevin.Beagan@mass.gov or, in the alternative, via postal mail on a USB or other electronic media storage mode to Division of Insurance, 1000 Washington Street, 8th Floor, Boston, MA 02118.