Maine Quality Forum

MEASURING TO IMPROVE

Public Law, Chapter 603

Annual Report:

Maine Behavioral Health Care Spending, 2021-2023

November 20, 2025

(Revised from March 7, 2025)

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Overview

Public Law 2021, Chapter 603, *An Act Regarding Reporting on Spending for Behavioral Health Care Services and To Clarify Requirements for Credentialing by Health Insurance Carriers*, requires the Maine Quality Forum (MQF) to submit an annual report on behavioral health (BH) care spending in Maine to the Joint Standing Committee on Health Coverage, Insurance and Financial Services and the Commissioner of the Department of Health and Human Services (*Attachment B*).[1]

The Maine Quality Forum (MQF) contracts with the University of Southern Maine, Muskie School of Public Service, with consultation from Judy Loren and McGuire Consulting Services, for technical support in the preparation of this report.

Behavioral Health Spending estimates for CY 2023 rely on analyses of both claims payment data and non-claims-based payments submitted by payors to the MHDO as defined in 90-590 Chapter 243*, Uniform Reporting System for Health Care Claims Data Sets*, and 90-590 Chapter 247, *Uniform Reporting System for Non-Claims Based Payments and Other Supplemental Health Care Data Sets*.[*] [2,3] For this report, MaineCare estimates are based on claims accessed directly from the Department of Health and Human Services (ME DHHS), Office of MaineCare Services.[†] Throughout this report, the terms "payment" and "spending" are equivalent.

As required by the statute, MQF conducts an environmental scan of other state and national reports to identify improvements to our definition of behavioral health care, allowing Maine to align with current best practices of measuring behavioral health care spending. Based on our updated review, there continues to be no consistent definition across states; only two other states (MA, RI) separately report behavioral health spending from primary care and the data sources used and definitions of what is considered behavioral health care vary. Therefore, MQF's methodology of measuring behavioral health care spending remains the same as prior reports. See *Attachment C* for a more detailed summary of behavioral health care reporting in other states and nationally.

This report provides a comprehensive estimate of behavioral health care payments made by payors and reported to MHDO in claims, non-claims and supplemental payments (Part I). For the claims analyses of behavioral health spending estimates, this represents the payors' paid amount and does not include consumer payments (e.g., copayments, coinsurance). As in prior reports, we also include *claims-only* estimates of insured members' behavioral health utilization by payor (Part II), behavioral health care spending for telehealth services based on payor paid amounts and an analysis of commercially insured consumers' cost share as a portion of total allowed amounts (payor paid amounts plus consumer cost share amounts) for behavioral health and non-behavioral health payments (Part III).

For details on the methodology used to estimate behavioral health care spending and member use see *Attachments D* and *E*.

Note: The MQF behavioral health care spending report is separate from the report on Primary Care Spending in Maine required under Public Law 2019, Chapter 244, *An Act to Establish Transparency in Primary Care Health Care Spending*. Some services provided by a primary care provider as defined by the list of Primary Care taxonomy codes and/or service codes also have a primary diagnosis of behavioral health and, therefore, will be

[*] Effective October 2022, Chapter 247 requires submission of both non-claims and supplemental aggregated SUD payment data for those commercial and Medicare Advantage plans redact from their claims submissions to MHDO per their interpretation of the federal rule, 42 CFR Part 2.

[†] Maine's DHHS Office of MaineCare Services has a memorandum of understanding with the University of Southern Maine to conduct analyses of MaineCare data on behalf of the Maine Quality Forum to assist in developing PL 244, PL 603 mandated primary care and behavioral health spending reports. Given the different data source and method for excluding LTSS, total MaineCare $s will differ from the Primary Care spending report.

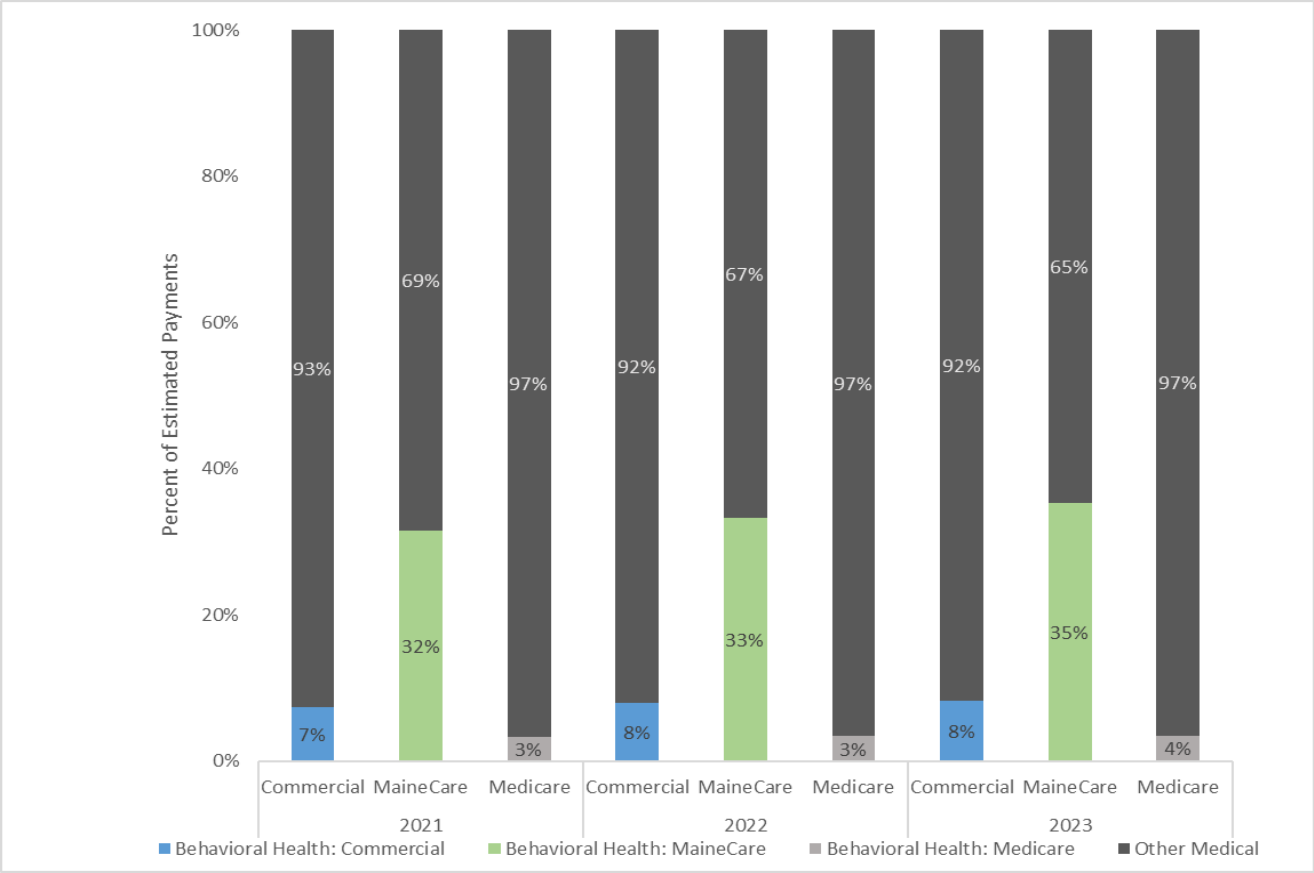
part of both calculations. In 2023, approximately 7% of commercial, 13% of MaineCare, and 15% of Medicare behavioral health care was delivered by a Primary Care provider.

Key Findings

2023 Behavioral Health Care Spending and Utilization Estimates

- Across the three-year period CY 2021 to CY 2023, behavioral health care spending as a percent of total medical spending by all payors has increased from approximately 12.1% in 2021 to 14.1% of total spending in 2023, primarily because of the increases in MaineCare's behavioral health spending.
- Similar to prior reports, in 2023, behavioral health care spending as a percent of total payments was highest for MaineCare (35.3%), followed by commercial payors (8.3%) and Medicare (3.5%). (Figure 1, Table 1)
- Compared to 2022, the percentage of behavioral health care spending as a share of total medical payments remained relatively flat in 2023 for Commercial and Medicare, and increased for MaineCare (from approximately 33% to 35.3%).

Figure 1. Behavioral Health Care Payments as a Percentage of Total Reported Medical Payments by Payor*, 2021-2023



Data Source: MHDO 2021-2023 APCD claims data, non-claims-based payments and supplemental SUD non-claims payments, and USM MaineCare data repository (includes SUD). Percentages shown are rounded up to the nearest whole number.
*MaineCare's percent of behavioral health spending, as shown in this figure, is reported at the high end of the estimated range in years 2021 and 2022. The 2023 data was adjusted by MaineCare and provided non-claims data without LTSS, so no estimate was needed.

- The percentage of members accessing behavioral health care services remained relatively consistent over time by payor. In 2023, 29% of members eligible for MaineCare, 17% of commercially insured members and 17% of Medicare members insured had at least one behavioral health care claim.
- From 2021 to 2023, there has been a decline in behavioral health care payments for tele-behavioral health for all payors (Commercial, MaineCare, and Medicare). Commercial payor behavioral health care payments (excluding SUD redacted claims) for tele-behavioral health care have declined (from 40% to 30%), Medicare (from 21% to 16%) and MaineCare (from 12% to 9%).

Enhancements to This Year's MQF Behavioral Health Care Spending Report

In this report, several new analyses have been added to provide additional context about behavioral health care spending and utilization in Maine. New analyses include:

- **Behavioral health care spending by healthcare setting[‡], age group, health insurance rating areas and county** (Figures 3-4 and *Attachment A* – Tables 4-6 and Figure 8).
- **Behavioral health care use as measured by the percent of insured people with at least one behavioral health care claim by county, insurance rating area, and age group by the payor[§]** (Table 3 and *Attachment A* – Table 7 and Figures 9-11).
- **Telehealth spending by payor, county and health insurance rating area** (*Attachment A* – Table 8 and Figures 12-14).

[‡] The healthcare setting in which services were delivered defined as inpatient acute, residential inpatient, emergency department, federally qualified health centers/rural health centers and Indian Health Services, other outpatient settings not in ED/FQHC that may include medical offices, private practice, community mental health, and telehealth. Crisis services that can be provided in any setting or in the member's home, school, street/mobile clinic or emergency shelter were analyzed separately.

[§] For this report, members who were insured by more than one payer or members whose primary payor changed during the year were counted only once for the year in the primary payor in which they were enrolled in the latest month in the year. Given this change in methods, enrollment and utilization results by payor will differ from the prior BH spending report.

Part I: Behavioral Health Care Spending Estimates by Payor, Geography and Age

The Behavioral Health Care Spending estimates for calendar year 2021-2023 shown in Table 1 and Figure 1 of this report reflect behavioral health care payments as a percentage of total medical payments by type of payor. Estimates reflect payments including claims, non-claims and supplemental data reported to the MHDO per the requirements in 90-590 Chapter 243, *Uniform Reporting System for Health Care Claims Data Sets*, in addition to non-claims-based payments and supplemental data as defined in Chapter 247, *Uniform Reporting System for Non-Claims Based Payments and Other Supplemental Health Care Data Sets.* Non-claims-based means payments that are for something other than a fee-for-service claim. Some examples include Capitation Payments, Care Management/Care Coordination/Population Health Payments, and Pay-for-Performance Payments. Further examples of non-claims-based payments can be found in Attachment D

Behavioral health care is defined in 24-A MRSA §6903, sub-§1-A, as "services to treat mental health and substance use conditions". To operationalize this definition in the analysis of the MHDO claims data, MQF further defines behavioral health as a claim in the MHDO's all-payor claims data or the MaineCare data repository that has one of the following:[**] *(Attachment D)*

- A primary diagnosis indicating that the purpose of the treatment was to address a behavioral health issue as defined by Substance Abuse and Mental Health Services Administration (SAMHSA) criteria or
- All services delivered by a provider taxonomy (rendering or billing) whose claims are "primarily" for the treatment of mental health or substance use conditions. "Primarily" is defined as when 70% or more of the provider's claims payments in the last four years of MHDO data had a behavioral health condition listed as the primary diagnosis.

Based on feedback from the MQF Behavioral Health Spending Advisory Committee and SAMHSA definitions of behavioral health conditions, Dementia and Intellectual and Developmental Disabilities are excluded from MQF's definition of behavioral health diagnoses. A detailed list of diagnoses and provider taxonomy codes used to identify behavioral health services can be found in *Attachment E*.[††]

In reviewing data in this report and estimates in Figure 1 and Table 1, note the following caveats:

- Estimates are based on claims and non-claims data reported to MHDO, which include all MaineCare members, all Medicare members (both Medicare Advantage and Original Medicare), and approximately 73% of commercially insured members[‡‡] in the State of Maine.[§§]
- Commercial/SEHC/MEABT[***] Supplemental SUD non-claims payments are payments reported in aggregate by commercial plans that redact SUD from their claims submissions to MHDO per their

[††] See *Attachment E* for a list of behavioral health diagnoses and provider taxonomies whose services are primarily behavioral health related. The list of ICD-10 diagnosis codes considered behavioral health was compiled from multiple sources and cross-referenced with Substance Abuse and Mental Health Services Administration's (SAMHSA) criteria for behavioral health conditions. The ICD-10 coding system groups most behavioral health diagnoses into the series of codes starting with F.

[‡‡]Commercially insured members in MHDO's APCD include non-ERISA self-insured plans and ERISA self-insured plans that voluntarily submit their data to MHDO.

[§§] MaineCare claims estimates are based on data directly accessed through the USM MaineCare data repository to assist MQF in developing mandated legislative Behavioral Health reports through a Memorandum of Understanding between the Department and USM.

[***] Maine Education Association Benefits Trust (MEABT) is a benefit plan that provides health insurance to Maine public school employees and their families. State Employees Health Commission (SEHC) is a health insurance plan that provides

interpretation of the federal rule, 42 CFR Part 2. All supplemental Substance Use Disorder (SUD) non-claims payments reported to MHDO by commercial payors (including those by the SEHC, MEABT, and Medicare Advantage plans) are considered behavioral health care payments.

- MaineCare **claims** estimates in this report are based on data directly accessed through USM MaineCare data repository that include claims for SUD MaineCare non-claims payments in 2023 are based on data reported to MHDO and did not include LTSS.[†††] For a listing of what MaineCare considers LTSS, see *Attachment D* - Table 9.
- Medicare estimates include both original Medicare and Medicare Advantage payments. Original Medicare claims include SUD-related payments. The reported non-claims payments and supplemental SUD non-claims payments for Medicare reflect only those reported by Medicare Advantage plans.
- Absolute $s All payments shown in Table 1 are presented in millions (M) and billions (B). For example, $500,000,000 equals $500 (M) million dollars; $2,500,000,000 equals $2.5 (B) billion dollars.

Table 1 shows the total medical and behavioral health care payments by payor and the percentage of behavioral health care spending in total and for claims, non-claims and supplemental SUD non-claims payments.

- Total claims payments for behavioral health increased for all major payors across the three-year period, particularly for MaineCare (includes SUD).
- Total non-claims-based payments reported to MHDO for all payor categories in CY 2023 were $750M ($689M for MaineCare, $30M for Medicare Advantage, and $30M for commercial payors).
- Of 2023 total non-claims-based payments, behavioral healthcare-related payments represented $8M or 25.1% of total non-claims payments for commercial payors (up from 19.6% in 2022) and $262M or 38% of MaineCare's total non-claims (up from 28.4% - 32.2% in 2022).
- Supplemental SUD non-claims payments not reported in claims by commercial plans was $77 million in 2023 representing 43% of total commercial behavioral health payments ($178M).
- Year- to- year differences in behavioral health care spending levels relative to total medical spending may be due to changes in enrollment and/or changes in the health needs of the insured members (see, e.g., Table 2 for changes in member enrollment and behavioral health care utilization).

health insurance for employees of Maine State Government. The legislation requires that spending for these two plans be reported.

[†††] 2021 and 2022 non-claims data included LTSS, which to be comparable to other payors, we removed an estimated portion of in those years and presented as a range. For more details see Attachment D.

Table 1. Total Medical and Behavioral Health Care Payments (Claims Payments, Non-Claims Payments and SUD Non-Claims Payments) and Percent Behavioral Health Care Spending by Payor, CY 2021-2023

Payor Category	CY 2021			CY 2022			CY 2023		
	Total Reported Dollars (M millions B Billions)	Behavioral Health Care (M Millions)	% Behavioral Health Care	Total Reported Dollars (M Millions B Billions)	Behavioral Health Care (M Millions)	% Behavioral Health Care	Total Reported Dollars (M Millions B Billions)	Behavioral Health Care (M Millions)	% Behavioral Health Care
Commercial									
Claims	$1.98B	$83M	4.2%	$2.02B	$88M	4.3%	$2.04B	$93M	4.6%
Non-claims	$40M	$6M	13.9%	$34M	$7M	19.6%	$30M	$8M	25.1%
SUD non-claims	$64M	$64M	100.0%*	$76M	$76M	100.0%*	$77M	$77M	100.0%*
Total Payments	$2.09B	$153M	7.3%	$2.13B	$171M	8.0%	$2.15B	$178M	8.3%
SEHC									
Claims	$162M	$7M	4.2%	$155M	$7M	4.3%	$171M	$8M	4.9%
Non-claims	$1M	$0M	0.0%	$2M	$0M	0.0%	$1M	$0M	0.0%
SUD non-claims	$5M	$5M	100.0%*	$6M	$6M	100.0%*	$7M	$7M	100.0%*
Total Payments	$168M	$12M	7.0%	$162M	$12M	7.6%	$179M	$15M	8.5%
MEABT									
Claims	$320M	$16M	5.1%	$323M	$16M	5.1%	$352M	$20M	5.7%
Non-claims	$3M	$0M	0.0%	$3M	$0M	0.0%	$3M	$0M	0.0%
SUD non-claims	$9M	$9M	100.0%*	$11M	$11M	100.0%*	$11M	$11M	100.0%*
Total Payments	$332M	$25M	7.5%	$337M	$27M	8.1%	$366M	$31M	8.5%
MaineCare									
Claims^^	$1.40B	$452M	32.4%	$1.48B	$499M	33.8%	$1.66B	568M	34.2%
Non-claims	$573 - $649^M	$168M	25.8% - 29.3%	$640-$726^M	$206M	28.4%-32.2%	$689M	$262M	38.0%
SUD non-claims^^	Included in claims	Included in claims		Included in claims	Included in claims		Included in claims	Included in claims	
Total Payments	$1.97 - $2.05B	$620M	30.3% - 31.5%	$2.12-$2.20B	$705M	32.0-33.3%	$2.35B	$830M	35.3%

Payor Category	CY 2021			CY 2022			CY 2023		
	Total Reported Dollars (M millions B Billions)	Behavioral Health Care (M Millions)	% Behavioral Health Care	Total Reported Dollars (M Millions B Billions)	Behavioral Health Care (M Millions)	% Behavioral Health Care	Total Reported Dollars (M Millions B Billions)	Behavioral Health Care (M Millions)	% Behavioral Health Care
Medicare (Original and Medicare Advantage)**									
Claims	$3.15B	$86M	2.7%	$3.24B	$84M	2.6%	$3.46B	$91M	2.6%
Non-claims	$1M	$0M	0.0%	$24M	$5M	19.7%	$30M	$7M	22.4%
SUD non-claims	$19M	$19M	100.0%*	$24M	$24M	100.0%*	$25M	$25M	100.0%*
Total Payments	$3.17B	$105M	3.3%	$3.29B	$112M	3.4%	$3.5B	$123M	3.5%
Total (Commercial, MaineCare, Medicare)‡									
Claims	$6.53B	$622M	9.5%	$6.74B	$671M	9.9%	$7.16B	$752M	10.5%
Non-claims	$614-$690M	$173M	25.1%-28.2%	$698-$784M	$218M	27.8%-31.2%	$750M	$276M	36.9%
SUD non-claims	$83M	$83M	100.0%	$100M	$100M	100.0%	$102M	$102M	100.0%
Total Payments	$7.23-$7.30B	$878M	12.0%-12.2%	$7.54-$7.62B	$988M	13.0%-13.1%	$8.01B	$1.13B	14.1%

Data Sources: MHDO 2021-2023 APCD claims data, non-claims-based and supplemental SUD non-claims payments, MaineCare claims data in USM MaineCare data repository (includes SUD).
SEHC = State Employee Health Commission; MEABT = Maine Education Association Benefits Trust; SEHC and MEABT are reported separately as required by PL Chapter 603 and are also included in the Commercial payor category.

* SUD aggregate non-claims payments are reported by commercial and Medicare Advantage plans that redact SUD from their claims submissions to MHDO per their interpretation of the federal rule, 42 CFR Part 2. All supplemental SUD non-claims payments are for the treatment of substance use conditions included in this report's definition of Behavioral Health.

^ The total non-claims information reported by MaineCare in 2023 under Chapter 247 excluded payments for long term services and supports (LTSS). In 2021 and 2022, MaineCare non-claims included LTSS, that to have estimates comparable to other payors in these years, we removed an estimated portion of MaineCare total non-claims payments for LTSS and reported as a range.

^^ MaineCare SUD payments are included in claims.

**Medicare estimates include both original and Medicare Advantage claims payments. For Original Medicare SUD claims are included in claims payments. Original Medicare is not subject to requirements in Chapter 247 reporting requirements for non-claims payments. Medicare non-claims and SUD non-claims payments are only for Medicare Advantage plans reporting to MHDO.

‡ Totals reflect the sum of the payors reporting data to MHDO, which includes public payors and the majority of commercial payors and does not reflect total behavioral health care and healthcare spending in the state.

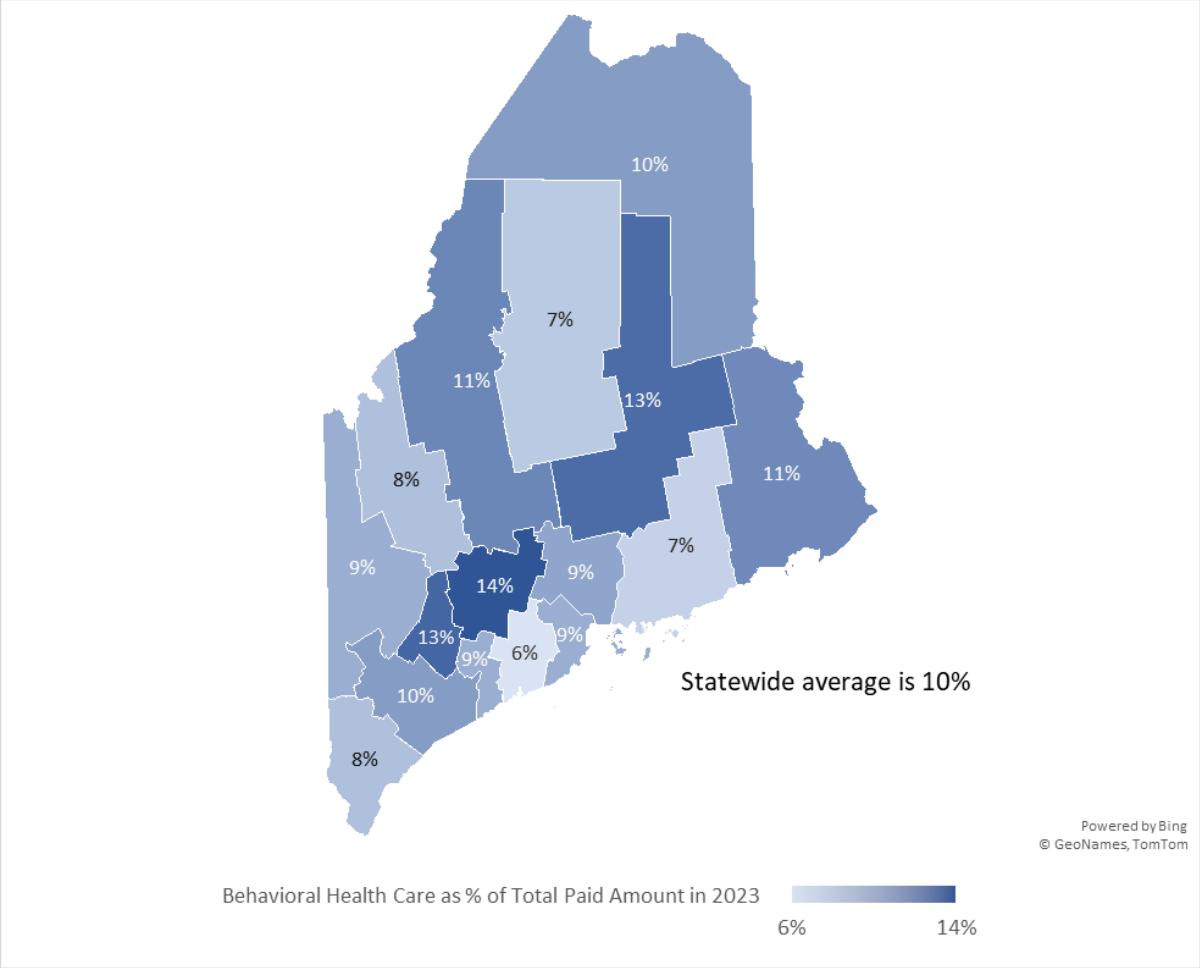
Geographic Variation in Behavioral Health Care Claims Spending (Revised)

Figure 2 shows behavioral health care payments as a percent of **claims** payments only in 2023 (MHDO's non-claims and supplemental SUD non-claims payments are not included in this analysis).

In 2023, the percentage of behavioral health claims spending varied by county, from a low of 6% in Lincoln County to a high of 14% in Kennebec County. The statewide average is 10%. Variations in spending may be due to differences in county demographics, behavioral health needs and/or access to behavioral health providers.

See *Attachment A* for information by health insurance rating area. See *Attachment A* Table 4 and Figure 7 for the percent of behavioral health care spending by payor for member residence county and health insurance rating area.

Figure 2. Percent of Behavioral Health Care Medical Paid Amount by County of Member Residence, 2023



Data Source: MHDO 2023 APCD claims data and USM MaineCare data repository (includes SUD). Non-claims and supplemental SUD non-claims payments from Commercial and Medicare Advantage are not included.

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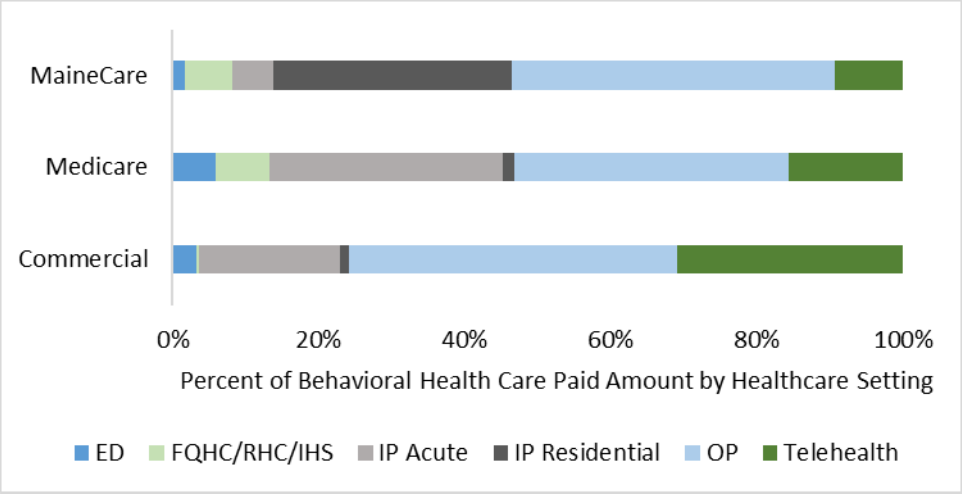
Behavioral Health Care Claims Spending by Healthcare Setting

As a new analysis in this year's report, at the request of the BH Advisory Committee, we examined payors' behavioral health claims payments by the healthcare setting in which services were delivered. Settings and modalities were defined as behavioral health services provided in inpatient acute, residential inpatient, emergency department, federally qualified health centers/rural health centers and Indian Health Services, outpatient settings (e.g. medical offices, private practice, community mental health) and care provided via telehealth.

At the request of the Advisory Committee, we separately assessed behavioral health payments for crisis services provided during a psychiatric emergency to ameliorate and stabilize the person experiencing extreme emotional disturbances to ensure safety. These services may be provided in an office, emergency department, inpatient residential setting or on scene in the member's home, school, street/mobile clinic or emergency shelter and as such, were analyzed separately from health care settings. Crisis services represented a small percentage of total behavioral health spending accounting for 4% of MaineCare total behavioral health payments, 2% of commercial payors (2%) and 0% of Medicare. See Attachment D for more details on how crisis services were defined.

As shown in Figure 3, outpatient behavioral health settings accounted for the highest percentage of behavioral health care payments for all three payors in 2023 (approximately, 45% for Commercial, 44% for MaineCare, and 38% for Medicare). However, the treatment types that behavioral health payments supported varied significantly by payer. Payments for Inpatient residential settings by MaineCare accounted for approximately 33% of total behavioral health payments, compared to only 2% of Medicare and 1% of commercial insurers. For MaineCare, 6% of total behavioral health spending was for inpatient acute care, compared to 19% of commercial and 32% of Medicare. For commercial insurers, telehealth accounted for 31% of total non-crisis behavioral health payments included in claims. Differences between payors may reflect differences in the health needs of their members and/or the behavioral health services that are covered.

Figure 3. Percent Behavioral Health Care Payments of Total Medical Claims Paid Amount, by Healthcare Setting and Payor, 2023



Data Source: MHDO 2023 APCD claims data and USM MaineCare data repository (includes SUD). Non-claims and supplemental SUD non-claims payments from Commercial and Medicare Advantage are not included. Crisis services are excluded from this analysis.

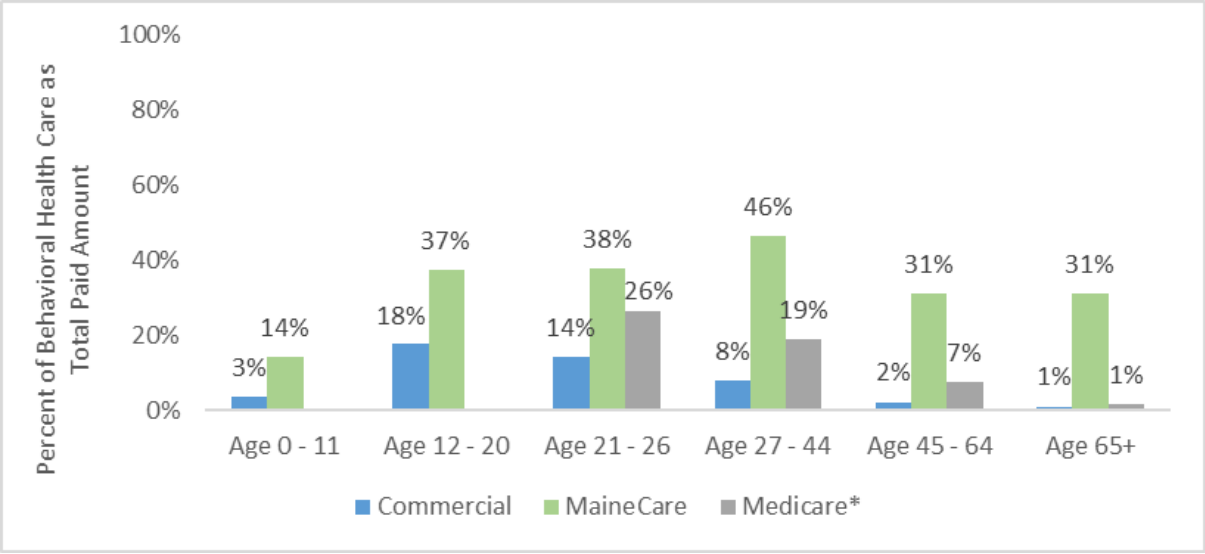
ED=Emergency Department
FQHC/RHC=Federally Qualified Healthcare Center/Rural Health Center/ Indian Health Service
IP Acute= Inpatient Acute
IP Residential=Inpatient Residential
OP=Outpatient

Percent of Behavioral Health Care Claims Spending by Age and Payor

We examined the percent of behavioral health care of total medical spending by age group – defined in six age categories (0-11, 12-20, 21-26, 27-44, 45-64, 65+).* For each of these age groups we measured their behavioral health claims spending (numerator) as a percentage of overall medical claims spending (denominator).

As shown in Figure 4, behavioral health care as a percentage of total medical claims payments was highest for MaineCare both overall and for every age group. By age, the share of total MaineCare claims paid amounts for behavioral health care was highest for individuals ages 27-44 (46%), ages 21-26 (38%), and ages 12-20 (37%). For Medicare, the behavioral health spending rates were highest for individuals ages 21-26 (26%) and ages 27-44 (19%). Commercial behavioral health spending in claims was highest for individuals 12-20 (18%) and age 21-26 (14%).

Figure 4. Percent Behavioral Health Care Payments of Total Medical Claims Paid Amount, by Age and Payor, 2023



*Medicare covers persons aged 65+ and persons under 65 who qualify for Medicare based on their condition (e.g. disability, End-Stage Renal Disease, or ALS). Medicare payment estimates for age groups 0-11 and 12-20 were suppressed due to small cell sizes.

Data Source: MHDO 2023 APCD claims data and USM MaineCare data repository (includes SUD). Non-claims and supplemental SUD non-claims payments from Commercial and Medicare Advantage are not included.

Part II: Utilization of Behavioral Health Care Services

Percent of Insured Members with Behavioral Health Care Claims by Payor (Revised)

Various factors contribute to variations in behavioral health claims spending by payor including changes in the number of insured members enrolled and utilization of behavioral health services. To assess how behavioral health care utilization has changed, we examined the proportion of insured members who accessed behavioral health care (defined as having at least one behavioral health claim (identified by diagnosis or provider taxonomy code) with a service date in 2021, 2022, and 2023. For this year's report, insured members who were insured by more than one payor or members whose primary payor changed during the year are counted only once per year under the payor that was their primary medical insurer in the latest month of the year in which the person was enrolled/insured. See *Attachment E* for more details on this revised method.[‡‡‡]

Table 2 shows the total insured members by payor category and the percentage of members that had at least one behavioral health claim within the year. The percentage of members accessing behavioral health care services remained relatively consistent over time by payor. In 2023, 29% of members eligible for MaineCare, 17% of commercially insured members and 17% of Medicare members insured had at least one behavioral health care claim. Commercial estimates may be understated because supplemental SUD non-claims payments are not included in claims data.

[‡‡‡] Given this change in methods, enrollment and utilization results differ from the prior behavioral health spending report.

Table 2. Percent of Insured Members with at Least One Behavioral Health Care Claim, by Payor, 2021-2023

	2021			2022			2023		
Payor	Members with a Behavioral Health Claim	Insured Members	% Members Utilizing Behavioral Health	Members with a Behavioral Health Claim	Insured Members	% Members Utilizing Behavioral Health	Members with a Behavioral Health Claim	Insured Members	% Members Utilizing Behavioral Health
Commercial	69,669	407,092	17%	69,685	401,762	17%	64,291	369,283	17%
MaineCare	81,039	293,512	28%	82,609	271,714	30%	84,240	287,372	29%
Medicare	66,220	393,024	17%	67,839	402,885	17%	72,237	414,443	17%

Data Source: MHDO 2021-2023 APCD claims data and USM MaineCare data repository (includes SUD). Non-claims and supplemental SUD non-claims payments reported from Commercial and Medicare Advantage plans are not included.

* Insured members are de-duplicated and only counted once in the primary payor in which they were enrolled in the latest month of the calendar year. Enrolled members for MaineCare exclude dually eligible members or those with third party primary commercial coverage, who are included in Medicare or commercial enrollment as the primary payor.

Behavioral health care utilization varied across counties Table 3 shows members who had at least one behavioral health claim by county and rating area in 2023. Cumberland, Androscoggin, and Sagadahoc had the highest behavioral health care use across payors while Piscataquis had lower overall utilization of behavioral health care. Maps showing this data by payor and county can be found in *Attachment A – Figures 9, 10, 11*.

Table 3. Percent of Insured Members with at Least One Behavioral Health Care Claim by Member County of Residence and Health Insurance Rating Area by Payor, 2023

Health Insurance Rating Area	County Name	Commercial	MaineCare	Medicare
Rating Area 1	Cumberland	20%	27%	19%
	Sagadahoc	18%	30%	16%
	York	17%	29%	16%
Rating Area 1 Total		**19%**	**28%**	**17%**
Rating Area 2	Kennebec	17%	32%	20%
	Knox	16%	29%	15%
	Lincoln	17%	26%	14%
	Oxford	15%	31%	16%
Rating Area 2 Total		**17%**	**31%**	31%
Rating Area 3	Androscoggin	18%	29%	21%
	Franklin	15%	27%	15%
	Waldo	17%	29%	15%
Rating Area 3 Total		**17%**	**29%**	**20%**
Rating Area 4	Penobscot	17%	32%	20%
	Piscataquis	13%	22%	15%
	Somerset	13%	28%	17%
Rating Area 4 Total		**15%**	**30%**	**16%**
Rating Area 5	Aroostook	13%	36%	17%
	Hancock	17%	30%	16%
	Washington	16%	27%	16%
Rating Area 5 Total		**15%**	**32%**	**17%**

Data Source: MHDO 2023 APCD claims data and USM MaineCare data repository (includes SUD).

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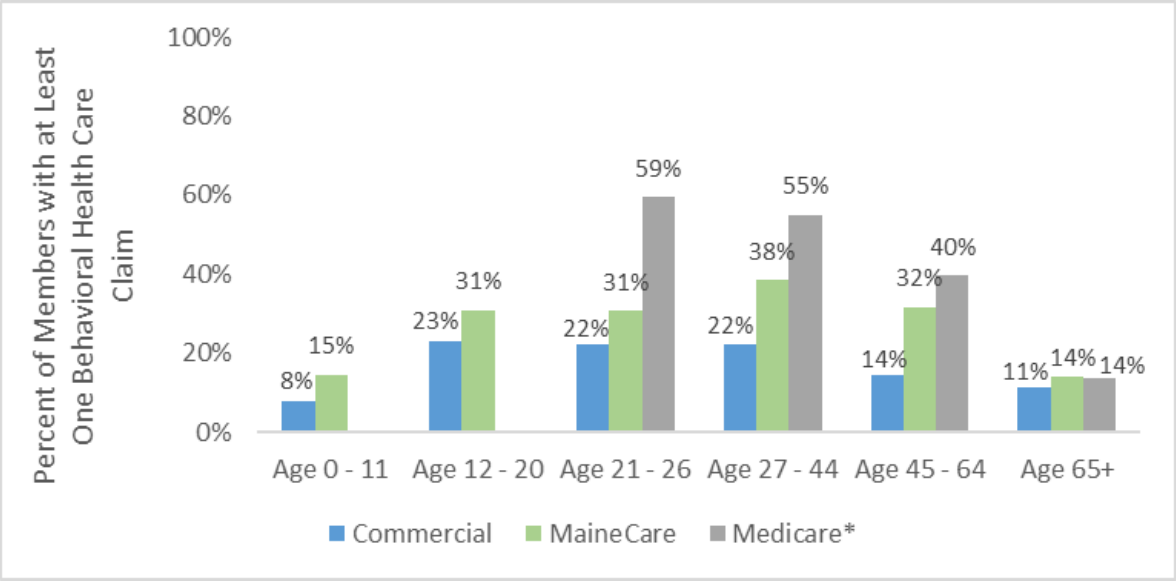
Figure 5 shows the differences in behavioral health care use by age group. Medicare had the highest percentage of members aged 21-26 with at least one behavioral health claim (approximately 60%). Among people with commercial insurance, children ages 0-11 had the lowest percentage of members with at least one behavioral health claim (approximately 8%). Among commercial members, adults ages 65 and older had the lowest percentage of members with at least one behavioral health claim (approximately 11%). For more information, see *Attachment A – Table 7.*

Figure 5. Percent of Insured Members with at Least One Behavioral Health Care Claim by Payor and Age Group, 2023



* Medicare is generally the primary payor for persons aged 65+ but also is for persons under 65 who qualify for Medicare based on their condition (e.g. disability, End-Stage Renal Disease, or ALS). Medicare members under 65 include persons dually-eligible for Medicare, which is the primary payor, with MaineCare as the secondary payor. Medicare estimates for age groups 0-11 and 12-20 were suppressed due to small cell sizes.

Data Source: MHDO 2023 APCD claims data and USM MaineCare data repository (includes SUD).

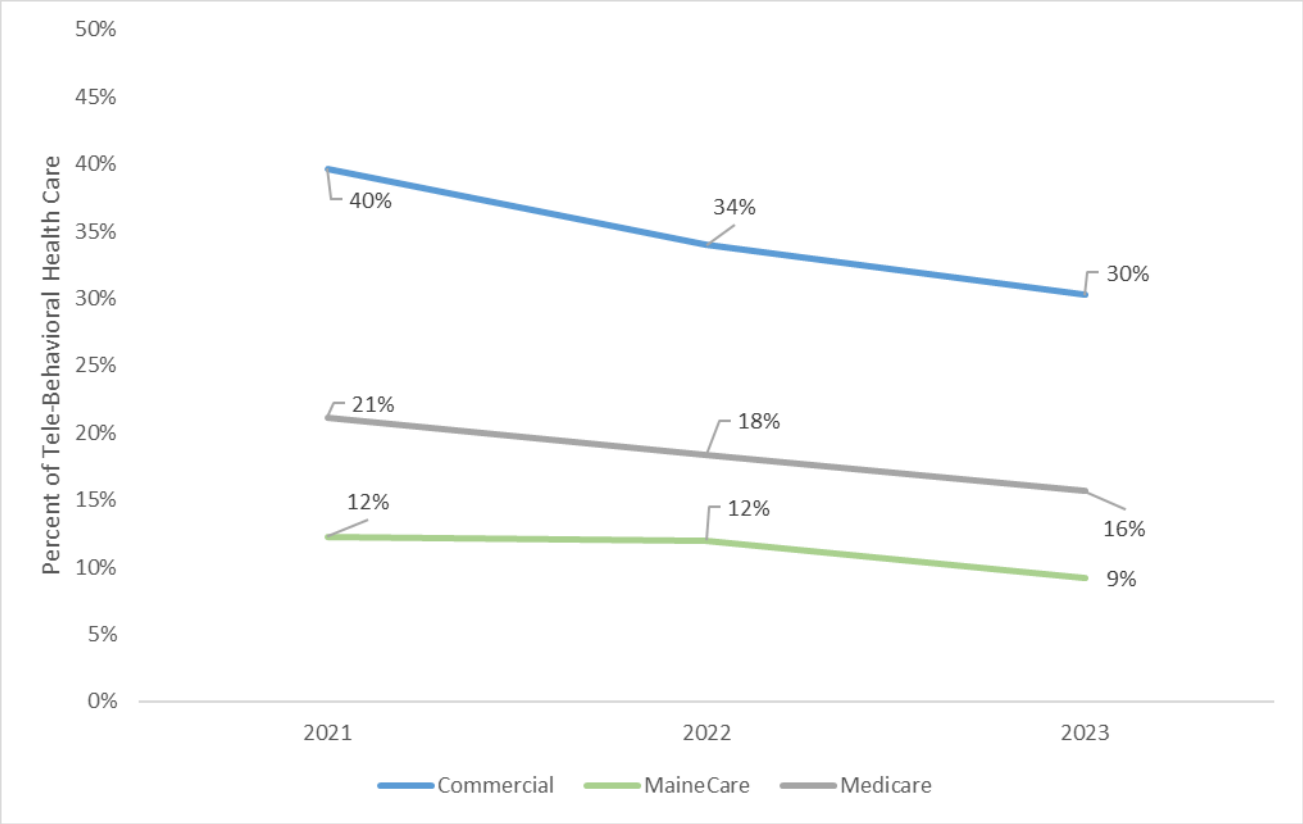
Part III: Telehealth and Consumer Cost Share Analysis

Tele-Behavioral Health Care Claims Analysis

For the purposes of this report, we have defined telehealth broadly to encompass telecommunication technologies used to provide health services from a distance: Thus, we include video/audio conferencing from a patient's home or medical office/facility, remote patient monitoring, and provider communications/E-consults. See *Attachment D* for the full list of telehealth procedure codes included.

From 2021 to 2023, there has been a decline in behavioral health care payments for tele-behavioral health for all payors (Commercial, MaineCare, and Medicare). Commercial payor behavioral health care payments (excluding SUD redacted claims) for tele-behavioral health care have declined (from 40% to 30%), Medicare (from 21% to 16%) and MaineCare (from 12% to 9%). Declines in tele-behavioral health care payments for commercial payors are consistent with national trends and may be associated with changes in COVID tele-behavioral health care payment policies.

Figure 6. Tele-Behavioral Health as a Percent of Behavioral Health Care Paid Amount, 2021-2023



Data Source: MHDO 2021-2023 APCD claims data and USM's MaineCare data repository (includes SUD). Non-claims and supplemental SUD non-claims payments from Commercial and Medicare Advantage are not included.

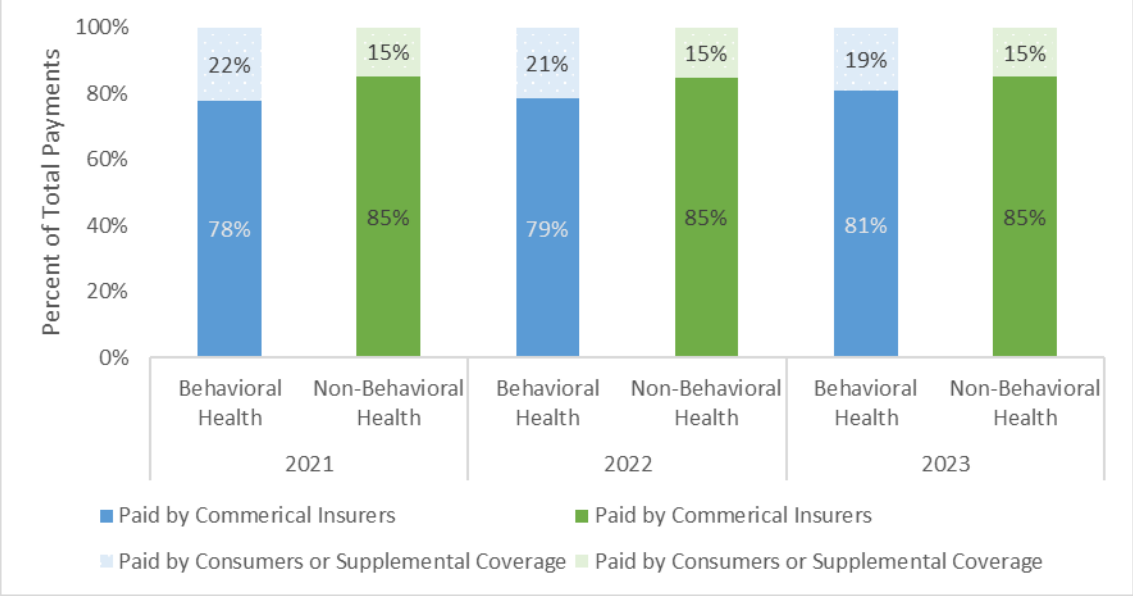
Maps showing the percentage of behavioral health care utilization delivered via telehealth by member county of residence in Maine and by health insurance rating area for 2023 are included in *Attachment A – Figures 12, 13, 14*. There was considerable variation across counties in tele-behavioral health care utilization. While some counties, such as Piscataquis, had higher percentages in each payor category, other counties, like Aroostook, showed variations across payors. Additionally, the findings indicate that commercial beneficiaries tended to have a higher percentage of spending for behavioral health care delivered via telehealth compared to MaineCare and Medicare beneficiaries in all counties. A table showing this information by health insurance rating areas is included in *Attachment A – Table 8*.

Commercial Payors' Share and Consumer Payments for Behavioral Health Care and All Other Medical Expenditure

Figure 7 reflects how claims payments for behavioral health care and non-behavioral health care medical expenditures reported in MHDO claims data are shared between commercial payors and the consumer (including consumer's supplemental coverage). This analysis is based on the consumer's cost share in the commercial category as a portion of total allowed amounts (commercial payor paid amounts plus consumer cost share amounts).

- In 2023, commercial payors paid approximately 81% of the total behavioral health care claims payments, while approximately 19% was paid out-of-pocket by consumers (or their supplemental coverage).
- The consumers' share of commercial behavioral health care payments (19%) is higher than the share paid for other medical non-behavioral health care services (15%).
- However, the share of behavioral health care payments paid by consumers with commercial insurance (or supplemental coverage plans) has decreased from 22% in 2021 to 19% in 2023.

Figure 7. Percent of Total Medical Payments Paid by Commercial Payors and Consumers or Supplemental Coverage Plans for Behavioral Health Care and Non-Behavioral Health Care Payments, 2021-2023*



Data Source: MHDO 2021-2023 APCD claims data

*Member share of the redacted SUD data not available for inclusion in this analysis.

Conclusions and Future Considerations

This third annual report on behavioral health spending adds an additional year of data (CY 2023) and reveals that on average, for the three categories of payors combined (Commercial, MaineCare and Medicare), behavioral health care spending as a percent of total spending has increased from approximately 12% in 2021 to 14% in 2023. Compared to 2022, the percentage of behavioral health care spending as a share of total medical payments remained relatively flat in 2023 for Commercial and Medicare and increased for MaineCare (from approximately 33% to 35%), which was the primary contributor to the increase in the overall behavioral health spending rate in the state.

As noted in prior annual reports, understanding why behavioral health care spending varies between payors as a percent of total spending requires more research. A variety of factors can contribute to both changes in behavioral health (numerator) and non-behavioral medical spending (denominator) including but not limited to improvements in the data allowing greater precision in identifying providers and service settings, within payor changes in provider reimbursement or billing practices, service price and intensity, or changes in enrollment, service use, demographics (i.e., age, gender, rural/urban residence), and behavioral health needs among insured members.

This report expanded prior analyses of how member enrollment, utilization, and county variations in behavioral health spending might be contributing to changes in behavioral health spending. In consultation with MQF's Behavioral Health Spending Advisory Committee, we added claims analyses to assess the percent of behavioral health spending by healthcare setting and spending/utilization/tele-behavioral health use by geography (county and rating area), and age. These more detailed analyses reveal that behavioral health care spending rates vary both by county and by age group both between and within payors, suggesting that demographic differences and service needs of enrolled members in different payors and differences in the and/or other behavioral health services covered or available (i.e. telehealth adoption) may also be affecting variations in behavioral health spending and access across the state.

The Maine Health Data Organization (MHDO) adopted revisions to 90-590 Chapter 243, *Uniform Reporting System for Health Care Claims Data Sets*, that go into effect in January 2025 and require payors to include de-identified SUD data in their claims submissions to MHDO. This change will allow for more precise, granular analyses.

How these and other factors contribute to shifts in behavioral health or total spending requires further research and analysis. Future reports may want to explore other metrics (e.g. workforce capacity and access) that could be useful for policymakers.

We welcome the opportunity to discuss how to refocus this level of reporting to better support policy discussions specific to improving access to affordable, quality behavioral health services in the state of Maine.

Attachments: Supporting Documentation

A. Additional Tables and Figures

B. Public Law Chapter 603

C. Review of Behavioral Health Care Reports and Studies

D. Methodology for Estimating Behavioral Health Care Spending

E. Codes Used in Behavioral Health Spending Analyses

F. Endnotes

Attachment A (Revised) Additional Tables and Figures

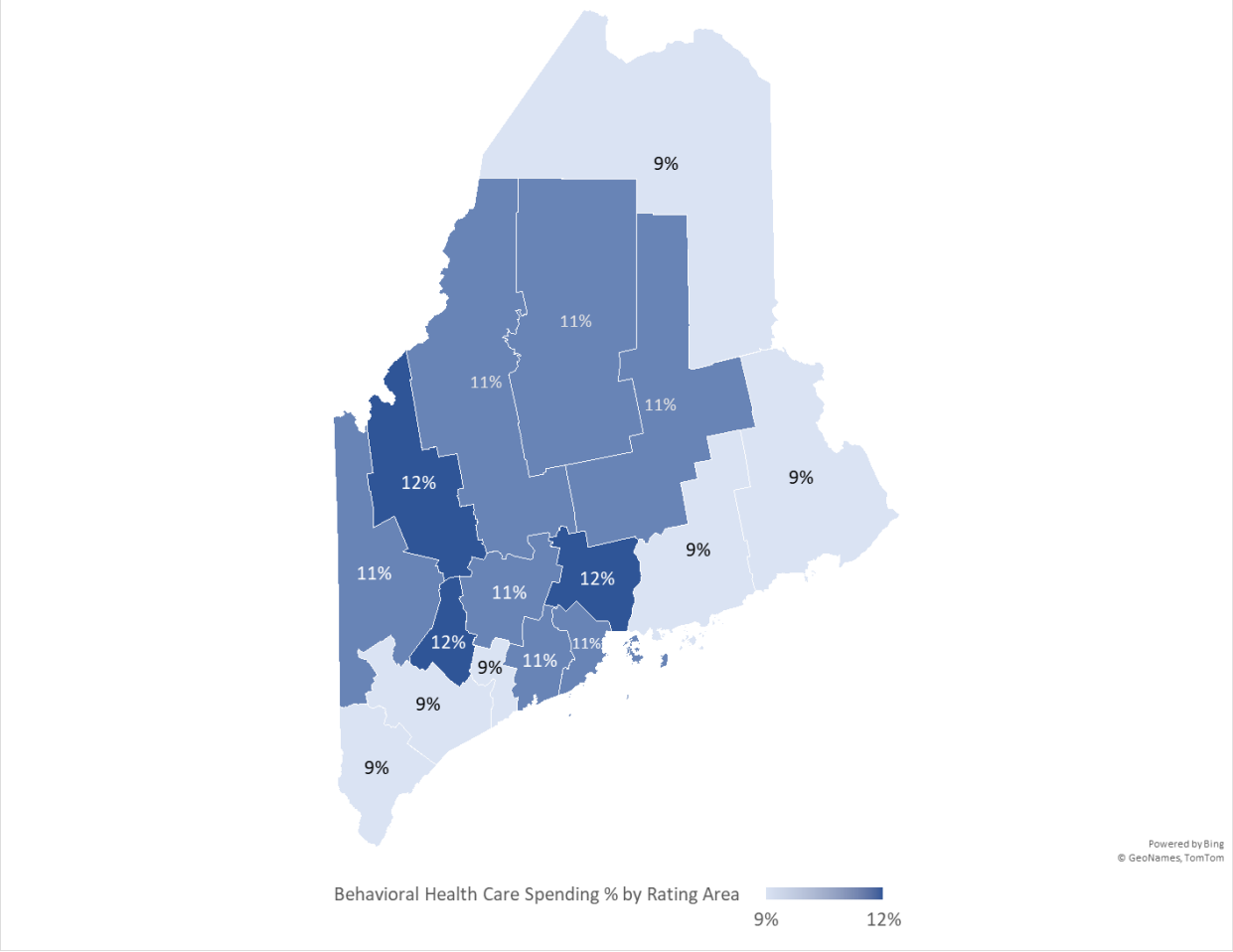
Table 4. Percent of Behavioral Health Care Payments of Total Medical Paid Amount, by County and Health Insurance Rating Area, 2023

Health Insurance Rating Area	County Name	Behavioral Health Care % Total
Rating Area 1	Cumberland	10%
	Sagadahoc	9%
	York	8%
Rating Area 1 Total		**9%**
Rating Area 2	Kennebec	14%
	Knox	9%
	Lincoln	6%
	Oxford	9%
Rating Area 2 Total		**11%**
Rating Area 3	Androscoggin	13%
	Franklin	8%
	Waldo	9%
Rating Area 3 Total		**9%**
Rating Area 4	Penobscot	13%
	Piscataquis	7%
	Somerset	11%
Rating Area 4 Total		**16%**
Rating Area 5	Aroostook	10%
	Hancock	11%
	Washington	11%
Rating Area 5 Total		**9%**
Maine Counties Average		**10%**

Data Source: MHDO 2023 APCD claims data and USM's MaineCare data repository (includes SUD). Non-claims and supplemental SUD non-claims payments from Commercial and Medicare Advantage are not included.

Revised November 2025

Figure 8. Percent Behavioral Health Care Payments of Total Medical Claims Paid Amount by Health Insurance Rating Area, 2023



Data Source: 2023 MHDO APCD claims data and USM's MaineCare data repository (includes SUD). Non-claims and supplemental SUD non-claims payments from Commercial and Medicare Advantage are not included.

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Table 5. Percent Behavioral Health Care Payments of Total Medical Claims Paid Amount, by Healthcare Setting and Payor, 2023

Age Group	Commercial	MaineCare	Medicare
ED	3%	2%	6%
FQHC/RHC/IHS	0.3%	6%	7%
IP Acute	19%	6%	32%
IP Residential	1%	33%	2%
OP	45%	44%	38%
Telehealth	31%	9%	16%

Data Source: 2023 MHDO APCD claims data and USM's MaineCare data repository (includes SUD). Non-claims and supplemental SUD non-claims payments from Commercial and Medicare Advantage are not included. Crisis services are excluded from the analysis.

Table 6. Percent Behavioral Health Care Payments of Total Medical Claims Paid Amount, by Age and Payor, 2023

Age Group	Commercial	MaineCare	Medicare
Age 0 - 11	3%	14%	-
Age 12 - 20	18%	37%	-
Age 21 - 26	14%	38%	26%
Age 27 - 44	8%	46%	19%
Age 45 - 64	2%	31%	7%
Age 65+	1%	31%	2%

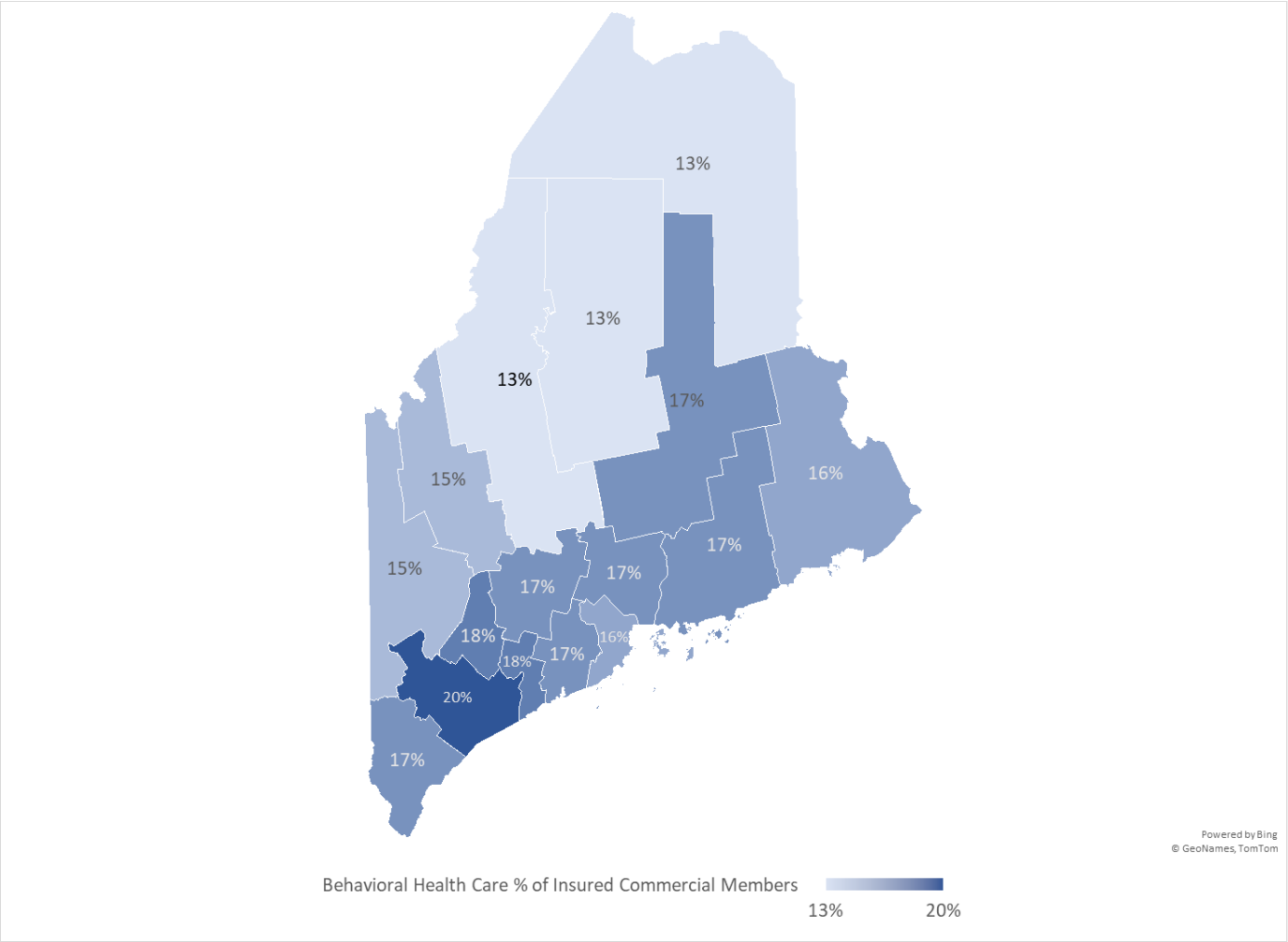
Data Source: 2023 MHDO APCD claims data and USM's MaineCare data repository (includes SUD). Non-claims and supplemental SUD non-claims payments from Commercial and Medicare Advantage are not included.
* Estimates for Medicare within age groups 0-11 and 12-20 were suppressed due to small cell sizes.

Table 7. Percent of Insured Members with at Least One Behavioral Health Care Claim by Payor and Age Group, 2023

Age Group	Commercial	MaineCare	Medicare
Age 0 - 11	8%	15%	-
Age 12 - 20	23%	31%	-
Age 21 - 26	22%	31%	60%
Age 27 - 44	22%	38%	55%
Age 45 - 64	14%	32%	40%
Age 65+	11%	14%	14%

Data Source: 2023 MHDO APCD claims data and USM's MaineCare data repository (includes SUD)
* Estimates for Medicare within age groups 0-11 and 12-20 were suppressed due to small cell sizes.

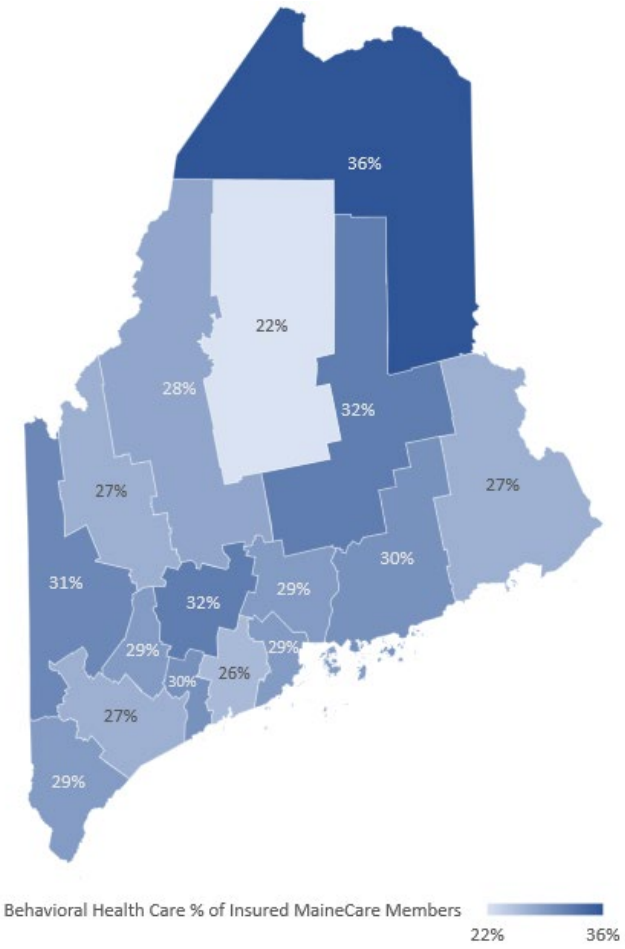
Figure 9. Commercial: Percent of Insured Members with at Least One Behavioral Health Care Claim by Member County of Residence, 2023



Data Source: 2023 MHDO APCD claims data

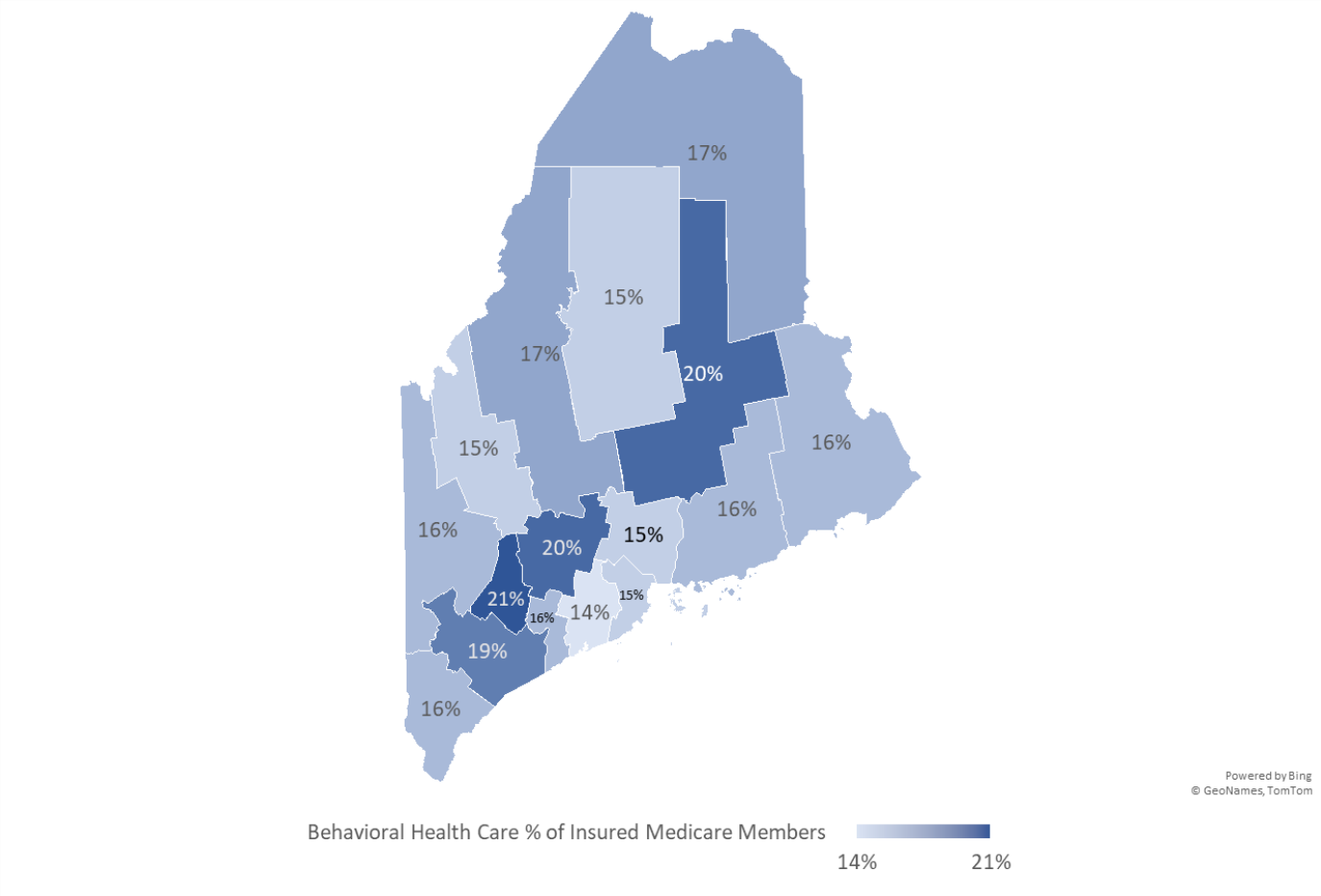
Revised November 2025

Figure 10. MaineCare: Percent of Insured Members with at Least One Behavioral Health Care Claim by Member County of Residence, 2023



Data Source: 2023 USM's MaineCare data repository (includes SUD)

Figure 11. Medicare: Percent of Insured Members with at Least One Behavioral Health Care Claim by Member County of Residence, 2023



Data Source: 2023 MHDO APCD claims data

Revised November 2025

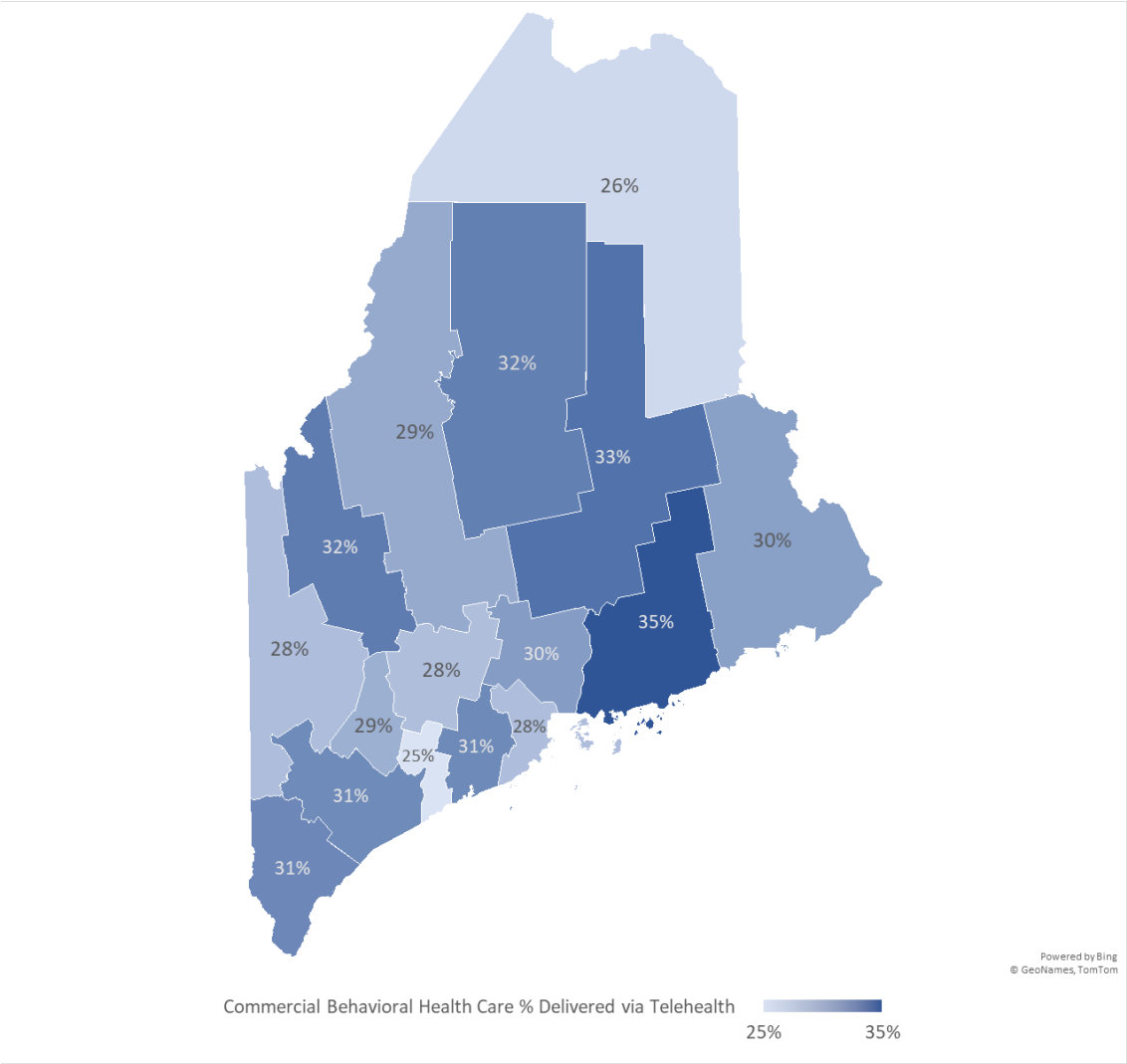
Table 8. Percent of Behavioral Health Care Paid Amount Delivered via Telehealth, 2023

Health Insurance Rating Area and County		Commercial	MaineCare	Medicare
Rating Area 1	Cumberland	31%	10%	16%
	Sagadahoc	25%	12%	17%
	York	31%	11%	17%
Rating Area 1 Total		**31%**	**9%**	**16%**
Rating Area 2	Kennebec	28%	8%	11%
	Knox	28%	10%	15%
	Lincoln	31%	15%	14%
	Oxford	28%	13%	14%
Rating Area 2 Total		**31%**	**8%**	**13%**
Rating Area 3	Androscoggin	29%	9%	17%
	Franklin	32%	12%	10%
	Waldo	30%	13%	16%
Rating Area 3 Total		**29%**	**9%**	**16%**
Rating Area 4	Penobscot	33%	12%	17%
	Piscataquis	32%	14%	26%
	Somerset	29%	10%	14%
Rating Area 4 Total		**32%**	**11%**	**17%**
Rating Area 5	Aroostook	26%	12%	16%
	Hancock	35%	15%	18%
	Washington	30%	7%	16%
Rating Area 5 Total		**31%**	**11%**	**17%**
Maine Counties Average		**31%**	**9%**	**16%**

Data Source: MHDO 2023 APCD claims data and USM's MaineCare data repository (includes SUD). Non-claims and supplemental SUD non-claims payments from Commercial and Medicare Advantage are not included.

Revised November 2025

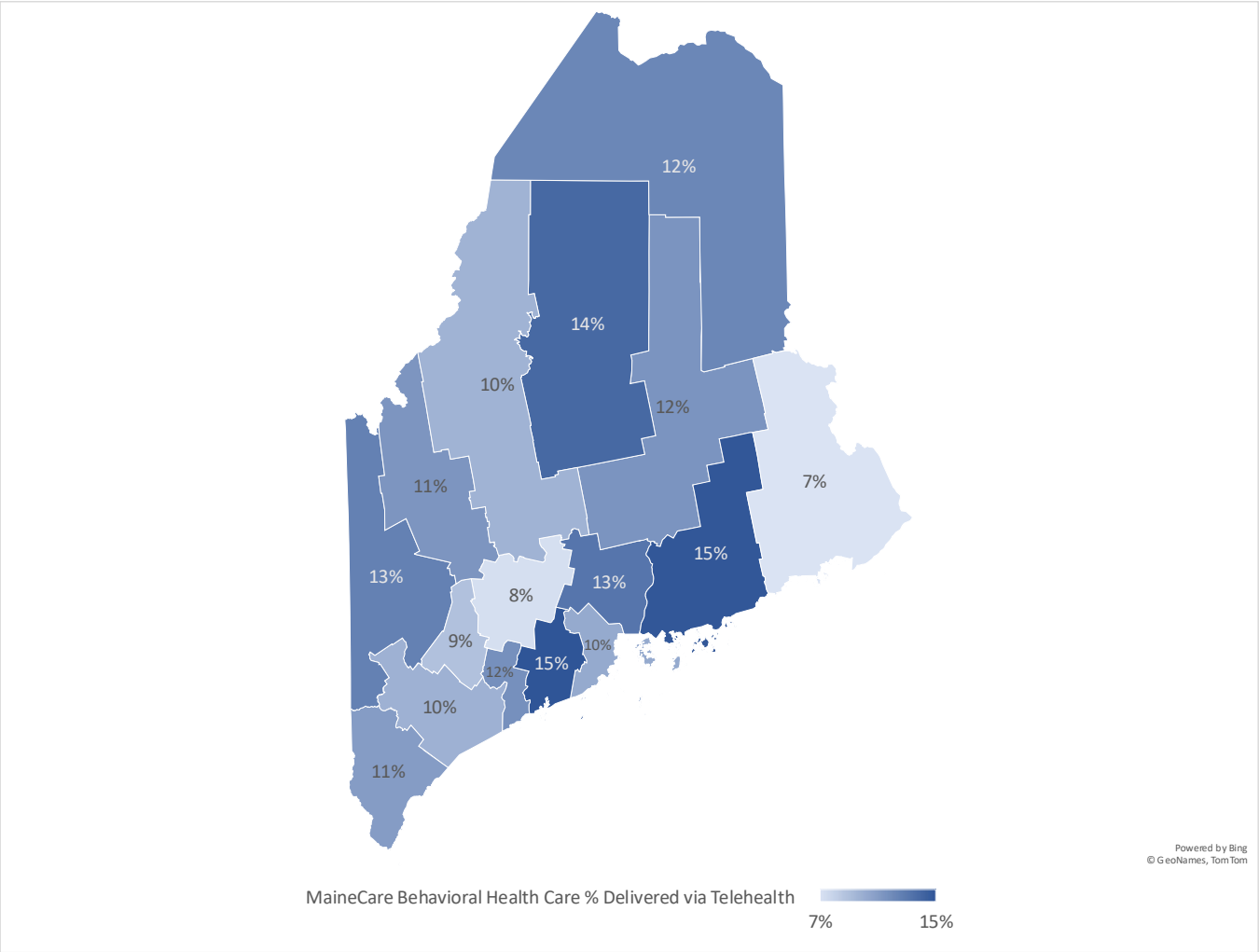
Figure 12. Commercial: Percent of Behavioral Health Care Paid Amount Delivered via Telehealth, 2023 by Member County of Residence



Data Source: 2023 MHDO APCD claims data

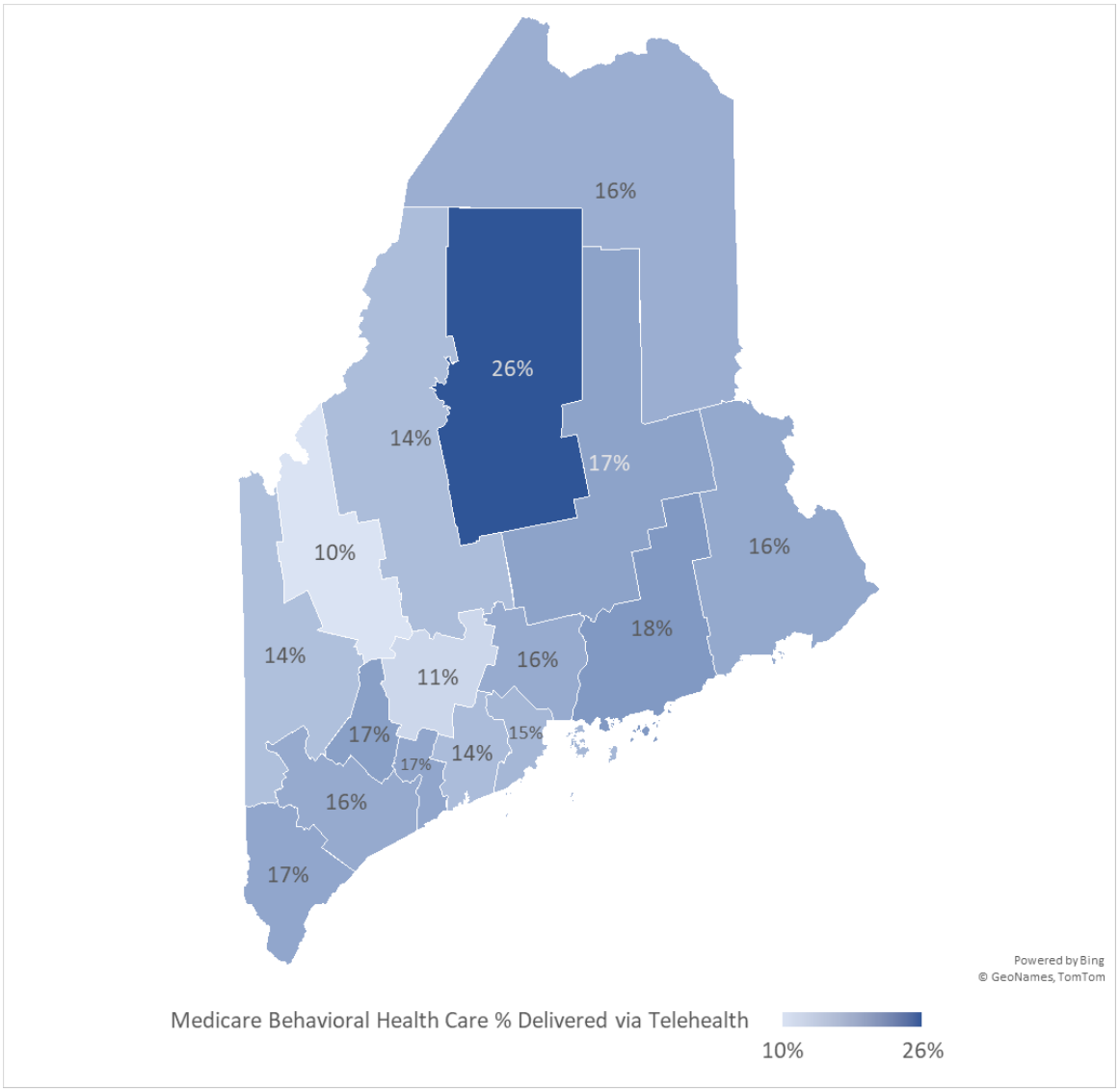
Revised November 2025

Figure 13. MaineCare: Percent of Behavioral Health Care Paid Amount Delivered via Telehealth, 2023 by Member County of Residence



Data Source: 2023 USM's MaineCare data repository (includes SUD)

Figure 14. Medicare: Percent of Behavioral Health Care Paid Amount Delivered via Telehealth, 2023 by Member County of Residence



Data Source: 2023 MHDO APCD claims data

Revised November 2025

Attachment B – Public Law Chapter 603

APPROVED	CHAPTER
APRIL 14, 2022	603
BY GOVERNOR	PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-TWO

H.P. 874 - L.D. 1196

An Act Regarding Reporting on Spending for Behavioral Health Care Services and To Clarify Requirements for Credentialing by Health Insurance Carriers

Be it enacted by the People of the State of Maine as follows:

PART A

Sec. A-1. 24-A MRSA §6903, sub-§1-A is enacted to read:

1-A. **Behavioral health care.** "Behavioral health care" means services to address mental health and substance use conditions.

Sec. A-2. 24-A MRSA §6951, sub-§13 is enacted to read:

13. **Behavioral health care reporting.** Beginning January 15, 2023 and annually thereafter, the forum shall submit to the Department of Health and Human Services and the joint standing committee of the Legislature having jurisdiction over health coverage and health insurance matters a report on behavioral health care spending using claims data from the Maine Health Data Organization and information on the methods used to reimburse behavioral health care providers requested annually from payors. As used in this subsection, "payor" has the same meaning as in Title 22, section 8702, subsection 8. The report must include:

A. Of their respective total medical expenditures, the percentage paid for behavioral health care by commercial insurers, the MaineCare program, Medicare, the organization that administers health insurance for state employees and the Maine Education Association benefits trust and the average percentage of total medical expenditures paid for behavioral health care across all payors;

B. The total behavioral health care-related nonclaims-based payments and associated member months;

C. The total payments associated with substance use disorder services that are redacted from the payor's claims data submissions to the Maine Health Data Organization as required under 42 Code of Federal Regulations, Part 2, the methods used to redact the substance use disorder claims, the specific code lists that are used for procedure codes,

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revenue codes and diagnosis codes, provider types and any other detail on the claim that is required to select the substance use disorder redacted claim; and

D. The methods used by commercial insurers, the MaineCare program, Medicare, the organization that administers health insurance for state employees and the Maine Education Association benefits trust to pay for behavioral health care.

Within 60 days of a request from the Maine Health Data Organization, a payor shall provide the supplemental datasets specific to payments for behavioral health care services necessary to provide the information required in paragraphs B and C. In its request to a payor, the organization shall specify the time period for which the data is requested and define the datasets requested to ensure uniformity in the data submitted by payors.

Sec. A-3. Maine Quality Forum to conduct health spending reporting study. The Maine Quality Forum, established in the Maine Revised Statutes, Title 24-A, section 6951, shall consult with other state and national agencies and organizations to determine the best practices for reporting spending on behavioral health care by insurers. For purposes of this section, "behavioral health care" means services to address mental health and substance use conditions.

PART B

Sec. B-1. 24-A MRSA §4303, sub-§2, ¶D, as amended by PL 2015, c. 84, §1, is further amended to read:

D. A carrier shall make credentialing decisions, including those granting or denying credentials, within 60 days of receipt of a completed credentialing application from a provider. ~~The time period for granting or denying credentials may be extended upon written notification from the carrier within 60 days following submission of a completed application stating that information contained in the application requires additional time for verification. All credentialing decisions must be made within 180 days of receipt of a completed application.~~ For the purposes of this paragraph, an application is completed if the application includes all of the information required by the uniform credentialing application used by carriers and providers in this State, such attachments to that application as required by the carrier at the time of application and all corrections required by the carrier. ~~A~~ Within 30 days of initial receipt of a credentialing application, a carrier shall review the entire application ~~before returning~~ and, if it is incomplete, shall return it to the provider for corrections with a comprehensive list of all corrections needed at the time the application is first returned to the provider. A carrier may not require that a provider have a home address within the State before accepting an application. A carrier that is unable to make a credentialing decision on a completed credentialing application within the 60-day period as required in this paragraph shall notify the bureau in writing prior to the expiration of the 60-day period on that application and request authorization for an extension on that application. A carrier that requests an extension shall also submit to the bureau an explanation of the reasons why the credentialing decision on an application is taking longer than is permitted or, if the problem is not specific to a particular application, a written remediation plan to bring the carrier's credentialing practices in line with the 60-day limit in this paragraph.

Attachment C – Overview of Behavioral Health Care Measurement in Other States and Nationally

Behavioral Health Spending Definitions

Annually, the Maine Quality Forum is required to complete a report on behavioral health care spending in the state of Maine. As required by the statute, we evaluate state and national reports to identify possible ways to improve our definition of behavioral health care, allowing Maine to align with current best practices of measuring behavioral health care spending. Based on our updated review, there continues to be no consistent definition of behavioral health spending across states. While there are some similarities in what services, settings, provider types, and data sources are included, states differ in key areas. For example, some states include pharmacy, long-term care, dementia, and developmental disabilities in their methodology, which are not included in MQF's definition.

The Milbank Memorial Fund has been studying approaches to measuring behavioral health with the goal of establishing a consensus definition so that spending may be compared across states. In a recently released report, they recommended a core definition of behavioral health spending based partly on methods used in Massachusetts, Maine,[§§§] and Rhode Island.[4] This included:

- A specific procedure code set based on BH services, without relying on diagnosis alone.
- Sorting results by service categories such as inpatient, outpatient primary care, outpatient non-primary care and pharmacy, and subcategories such as long-term care, residential care, and mobile services.
- A set of national drug codes used to treat people with BH conditions.
- BH services delivered by primary care providers in a primary care setting.
- Assigning services to specific care settings based on place of service and revenue codes.
- Non-claims spending based on an expanded framework.
- Dementia and developmental disorders in the list of BH diagnoses.[****]

National and State-based Efforts to Measure Behavioral Health Care

In addition to behavioral health spending, several organizations and states are measuring workforce capacity, access to care, and utilization to gain a more comprehensive understanding of the behavioral health system. These results are being shared through behavioral health dashboards or static reports. The specific focus areas and methodologies employed in the dashboards and reports vary, including what provider types are included, how diagnoses are identified and grouped, and how data are segmented. Here are some notable examples:

- **Massachusetts:** The Center for Health Information and Analysis (CHIA) recently released a dashboard of metrics to monitor the performance of behavioral health care in Massachusetts. The interactive dashboard includes measures focused on spending for behavioral health care services (inpatient, outpatient, ED, and pharmacy, member cost share, and by physician group). Spending estimates are based on medical claims with a principal diagnosis of a mental health and substance use disorder (based on ICD-10), and services are identified by procedure, place of service, and revenue codes. The data is sourced from a file submitted by payors to CHIA. The Equity measures use data from the MA Health

[§§§] Note: Milbank is releasing a revised version of the report to correct mischaracterizations of Maine's methodology.
[****] This differs from Maine's method which specifically excluded dementia and developmental disorders.

Insurance Survey and include indicators of service utilization, mental health status, access to care/unmet BH care needs, and out-of-pocket costs.[5]

- **New Mexico:** The New Mexico Health Care Workforce Committee produces a legislatively mandated annual report on the health care workforce, including primary care physicians and behavioral health providers. The mandate requires that health professionals be surveyed at each license renewal. The committee assesses the workforce and makes recommendations on ways to increase capacity in the state. The report provides county-level counts by primary practice location, provider type, race and ethnicity, and gender.[6]
- **Rhode Island:** Rhode Island's OHIC Data Hub is a series of dashboards focused on increasing transparency about healthcare spending. Using all payer claims data, the dashboards track cost trends across several different service categories, such as retail pharmacy, outpatient and professional procedures, and emergency department visits. The mental health dashboard measures spending and utilization which can be stratified by diagnosis category, age, gender, insurance type, and service category or care setting. Mental health diagnoses are based on ICD 10 codes and are categorized into diagnosis groups, such as mood disorders, anxiety disorders, Schizophrenia, adult personality disorders, developmental disorders, and mental disorders due to physiological conditions (which includes dementia).[7]
- **Virginia:** Virginia Hospital and Healthcare Association's Behavioral Health Inpatient Dashboard tracks admissions to state and private hospitals. Psychiatric bed revenue codes are used to identify BH-related admissions, including SUD. The data is sourced from the VA Department of Behavioral Health's inpatient database.[8]

  The Virginia Department of Health Professions created the Health Care Workforce Data Center to track the BH workforce by county, provider type, average hours worked per week, payment types accepted, estimated total number of patient visits per week, job satisfaction, median income, retirement intentions, and full-time equivalency (FTE) units. Using a map of Virginia, the FTEs can be viewed at the county level and filtered by different BH professions. Data is based on voluntary surveys of licensees through the state's application and renewal process.[9]
- **Washington:** Washington State's Office of the Insurance Commissioner, working with OnPoint Health Data,[††††] produced a mental health dashboard that uses all-payer claims data to report county and state-level rates of mental health utilization by treatment settings and mental health condition. This includes emergency department visits, inpatient admission rate, outpatient office visits rate, psychotherapy rate, and pharmacy claims.[10]
- **State Medicaid Child Behavioral Health Dashboard Library:** Georgetown University has compiled a library of state dashboards that use state Medicaid data or other data collected at the state level to measure children's behavioral health services. Several state Medicaid programs, including Maine, report statewide or managed care plan level data on different access, utilization and quality measures that vary by state. Examples in the State Medicaid Child Behavioral Health Dashboard Library include AZ, CA, LA, ME, NH, ND, VT, VA, WA.[11]
- **George Washington University's Fitzhugh Mullan Institute for Health Workforce Equity** created the Behavioral Health Workforce Tracker with funding from SAMHSA. The dashboard is a customizable interactive map that allows users to visualize the geographic distribution of the behavioral health workforce by provider type, Medicaid acceptance status, and medication prescriptions. Users can drill

[††††] Maine, Maryland, and New York have also been working with OnPoint to create similar dashboards using APCD data.

down to the county level to see the provider-to-population ratio and number of providers in the county by type of provider. Data sources include state licensure data and national pharmacy data.[12]

- **Maine's Behavioral Health Access and Workforce Coalition**, with funding from the Maine Health Access Foundation and Maine Behavioral Health Foundation, released a 2024 report focused on access and workforce challenges based on a point-in-time survey of providers. The report found the highest unmet need and wait times were for mental health counseling and mental health medication evaluations. Organizations reported workforce vacancy rates up to 20% for some positions. Factors contributing to these issues included financing of services, onerous paperwork/regulations, barriers to pursuing a career in BH, and provider retention.[13]
- A report from **USC-Brookings Schaeffer Initiative for Health Policy** examined the geographic distribution of mental health providers and factors that contribute to mental health provider shortage areas (MHPSAs). Through an analysis of National Ambulatory Medical Care Survey data, the authors found that self-pay patients accounted for 21% of visits to psychiatrists. In comparison, only 4% of visits to primary care physicians and non-psychiatric specialists were self-pay. The report includes measures of supply and demand for behavioral health services across the country.[14]

Attachment D - Methodology for Estimating Behavioral Health Care Spending and Use by Insured Members

To determine the percentage of total healthcare payor payments that support behavioral health care in Maine, we used the Maine Health Data Organization's (MHDO) all-payer claims data (APCD) for claims-based payments from commercial payors and Medicare. The calculations for MaineCare (Medicaid) were based on a separate source of MaineCare claims containing the additional fields necessary to identify Long Term Support Services (LTSS). We removed LTSS payments from the calculations of both the total claims-based payment (the denominator) and the behavioral health care amount (the numerator) because they are not comparable to anything on the commercial or Medicare side.

We added information collected from payors about payments made outside of claims (non-claims-based payments), as well as information about claims that were redacted by payors per interpretation of the federal requirements defined in 42 CFR Part 2 substance use disorders (SUD) before submission to the MHDO due to SUD-related codes. This information was collected to support both the Primary Care report and this Behavioral Health Care report. The separate MaineCare data source described above had the additional benefit of including claim-level information on SUD claims, which the MHDO ACPD does not.

Non-Claims Data: As required by Chapter 247, *Uniform Reporting System for Non-Claims Based Payments and Other Supplemental Health Care Data Sets*, payors are to report annually to MHDO the amounts paid to healthcare providers that are not included in claims submissions to the MHDO.[3] "Non-claims-based" means payments that are for something other than a fee-for-service claim. As defined in Chapter 247, these payments include but are not limited to Capitation Payments, Care Management/Care Coordination/Population Health Payments, Electronic Health Records/Health Information Technology Infrastructure/Other Data Analytics Payments, Global Budget Payments, Patient-centered Medical Home Payments, Pay-for-performance Payments, Pay-for-reporting Payments, Primary Care and Behavioral Health Integration Payments, Prospective Case Rate Payments, Prospective Episode-based Payments, Provider Salary Payments, Retrospective/Prospective Incentive Payments, Risk-based Payments, Shared-risk Recoupments, Shared-savings Distributions. Non-claims payments are submitted in total and by payments specific to primary care and behavioral health care providers for 2021 going forward.

For total behavioral health care spending estimates, we added non-claims data, which was submitted by the majority of payors (those that account for 95% of the claims-reported dollars) and MaineCare, to claims-based behavioral health care and total dollars to estimate total behavioral health care spending.

CMS does not report non-claims-based payments, so those could not be included in the calculation for Medicare. SUD claims are included in the information CMS sends to the MHDO APCD. Medicare Advantage plans, which are operated by commercial payors, did report both aggregated non-claims-based payments and aggregated SUD redacted payments.

Claims Data: For this report, a claim was determined to represent behavioral health care if it had one of the following:

- A primary diagnosis indicating that the purpose of the treatment was to address a behavioral health issue;
- A rendering provider whose taxonomy code is mostly associated with behavioral health primary diagnoses.

Using both rules (meaning a claim that meets either of the above criteria is considered behavioral health) is necessary because of ambiguous diagnoses such as Z5189 [Encounter for other specified aftercare], which occurs quite frequently among providers who are mostly associated with behavioral health care diagnoses.

The list of ICD-10 diagnosis codes considered behavioral health care is compiled from multiple sources and cross-referenced with SAMHSA (Substance Abuse and Mental Health Services Administration) materials. ICD-10 is based on a categorization that groups almost all behavioral health diagnoses into the series of codes starting with F. For this report, based on advice from SAMHSA and the Behavioral Health Spending Advisory Committee, we removed codes for Dementia and Developmental Disabilities, as these were determined to be more medical than behavioral. We added codes for Intentional Self-Harm (selected codes from the X and T series in ICD-10).

See *Attachment E* for the list of ICD-10 codes included in the behavioral health care definition. The list of taxonomy codes for whom any claim, regardless of diagnosis code, was considered behavioral health care is shown in *Attachment E*. These taxonomy codes had 70% or more of their claim dollars in the years 2020-2023 associated with a primary diagnosis in the list described above.

Since the third annual primary care spending report was mandated, legislation was passed to report on Behavioral Health Spending in Maine (Public Law 2021, Ch 603).[1] The primary care spending and the behavioral health care spending reports are separate reports. Note that some services provided by a primary care provider as defined by the list of Primary Care taxonomy codes and/or service codes also have a primary diagnosis of behavioral health and therefore will be part of both calculations. Seven percent of commercial behavioral health care was delivered by a Primary Care provider and 13% for MaineCare. For Medicare, the figure is higher, at 15%.

Understanding consumer cost-sharing is relevant in reporting total payments for behavioral health. The challenge in measuring consumer cost sharing in all-payer claims data is that the amount that the primary claims processor assigns to the consumer may be paid by additional benefits the consumer has, such as a supplemental plan or membership in two primary plans. This kind of overlap is likely to be particularly large for the population covered by both Medicare and MaineCare, also known as the dually eligible, where MaineCare covers most or all of the members' Medicare out of pocket expenses. As entered in the APCD, the primary claim shows any amount owed to the provider that the plan does not cover as a consumer expense. Secondary processing may show those same amounts paid by another plan on a separate claim making it difficult to isolate which payments are actually paid by consumers. Since Medicare and MaineCare insured beneficiaries are more likely to have supplemental policies, we focused our consumer cost-sharing analysis on commercial claims only.

Data Source

Information for calendar year 2023 from Maine's APCD maintained by the MHDO was used to calculate the claims-based portion of overall behavioral health spending for commercial payors and Medicare. The Maine APCD contains claims and enrollment information for commercial insurance carriers, third party administrators, pharmacy benefit managers, dental benefit administrators, MaineCare, and Medicare.[‡‡‡‡] Only medical claims (not dental or pharmacy) were included in the total for this study. The Maine APCD does not have the information necessary to separate LTSS from medical services among claims with a behavioral health diagnosis, so a different source of MaineCare claims was used for this Behavioral Health report.

The submission of claims data to the MHDO is governed under the terms and conditions defined in 90-590 CMR Chapter 243, Uniform Reporting System for Health Care Claims Data Sets.[2]

As defined in 90-590 CMR Chapter 243, MHDO's APCD does not include claims information from:

[‡‡‡‡] Medicare Advantage plans and regular fee-for-service Medicare are included.

- Claims processors with less than $2 million per calendar year of Maine adjusted premiums or claims processed;[§§§§]
- Claims for health care policies issued for specific diseases, accident, injury, hospital indemnity, disability, long-term care, vision,[*****] coverage of durable medical equipment;
- Claims related to Medicare supplemental, [†††††] and Tricare supplemental; and
- Claims for workplace injuries covered by worker's compensation insurance.

The self-funded ERISA plans in Maine are exempt from the state mandate to submit information to the MHDO due to a Supreme Court ruling,[‡‡‡‡‡] but many of the largest self-funded ERISA plans in the State voluntarily submit claims data to the MHDO.

Additionally, the APCD does not include information about Mainers who are uninsured or any health care that is not covered by insurance.

Maine's APCD is a large representative sample of data as it includes claims data for approximately 90% of Maine's insured population including 100% of Medicare and MaineCare claims for Maine members and approximately 70% of the commercially insured population in Maine.

This study used medical claims (CY 2021-2023), excluding dental and pharmacy claims. Long-term services and support (LTSS) are excluded from MaineCare claims. The MaineCare LTSS definition used for this report aligns with the Office of MaineCare Services (OMS) definition of LTSS used in their alternative payment methodology (APM). Policy sections from the MaineCare Benefits Manual (MBM) in Table 9 were considered LTSS.[15]

Table 9. MaineCare LTSS Policy Sections

Section	Title
2	Adult Family Care Services
12	Consumer Directed Attendant Services
18	Home and Community-Based Services (HCBS) for Adults with Brain Injury
19	Home and Community Benefits (HCBS) for the Elderly and Adults with Disabilities
20	Home and Community Based Services (HCBS) for Adults with Other Related Conditions
21	Home and Community Benefits (HCBS) for Members with Intellectual Disabilities or Autism Spectrum Disorder
26	Day Health Services
29	Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder
40	Home Health Services
50	ICF-MR Services

[§§§§] With the exception of self-funded ERISA plans which are not required to report but may voluntarily submit their data. *Gobeille v. Liberty Mutual Insurance Company*, US Supreme Court Decision that Employee Retirement Income Security Act (ERISA) standards preempt state reporting requirements.

[*****] Quality review of the data has identified the submission of some of these types of plans. We have deleted these from this analysis.

[†††††] Quality review of the data has identified the submission of some of these types of plans. We have deleted these from this analysis.

[‡‡‡‡‡] *Gobeille v. Liberty Mutual Insurance Company*, US Supreme Court Decision that Employee Retirement Income Security Act (ERISA) standards preempt state reporting requirements.

67	Nursing Facility Services
96	Private Duty Nursing and Personal Care Services
97	Private Non-Medical Institution Services (PNMI) Appendix C and F
102	Rehabilitative Services

The MHDO's APCD contains information about the payor for the health care service. This information was used to categorize claims paid for the following populations: commercial (excluding Medicare Advantage); and Medicare (including both Medicare Advantage and Fee-for-service plans). Additionally, as required by the legislation, claims for two plan sponsors were tabulated: the Maine Education Association Benefit Trust (MEABT) and the State Employee Health Commission (SEHC).

Claims data for MaineCare came from the USM's Muskie School data warehouse containing MaineCare administrative data including claims, member enrollment and provider information. USM receives a monthly feed for the data repository, from the MaineCare program, to update all paid claims, provider and enrollment information from the prior month. MaineCare payments to Critical Access Hospitals are included in claims payments in this dataset. As MaineCare CAH payments were also reported in non-claims during this reporting period (CY 2021-2023), to avoid duplication, the Critical Access Hospital claims-based payments were excluded.

Behavioral Health Provider Identification

Medical claims contain identifiers (National Provider Identifiers (NPI)) for multiple levels of providers. To determine whether the main provider of a claim met the definition of a behavioral health provider, the billing, servicing, rendering and attending provider NPIs were examined to find an Individual provider and their primary taxonomy code. If all of those providers were organizations, the servicing or attending provider was used as the main provider. Once a single provider was identified for each claim, the taxonomy code (medical specialty of the provider) was determined using a copy of the National Plan and Provider Enumeration System (NPPES) database maintained in the MHDO Enclave data management system (updated 10/2024). Additionally, the NPI maintained in USM's MaineCare data repository was linked to the NPPES to identify the primary taxonomy code of the provider.

If the taxonomy code of the provider had 70% or more of their payments in 2020 – 2023 from claims with a behavioral health primary diagnosis, all of that provider's claims were considered behavioral health. As noted above, this was to ensure the inclusion of claims with ambiguous diagnoses.

Identification of Telehealth Delivered Services

Claim lines associated with delivery of services via telehealth were identified using specific procedure code modifiers, place of service (POS) codes or procedure codes (e.g. HEDIS, CMS, MaineCare) and are shown in *Attachment E*. The costs on these claim lines were attributed to telehealth delivery.

Identification of Costs

As mandated by the legislation, medical and behavioral health care costs identified in this study include payments by payors for claims incurred during the measurement year. For the payors that provided the information, non-claims-based payments were added to their estimates.[§§§§§] The denominator, or base for the calculation of behavioral health percentage, was the sum of payor paid amounts for all medical (not pharmacy or dental) claims used in this study (see *Data Source*, above) plus non-claims based and SUD redacted amounts.

[§§§§§] MaineCare non-claims-based payments included Prospective Interim and Supplemental Payments to critical access and select general acute care and Institutions for Mental Disease (IMD) hospitals. Payments for various Accountable Communities programs including behavioral and opioid health homes are also included in the non-claims payments.

The behavioral health amount (the numerator of the percentage calculation) is the sum of the payor paid amounts on claim lines that met the definition criteria for behavioral health plus the portions of non-claims payments for behavioral health) and all the SUD redacted claims.

Percent of Members with Behavioral Health Care

This report also displays the proportion of insured members who received care for a behavioral health diagnosis or from a behavioral health provider in 2023. This calculation relied on the Person ID in the MHDO APCD, which uses identification information available only to the MHDO, and not made public, to assign a unique anonymous identifier to the same person across changes in coverage. The number of insured members by payor is the number of distinct Person IDs who were eligible for any primary medical coverage in 2023, regardless of the number of months of eligibility. Note that due to redaction of SUD claims by Commercial payors, the proportion of people insured by a Commercial plan (including Medicare Advantage) with a Behavioral Health claim will be lower than the likely actual figure.

Members were counted as users of behavioral health services if they had at least one behavioral health claim with a service date in 2021, 2022 or 2023. Unique de-identified member IDs in MHDO APCD data were used to identify the same person across payors. Each person was counted only once, in the payor who provided their primary medical insurance in the latest month of the year that the person was insured. The MaineCare numbers reflect members with MaineCare as primary insurer and excludes individuals who are dually eligible for Medicare or have other third-party primary payors.

Behavioral Health Care by County

Another analysis breaks down the overall percentage of claims-based payments going to behavioral health care to the county level. Both the total medical amount paid by payors through claims and the amount paid for behavioral health care on those claims were assigned to the county of the member's residence. The calculation excludes payments associated with members whose residence is unknown or out of state (a tiny portion of the total APCD and MaineCare data). It does not factor in any non-claims-based payments.

Behavioral Health Care by Age

New this year are two analyses of behavioral health care by age group: behavioral health care as a percent of total medical claims payments, and percent of members who had any claims with a behavioral health care diagnosis. Members were categorized according to their age at the end of the year. Only a tiny number of members did not have age-related information available in the APCD or MaineCare data. The following age groups were used: 0-11, 12-20, 21-26, 27-44, 45-64, 65+.

Behavioral Health Care by Healthcare Setting and Crisis Services

To understand more about how behavioral health care dollars are spent, this report includes an analysis of the healthcare setting in which the care took place. We examined crisis services separately and exclude these services from other locations or settings in which BH services were provided. The HCPCS codes used to identify a claim as Crisis (S9485, S9484, H2011, H0018, G0017, G0018, H0007, T2034).[******] The mutually exclusive healthcare setting categories (excluding crisis services) used are: Acute Inpatient; Residential Inpatient; Emergency Department (with no admission); FQHC/RHC/IHS; Telehealth; and other Outpatient, which includes all medical offices, community mental health centers or outpatient setting not included in the other categories

[******] Source for codes: HCPCS Look-up 'Crisis' https://www.hipaaspace.com/medical_billing/coding/healthcare_common_procedure_coding_system/hcpcs_codes_lookup.aspx) and
MaineCare Benefits Manual (MBM) Section 65 CH. III

(e.g. FQHC/RHC/HIS). Several fields available on health care claims were examined to determine the best representation for each claim.). The Telehealth logic is described above. Bill type codes on facility claims and Place of Service codes on professional claims were used to classify a claim as Inpatient (Acute or Residential). Place of Service codes on professional claims and Revenue codes on facility claims were used to identify Emergency Department services. FQHCs, RHCs and IHS can be identified via bill type codes. As noted earlier, provider enrollment information included in the MaineCare data was also used to identify residential care as well as FQHC, RHC and "IHS" providers. Claims that had one or more of the codes identified for different settings were categorized in the setting category (after excluding crisis services from the analysis), using the following hierarchy to determine mutually exclusive categories: Telehealth, Acute Inpatient, Residential Inpatient, Emergency Department, FQHC/RHC, and Outpatient. Codes used in this analysis are included in Attachment E.

Redacted SUD Claims

Because of requirements defined in 42 CFR Part 2 substance use disorders (SUD), most payors do not submit claims with SUD-related codes to the MHDO. As can be seen in Table 1, the aggregated amount of SUD-redacted claims is more than 40% of the total amount Commercial payors spent on behavioral health care. As a result, the Commercial portion of the detailed analyses in this report that rely on claim level data should be regarded as rough estimates.

Attachment E – Codes Used in Behavioral Health Care Spending Analyses

ICD-10 Diagnosis Codes Included in Behavioral Health Care Definition

ICD-10 Code	Description
F0631	Mood disorder due to known physiol cond w depressv features
F0632	Mood disord d/t physiol cond w major depressive-like epsd
F0633	Mood disorder due to known physiol cond w manic features
F0634	Mood disorder due to known physiol cond w mixed features
F10	Alcohol related disorders
F101	Alcohol abuse
F1010	Alcohol abuse, uncomplicated
F1011	Alcohol abuse, in remission
F10120	Alcohol abuse with intoxication, uncomplicated
F10121	Alcohol abuse with intoxication delirium
F10129	Alcohol abuse with intoxication, unspecified
F10130	Alcohol abuse with withdrawal, uncomplicated
F10131	Alcohol abuse with withdrawal delirium
F10132	Alcohol abuse with withdrawal with perceptual disturbance
F10139	Alcohol abuse with withdrawal, unspecified
F1014	Alcohol abuse with alcohol-induced mood disorder
F10150	Alcohol abuse w alcoh-induce psychotic disorder w delusions
F10151	Alcohol abuse w alcoh-induce psychotic disorder w hallucin
F10159	Alcohol abuse with alcohol-induced psychotic disorder, unsp
F10180	Alcohol abuse with alcohol-induced anxiety disorder
F10182	Alcohol abuse with alcohol-induced sleep disorder
F10188	Alcohol abuse with other alcohol-induced disorder
F1019	Alcohol abuse with unspecified alcohol-induced disorder
F102	Alcohol dependence
F1020	Alcohol dependence, uncomplicated
F1021	Alcohol dependence, in remission
F10220	Alcohol dependence with intoxication, uncomplicated
F10221	Alcohol dependence with intoxication delirium
F10229	Alcohol dependence with intoxication, unspecified

ICD-10 Code	Description
F10230	Alcohol dependence with withdrawal, uncomplicated
F10231	Alcohol dependence with withdrawal delirium
F10232	Alcohol dependence w withdrawal with perceptual disturbance
F10239	Alcohol dependence with withdrawal, unspecified
F1024	Alcohol dependence with alcohol-induced mood disorder
F10250	Alcohol depend w alcoh-induce psychotic disorder w delusions
F10251	Alcohol depend w alcoh-induce psychotic disorder w hallucin
F10259	Alcohol dependence w alcoh-induce psychotic disorder, unsp
F1026	Alcohol depend w alcoh-induce persisting amnestic disorder
F1027	Alcohol dependence with alcohol-induced persisting dementia
F10280	Alcohol dependence with alcohol-induced anxiety disorder
F10281	Alcohol dependence with alcohol-induced sexual dysfunction
F10282	Alcohol dependence with alcohol-induced sleep disorder
F10288	Alcohol dependence with other alcohol-induced disorder
F1029	Alcohol dependence with unspecified alcohol-induced disorder
F1060	Unknown Dx code
F109	Alcohol use, unspecified
F10920	Alcohol use, unspecified with intoxication, uncomplicated
F10921	Alcohol use, unspecified with intoxication delirium
F10929	Alcohol use, unspecified with intoxication, unspecified
F10930	Alcohol use, unspecified with withdrawal, uncomplicated
F10932	Alcohol use, unspecified with w/drawal w perceptual disturb
F10939	Alcohol use, unspecified with withdrawal, unspecified
F1094	Alcohol use, unspecified with alcohol-induced mood disorder
F10950	Alcohol use, unsp w alcoh-induce psych disorder w delusions
F10951	Alcohol use, unsp w alcoh-induce psych disorder w hallucin
F10959	Alcohol use, unsp w alcohol-induced psychotic disorder, unsp
F1096	Alcohol use, unsp w alcoh-induce persist amnestic disorder
F1097	Alcohol use, unsp with alcohol-induced persisting dementia
F10980	Alcohol use, unsp with alcohol-induced anxiety disorder
F10982	Alcohol use, unspecified with alcohol-induced sleep disorder

ICD-10 Code	Description
F10988	Alcohol use, unspecified with other alcohol-induced disorder
F1099	Alcohol use, unsp with unspecified alcohol-induced disorder
F111	Opioid abuse
F1110	Opioid abuse, uncomplicated
F1111	Opioid abuse, in remission
F11120	Opioid abuse with intoxication, uncomplicated
F11129	Opioid abuse with intoxication, unspecified
F1113	Opioid abuse with withdrawal
F1114	Opioid abuse with opioid-induced mood disorder
F11151	Opioid abuse w opioid-induced psychotic disorder w hallucin
F11188	Opioid abuse with other opioid-induced disorder
F1119	Opioid abuse with unspecified opioid-induced disorder
F112	Opioid dependence
F1120	Opioid dependence, uncomplicated
F1121	Opioid dependence, in remission
F11220	Opioid dependence with intoxication, uncomplicated
F11221	Opioid dependence with intoxication delirium
F11222	Opioid dependence w intoxication with perceptual disturbance
F11229	Opioid dependence with intoxication, unspecified
F1123	Opioid dependence with withdrawal
F1124	Opioid dependence with opioid-induced mood disorder
F11250	Opioid depend w opioid-induc psychotic disorder w delusions
F11251	Opioid depend w opioid-induc psychotic disorder w hallucin
F11259	Opioid dependence w opioid-induced psychotic disorder, unsp
F11282	Opioid dependence with opioid-induced sleep disorder
F11288	Opioid dependence with other opioid-induced disorder
F1129	Opioid dependence with unspecified opioid-induced disorder
F119	Opioid use, unspecified
F1190	Opioid use, unspecified, uncomplicated
F11920	Opioid use, unspecified with intoxication, uncomplicated
F11929	Opioid use, unspecified with intoxication, unspecified

ICD-10 Code	Description
F1193	Opioid use, unspecified with withdrawal
F1194	Opioid use, unspecified with opioid-induced mood disorder
F11951	Opioid use, unsp w opioid-induc psych disorder w hallucin
F11959	Opioid use, unsp w opioid-induced psychotic disorder, unsp
F11982	Opioid use, unspecified with opioid-induced sleep disorder
F11988	Opioid use, unspecified with other opioid-induced disorder
F1199	Opioid use, unsp with unspecified opioid-induced disorder
F1210	Cannabis abuse, uncomplicated
F1211	Cannabis abuse, in remission
F12120	Cannabis abuse with intoxication, uncomplicated
F12121	Cannabis abuse with intoxication delirium
F12129	Cannabis abuse with intoxication, unspecified
F1213	Cannabis abuse with withdrawal
F12150	Cannabis abuse with psychotic disorder with delusions
F12151	Cannabis abuse with psychotic disorder with hallucinations
F12159	Cannabis abuse with psychotic disorder, unspecified
F12180	Cannabis abuse with cannabis-induced anxiety disorder
F12188	Cannabis abuse with other cannabis-induced disorder
F1219	Cannabis abuse with unspecified cannabis-induced disorder
F1220	Cannabis dependence, uncomplicated
F1221	Cannabis dependence, in remission
F12229	Cannabis dependence with intoxication, unspecified
F1223	Cannabis dependence with withdrawal
F12250	Cannabis dependence with psychotic disorder with delusions
F12259	Cannabis dependence with psychotic disorder, unspecified
F12280	Cannabis dependence with cannabis-induced anxiety disorder
F12288	Cannabis dependence with other cannabis-induced disorder
F1229	Cannabis dependence with unsp cannabis-induced disorder
F1290	Cannabis use, unspecified, uncomplicated
F12920	Cannabis use, unspecified with intoxication, uncomplicated
F12921	Cannabis use, unspecified with intoxication delirium

ICD-10 Code	Description
F12922	Cannabis use, unsp w intoxication w perceptual disturbance
F12929	Cannabis use, unspecified with intoxication, unspecified
F1293	Cannabis use, unspecified with withdrawal
F12950	Cannabis use, unsp with psychotic disorder with delusions
F12959	Cannabis use, unsp with psychotic disorder, unspecified
F12980	Cannabis use, unspecified with anxiety disorder
F12988	Cannabis use, unsp with other cannabis-induced disorder
F1299	Cannabis use, unsp with unsp cannabis-induced disorder
F1310	Sedative, hypnotic or anxiolytic abuse, uncomplicated
F1311	Sedative, hypnotic or anxiolytic abuse, in remission
F13129	Sedative, hypnotic or anxiolytic abuse w intoxication, unsp
F13130	Sedatv/hyp/anxiolytc abuse with withdrawal, uncomplicated
F13139	Sedatv/hyp/anxiolytc abuse with withdrawal, unspecified
F1314	Sedative, hypnotic or anxiolytic abuse w mood disorder
F13150	Sedatv/hyp/anxiolytc abuse w psychotic disorder w delusions
F13159	Sedatv/hyp/anxiolytc abuse w psychotic disorder, unsp
F13180	Sedative, hypnotic or anxiolytic abuse w anxiety disorder
F13182	Sedative, hypnotic or anxiolytic abuse w sleep disorder
F1319	Sedative, hypnotic or anxiolytic abuse w unsp disorder
F1320	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F1321	Sedative, hypnotic or anxiolytic dependence, in remission
F13220	Sedatv/hyp/anxiolytc dependence w intoxication, uncomp
F13230	Sedatv/hyp/anxiolytc dependence w withdrawal, uncomplicated
F13231	Sedatv/hyp/anxiolytc dependence w withdrawal delirium
F13232	Sedatv/hyp/anxiolytc depend w w/drawal w perceptual disturb
F13239	Sedatv/hyp/anxiolytc dependence w withdrawal, unsp
F1324	Sedative, hypnotic or anxiolytic dependence w mood disorder
F13280	Sedatv/hyp/anxiolytc dependence w anxiety disorder
F13282	Sedative, hypnotic or anxiolytic dependence w sleep disorder
F1390	Sedative, hypnotic, or anxiolytic use, unsp, uncomplicated
F13921	Sedatv/hyp/anxiolytc use, unsp w intoxication delirium

ICD-10 Code	Description
F13939	Sedatv/hyp/anxiolytc use, unsp w withdrawal, unsp
F1394	Sedative, hypnotic or anxiolytic use, unsp w mood disorder
F13980	Sedatv/hyp/anxiolytc use, unsp w anxiety disorder
F1399	Sedative, hypnotic or anxiolytic use, unsp w unsp disorder
F1410	Cocaine abuse, uncomplicated
F1411	Cocaine abuse, in remission
F14120	Cocaine abuse with intoxication, uncomplicated
F14121	Cocaine abuse with intoxication with delirium
F14122	Cocaine abuse with intoxication with perceptual disturbance
F14129	Cocaine abuse with intoxication, unspecified
F1413	Cocaine abuse, unspecified with withdrawal
F1414	Cocaine abuse with cocaine-induced mood disorder
F14151	Cocaine abuse w cocaine-induc psychotic disorder w hallucin
F14180	Cocaine abuse with cocaine-induced anxiety disorder
F1419	Cocaine abuse with unspecified cocaine-induced disorder
F142	Cocaine dependence
F1420	Cocaine dependence, uncomplicated
F1421	Cocaine dependence, in remission
F14220	Cocaine dependence with intoxication, uncomplicated
F14229	Cocaine dependence with intoxication, unspecified
F1423	Cocaine dependence with withdrawal
F1424	Cocaine dependence with cocaine-induced mood disorder
F14259	Cocaine dependence w cocaine-induc psychotic disorder, unsp
F1429	Cocaine dependence with unspecified cocaine-induced disorder
F1490	Cocaine use, unspecified, uncomplicated
F14921	Cocaine use, unspecified with intoxication delirium
F14929	Cocaine use, unspecified with intoxication, unspecified
F1494	Cocaine use, unspecified with cocaine-induced mood disorder
F14959	Cocaine use, unsp w cocaine-induced psychotic disorder, unsp
F1499	Cocaine use, unsp with unspecified cocaine-induced disorder
F1510	Other stimulant abuse, uncomplicated

ICD-10 Code	Description
F1511	Other stimulant abuse, in remission
F15120	Other stimulant abuse with intoxication, uncomplicated
F15121	Other stimulant abuse with intoxication delirium
F15122	Oth stimulant abuse w intoxication w perceptual disturbance
F15129	Other stimulant abuse with intoxication, unspecified
F1513	Other stimulant abuse with withdrawal
F1514	Other stimulant abuse with stimulant-induced mood disorder
F15150	Oth stimulant abuse w stim-induce psych disorder w delusions
F15151	Oth stimulant abuse w stim-induce psych disorder w hallucin
F15159	Oth stimulant abuse w stim-induce psychotic disorder, unsp
F15180	Oth stimulant abuse with stimulant-induced anxiety disorder
F15182	Other stimulant abuse with stimulant-induced sleep disorder
F15188	Other stimulant abuse with other stimulant-induced disorder
F1519	Other stimulant abuse with unsp stimulant-induced disorder
F152	Other stimulant dependence
F1520	Other stimulant dependence, uncomplicated
F1521	Other stimulant dependence, in remission
F15222	Oth stimulant dependence w intox w perceptual disturbance
F15229	Other stimulant dependence with intoxication, unspecified
F1523	Other stimulant dependence with withdrawal
F1524	Oth stimulant dependence w stimulant-induced mood disorder
F15250	Oth stim depend w stim-induce psych disorder w delusions
F15251	Oth stimulant depend w stim-induce psych disorder w hallucin
F15259	Oth stimulant depend w stim-induce psychotic disorder, unsp
F1590	Other stimulant use, unspecified, uncomplicated
F15920	Other stimulant use, unsp with intoxication, uncomplicated
F15921	Other stimulant use, unspecified with intoxication delirium
F15922	Oth stimulant use, unsp w intox w perceptual disturbance
F15929	Other stimulant use, unsp with intoxication, unspecified
F1593	Other stimulant use, unspecified with withdrawal
F1594	Oth stimulant use, unsp with stimulant-induced mood disorder

ICD-10 Code	Description
F15950	Oth stim use, unsp w stim-induce psych disorder w delusions
F15951	Oth stim use, unsp w stim-induce psych disorder w hallucin
F15959	Oth stimulant use, unsp w stim-induce psych disorder, unsp
F15980	Oth stimulant use, unsp w stimulant-induced anxiety disorder
F15988	Oth stimulant use, unsp with oth stimulant-induced disorder
F1599	Oth stimulant use, unsp with unsp stimulant-induced disorder
F1610	Hallucinogen abuse, uncomplicated
F16121	Hallucinogen abuse with intoxication with delirium
F16129	Hallucinogen abuse with intoxication, unspecified
F16151	Hallucinogen abuse w psychotic disorder w hallucinations
F16159	Hallucinogen abuse w psychotic disorder, unsp
F16180	Hallucinogen abuse w hallucinogen-induced anxiety disorder
F1620	Hallucinogen dependence, uncomplicated
F1690	Hallucinogen use, unspecified, uncomplicated
F16921	Hallucinogen use, unsp with intoxication with delirium
F16959	Hallucinogen use, unsp w psychotic disorder, unsp
F16983	Hallucign use, unsp w hallucign persist perception disorder
F16988	Hallucinogen use, unsp w oth hallucinogen-induced disorder
F1699	Hallucinogen use, unsp w unsp hallucinogen-induced disorder
F1810	Inhalant abuse, uncomplicated
F18120	Inhalant abuse with intoxication, uncomplicated
F1814	Inhalant abuse with inhalant-induced mood disorder
F1820	Inhalant dependence, uncomplicated
F1821	Inhalant dependence, in remission
F1890	Inhalant use, unspecified, uncomplicated
F18951	Inhalant use, unsp w inhalnt-induce psych disord w hallucin
F18959	Inhalant use, unsp w inhalnt-induce psychotic disorder, unsp
F1910	Other psychoactive substance abuse, uncomplicated
F1911	Other psychoactive substance abuse, in remission
F19120	Oth psychoactive substance abuse w intoxication, uncomp
F19121	Oth psychoactive substance abuse with intoxication delirium

ICD-10 Code	Description
F19122	Oth psychoactv substance abuse w intox w perceptual disturb
F19129	Other psychoactive substance abuse with intoxication, unsp
F19130	Other psychoactive substance abuse with withdrawal, uncomp
F19131	Other psychoactive substance abuse with withdrawal delirium
F19139	Other psychoactv substance abuse with withdrawal, unsp
F1914	Oth psychoactive substance abuse w mood disorder
F19150	Oth psychoactv substance abuse w psych disorder w delusions
F19151	Oth psychoactv substance abuse w psych disorder w hallucin
F19159	Oth psychoactive substance abuse w psychotic disorder, unsp
F19180	Oth psychoactive substance abuse w anxiety disorder
F19181	Oth psychoactive substance abuse w sexual dysfunction
F19182	Oth psychoactive substance abuse w sleep disorder
F19188	Oth psychoactive substance abuse w oth disorder
F1919	Oth psychoactive substance abuse w unsp disorder
F192	Other psychoactive substance dependence
F1920	Other psychoactive substance dependence, uncomplicated
F1921	Other psychoactive substance dependence, in remission
F19221	Oth psychoactive substance dependence w intox delirium
F19230	Oth psychoactive substance dependence w withdrawal, uncomp
F19231	Oth psychoactive substance dependence w withdrawal delirium
F19232	Oth psychoactv sub depend w w/drawal w perceptl disturb
F19239	Oth psychoactive substance dependence with withdrawal, unsp
F1924	Oth psychoactive substance dependence w mood disorder
F19259	Oth psychoactv substance depend w psychotic disorder, unsp
F1926	Oth psychoactv substance depend w persist amnestic disorder
F19288	Oth psychoactive substance dependence w oth disorder
F1929	Oth psychoactive substance dependence w unsp disorder
F1990	Other psychoactive substance use, unspecified, uncomplicated
F19920	Oth psychoactive substance use, unsp w intoxication, uncomp
F19921	Oth psychoactive substance use, unsp w intox w delirium
F19922	Oth psychoactv sub use, unsp w intox w perceptl disturb

ICD-10 Code	Description
F19929	Oth psychoactive substance use, unsp with intoxication, unsp
F19930	Oth psychoactive substance use, unsp w withdrawal, uncomp
F19931	Oth psychoactive substance use, unsp w withdrawal delirium
F19932	Oth psychoactv sub use, unsp w w/drawal w perceptl disturb
F19939	Other psychoactive substance use, unsp with withdrawal, unsp
F1994	Oth psychoactive substance use, unsp w mood disorder
F19950	Oth psychoactv sub use, unsp w psych disorder w delusions
F19951	Oth psychoactv sub use, unsp w psych disorder w hallucin
F19959	Oth psychoactv substance use, unsp w psych disorder, unsp
F1996	Oth psychoactv sub use, unsp w persist amnestic disorder
F1997	Oth psychoactive substance use, unsp w persisting dementia
F19980	Oth psychoactive substance use, unsp w anxiety disorder
F19982	Oth psychoactive substance use, unsp w sleep disorder
F19988	Oth psychoactive substance use, unsp w oth disorder
F1999	Oth psychoactive substance use, unsp w unsp disorder
F20	Schizophrenia
F200	Paranoid schizophrenia
F201	Disorganized schizophrenia
F202	Catatonic schizophrenia
F203	Undifferentiated schizophrenia
F205	Residual schizophrenia
F2081	Schizophreniform disorder
F2089	Other schizophrenia
F209	Schizophrenia, unspecified
F21	Schizotypal disorder
F22	Delusional disorders
F23	Brief psychotic disorder
F24	Shared psychotic disorder
F25	Schizoaffective disorders
F250	Schizoaffective disorder, bipolar type
F251	Schizoaffective disorder, depressive type

ICD-10 Code	Description
F258	Other schizoaffective disorders
F259	Schizoaffective disorder, unspecified
F28	Oth psych disorder not due to a sub or known physiol cond
F29	Unsp psychosis not due to a substance or known physiol cond
F3010	Manic episode without psychotic symptoms, unspecified
F3011	Manic episode without psychotic symptoms, mild
F3012	Manic episode without psychotic symptoms, moderate
F3013	Manic episode, severe, without psychotic symptoms
F302	Manic episode, severe with psychotic symptoms
F303	Manic episode in partial remission
F304	Manic episode in full remission
F308	Other manic episodes
F309	Manic episode, unspecified
F31	Bipolar disorder
F310	Bipolar disorder, current episode hypomanic
F311	Bipolar disorder, current episode manic w/o psych features
F3110	Bipolar disord, crnt episode manic w/o psych features, unsp
F3111	Bipolar disord, crnt episode manic w/o psych features, mild
F3112	Bipolar disord, crnt episode manic w/o psych features, mod
F3113	Bipolar disord, crnt epsd manic w/o psych features, severe
F312	Bipolar disord, crnt episode manic severe w psych features
F313	Bipolar disord, current episode depress, mild or mod severt
F3130	Bipolar disord, crnt epsd depress, mild or mod severt, unsp
F3131	Bipolar disorder, current episode depressed, mild
F3132	Bipolar disorder, current episode depressed, moderate
F314	Bipolar disord, crnt epsd depress, sev, w/o psych features
F315	Bipolar disord, crnt epsd depress, severe, w psych features
F3160	Bipolar disorder, current episode mixed, unspecified
F3161	Bipolar disorder, current episode mixed, mild
F3162	Bipolar disorder, current episode mixed, moderate
F3163	Bipolar disord, crnt epsd mixed, severe, w/o psych features

ICD-10 Code	Description
F3164	Bipolar disord, crnt episode mixed, severe, w psych features
F317	Bipolar disorder, currently in remission
F3170	Bipolar disord, currently in remis, most recent episode unsp
F3171	Bipolar disord, in partial remis, most recent epsd hypomanic
F3172	Bipolar disord, in full remis, most recent episode hypomanic
F3173	Bipolar disord, in partial remis, most recent episode manic
F3174	Bipolar disorder, in full remis, most recent episode manic
F3175	Bipolar disord, in partial remis, most recent epsd depress
F3176	Bipolar disorder, in full remis, most recent episode depress
F3177	Bipolar disord, in partial remis, most recent episode mixed
F3178	Bipolar disorder, in full remis, most recent episode mixed
F318	Other bipolar disorders
F3181	Bipolar II disorder
F3189	Other bipolar disorder
F319	Bipolar disorder, unspecified
F32	Depressive episode
F320	Major depressive disorder, single episode, mild
F321	Major depressive disorder, single episode, moderate
F322	Major depressv disord, single epsd, sev w/o psych features
F323	Major depressv disord, single epsd, severe w psych features
F324	Major depressv disorder, single episode, in partial remis
F325	Major depressive disorder, single episode, in full remission
F328	Other depressive episodes
F3281	Premenstrual dysphoric disorder
F3289	Other specified depressive episodes
F329	Major depressive disorder, single episode, unspecified
F3291	Unknown Dx code
F32A	Depression, unspecified
F33	Major depressive disorder, recurrent
F330	Major depressive disorder, recurrent, mild
F331	Major depressive disorder, recurrent, moderate

ICD-10 Code	Description
F332	Major depressv disorder, recurrent severe w/o psych features
F333	Major depressv disorder, recurrent, severe w psych symptoms
F334	Major depressive disorder, recurrent, in remission
F3340	Major depressive disorder, recurrent, in remission, unsp
F3341	Major depressive disorder, recurrent, in partial remission
F3342	Major depressive disorder, recurrent, in full remission
F338	Other recurrent depressive disorders
F339	Major depressive disorder, recurrent, unspecified
F34	Persistent mood [affective] disorders
F340	Cyclothymic disorder
F341	Dysthymic disorder
F348	Other persistent mood [affective] disorders
F3481	Disruptive mood dysregulation disorder
F3489	Other specified persistent mood disorders
F349	Persistent mood [affective] disorder, unspecified
F39	Unspecified mood [affective] disorder
F400	Agoraphobia
F4000	Agoraphobia, unspecified
F4001	Agoraphobia with panic disorder
F4002	Agoraphobia without panic disorder
F401	Social phobias
F4010	Social phobia, unspecified
F4011	Social phobia, generalized
F40210	Arachnophobia
F40218	Other animal type phobia
F40220	Fear of thunderstorms
F40228	Other natural environment type phobia
F40230	Fear of blood
F40231	Fear of injections and transfusions
F40232	Fear of other medical care
F40233	Fear of injury

ICD-10 Code	Description
F40240	Claustrophobia
F40241	Acrophobia
F40242	Fear of bridges
F40243	Fear of flying
F40248	Other situational type phobia
F40290	Androphobia
F40298	Other specified phobia
F408	Other phobic anxiety disorders
F409	Phobic anxiety disorder, unspecified
F41	Other anxiety disorders
F410	Panic disorder [episodic paroxysmal anxiety]
F411	Generalized anxiety disorder
F413	Other mixed anxiety disorders
F418	Other specified anxiety disorders
F419	Anxiety disorder, unspecified
F42	Obsessive-compulsive disorder
F420	Unknown Dx code
F422	Mixed obsessional thoughts and acts
F423	Hoarding disorder
F424	Excoriation (skin-picking) disorder
F428	Other obsessive-compulsive disorder
F429	Obsessive-compulsive disorder, unspecified
F430	Acute stress reaction
F431	Post-traumatic stress disorder (PTSD)
F4310	Post-traumatic stress disorder, unspecified
F4311	Post-traumatic stress disorder, acute
F4312	Post-traumatic stress disorder, chronic
F43123	Unknown Dx code
F432	Adjustment disorders
F4320	Adjustment disorder, unspecified
F4321	Adjustment disorder with depressed mood

ICD-10 Code	Description
F4322	Adjustment disorder with anxiety
F4323	Adjustment disorder with mixed anxiety and depressed mood
F4324	Adjustment disorder with disturbance of conduct
F4325	Adjustment disorder w mixed disturb of emotions and conduct
F4329	Adjustment disorder with other symptoms
F438	Other reactions to severe stress
F439	Reaction to severe stress, unspecified
F440	Dissociative amnesia
F441	Dissociative fugue
F442	Dissociative stupor
F444	Conversion disorder with motor symptom or deficit
F445	Conversion disorder with seizures or convulsions
F446	Conversion disorder with sensory symptom or deficit
F447	Conversion disorder with mixed symptom presentation
F4481	Dissociative identity disorder
F4489	Other dissociative and conversion disorders
F449	Dissociative and conversion disorder, unspecified
F450	Somatization disorder
F451	Undifferentiated somatoform disorder
F4520	Hypochondriacal disorder, unspecified
F4521	Hypochondriasis
F4522	Body dysmorphic disorder
F4541	Pain disorder exclusively related to psychological factors
F4542	Pain disorder with related psychological factors
F458	Other somatoform disorders
F459	Somatoform disorder, unspecified
F481	Depersonalization-derealization syndrome
F488	Other specified nonpsychotic mental disorders
F489	Nonpsychotic mental disorder, unspecified
F5000	Anorexia nervosa, unspecified
F5001	Anorexia nervosa, restricting type

ICD-10 Code	Description
F5002	Anorexia nervosa, binge eating/purging type
F502	Bulimia nervosa
F508	Other eating disorders
F5081	Binge eating disorder
F5082	Avoidant/restrictive food intake disorder
F5089	Other specified eating disorder
F509	Eating disorder, unspecified
F5101	Primary insomnia
F5102	Adjustment insomnia
F5103	Paradoxical insomnia
F5104	Psychophysiologic insomnia
F5105	Insomnia due to other mental disorder
F5109	Oth insomnia not due to a substance or known physiol cond
F5111	Primary hypersomnia
F5112	Insufficient sleep syndrome
F5113	Hypersomnia due to other mental disorder
F5119	Oth hypersomnia not due to a substance or known physiol cond
F513	Sleepwalking [somnambulism]
F514	Sleep terrors [night terrors]
F515	Nightmare disorder
F518	Oth sleep disord not due to a sub or known physiol cond
F519	Sleep disorder not due to a sub or known physiol cond, unsp
F520	Hypoactive sexual desire disorder
F521	Sexual aversion disorder
F5221	Male erectile disorder
F5222	Female sexual arousal disorder
F5231	Female orgasmic disorder
F5232	Male orgasmic disorder
F524	Premature ejaculation
F525	Vaginismus not due to a substance or known physiol condition
F526	Dyspareunia not due to a substance or known physiol cond

ICD-10 Code	Description
F528	Oth sexual dysfnct not due to a sub or known physiol cond
F529	Unsp sexual dysfnct not due to a sub or known physiol cond
F53	Mental and behavrl disorders assoc with the puerperium, NEC
F530	Postpartum depression
F531	Puerperal psychosis
F54	Psych & behavrl factors assoc w disord or dis classd elswhr
F550	Abuse of antacids
F551	Abuse of herbal or folk remedies
F552	Abuse of laxatives
F553	Abuse of steroids or hormones
F554	Abuse of vitamins
F558	Abuse of other non-psychoactive substances
F59	Unsp behavrl synd assoc w physiol disturb and physcl factors
F600	Paranoid personality disorder
F601	Schizoid personality disorder
F602	Antisocial personality disorder
F603	Borderline personality disorder
F604	Histrionic personality disorder
F605	Obsessive-compulsive personality disorder
F606	Avoidant personality disorder
F607	Dependent personality disorder
F6081	Narcissistic personality disorder
F6089	Other specific personality disorders
F609	Personality disorder, unspecified
F630	Pathological gambling
F631	Pyromania
F632	Kleptomania
F633	Trichotillomania
F6381	Intermittent explosive disorder
F6389	Other impulse disorders
F639	Impulse disorder, unspecified

ICD-10 Code	Description
F640	Transsexualism
F641	Dual role transvestism
F642	Gender identity disorder of childhood
F648	Other gender identity disorders
F649	Gender identity disorder, unspecified
F650	Fetishism
F651	Transvestic fetishism
F652	Exhibitionism
F653	Voyeurism
F654	Pedophilia
F6552	Sexual sadism
F6581	Frotteurism
F6589	Other paraphilias
F659	Paraphilia, unspecified
F66	Other sexual disorders
F6810	Factitious disorder imposed on self, unspecified
F6811	Factit disord imposed on self, with predom psych signs/symp
F6812	Factit disord impsd on self, with predom physcl signs/symp
F6813	Factit disord impsd on self,w comb psych & physcl signs/symp
F688	Other specified disorders of adult personality and behavior
F68A	Factitious disorder imposed on another
F69	Unspecified disorder of adult personality and behavior
F910	Conduct disorder confined to family context
F911	Conduct disorder, childhood-onset type
F912	Conduct disorder, adolescent-onset type
F913	Oppositional defiant disorder
F918	Other conduct disorders
F919	Conduct disorder, unspecified
F93	Emotional disorders with onset specific to childhood
F99	Mental disorder, not otherwise specified
K2920	Alcoholic gastritis without bleeding

ICD-10 Code	Description
K2921	Alcoholic gastritis with bleeding
K5902	Outlet dysfunction constipation
K7010	Alcoholic hepatitis without ascites
K7011	Alcoholic hepatitis with ascites
O99310	Alcohol use complicating pregnancy, unspecified trimester
O99311	Alcohol use complicating pregnancy, first trimester
O99312	Alcohol use complicating pregnancy, second trimester
O99313	Alcohol use complicating pregnancy, third trimester
O99320	Drug use complicating pregnancy, unspecified trimester
O99321	Drug use complicating pregnancy, first trimester
O99322	Drug use complicating pregnancy, second trimester
O99323	Drug use complicating pregnancy, third trimester
O99324	Drug use complicating childbirth
O99325	Drug use complicating the puerperium
O99340	Oth mental disorders complicating pregnancy, unsp trimester
O99341	Oth mental disorders complicating pregnancy, first trimester
O99342	Oth mental disorders comp pregnancy, second trimester
O99343	Oth mental disorders complicating pregnancy, third trimester
O99344	Other mental disorders complicating childbirth
O99345	Other mental disorders complicating the puerperium
R45851	Suicidal ideations
R780	Finding of alcohol in blood
T1491	Suicide attempt
T1491XA	Suicide attempt, initial encounter
T1491XD	Suicide attempt, subsequent encounter
T1491XS	Suicide attempt, sequela
T360X2A	Poisoning by penicillins, intentional self-harm, init encntr
T361X2A	Poisn by cephalospor/oth beta-lactm antibiot, slf-hrm, init
T368X2A	Poisoning by oth systemic antibiotics, self-harm, init
T375X2A	Poisoning by antiviral drugs, intentional self-harm, init
T378X2A	Poisn by oth systemic anti-infect/parasit, self-harm, init

ICD-10 Code	Description
T378X2D	Poisn by oth systemic anti-infect/parasit, self-harm, subs
T380X2A	Poisoning by glucocort/synth analog, self-harm, init
T381X2A	Poisoning by thyroid hormones and sub, self-harm, init
T383X2A	Poisn by insulin and oral hypoglycemic drugs, slf-hrm, init
T383X2D	Poisn by insulin and oral hypoglycemic drugs, slf-hrm, subs
T385X2A	Poisoning by oth estrogens and progestogens, self-harm, init
T38892A	Poisoning by oth hormones and synthetic sub, self-harm, init
T39012A	Poisoning by aspirin, intentional self-harm, init encntr
T39012D	Poisoning by aspirin, intentional self-harm, subs encntr
T39092A	Poisoning by salicylates, intentional self-harm, init encntr
T39092D	Poisoning by salicylates, intentional self-harm, subs encntr
T391X2A	Poisoning by 4-Aminophenol derivatives, self-harm, init
T391X2D	Poisoning by 4-Aminophenol derivatives, self-harm, subs
T391X2S	Poisoning by 4-Aminophenol derivatives, self-harm, sequela
T39312A	Poisoning by propionic acid derivatives, self-harm, init
T39312D	Poisoning by propionic acid derivatives, self-harm, subs
T39312S	Poisoning by propionic acid derivatives, self-harm, sequela
T39392A	Poisn by oth nonsteroid anti-inflam drugs, self-harm, init
T39392D	Poisn by oth nonsteroid anti-inflam drugs, self-harm, subs
T39392S	Poisn by oth nonsteroid anti-inflam drugs, slf-hrm, sequela
T398X2A	Poisn by oth nonopio analges/antipyret, NEC, self-harm, init
T3992XA	Poisn by unsp nonopi analgs/antipyr/antirheu, slf-hrm, init
T401X2A	Poisoning by heroin, intentional self-harm, init encntr
T402X2A	Poisoning by oth opioids, intentional self-harm, init encntr
T403X2A	Poisoning by methadone, intentional self-harm, init encntr
T403X2D	Poisoning by methadone, intentional self-harm, subs encntr
T40412A	Poisoning by fentanyl or fentanyl analogs, self-harm, init
T40412D	Poisoning by fentanyl or fentanyl analogs, self-harm, subs
T40422A	Poisoning by tramadol, self-harm, initial encounter
T40492A	Poisoning by other synthetic narcotics, self-harm, init
T40492D	Poisoning by other synthetic narcotics, self-harm, subs

ICD-10 Code	Description
T404X2A	Poisoning by oth synthetic narcotics, self-harm, init
T404X2D	Poisoning by oth synthetic narcotics, self-harm, subs
T405X2A	Poisoning by cocaine, intentional self-harm, init encntr
T40602A	Poisoning by unsp narcotics, intentional self-harm, init
T40602D	Poisoning by unsp narcotics, intentional self-harm, subs
T40692A	Poisoning by oth narcotics, intentional self-harm, init
T407X2A	Poisoning by cannabis (derivatives), self-harm, init
T41292A	Poisoning by oth general anesthetics, self-harm, init
T420X2A	Poisoning by hydantoin derivatives, self-harm, init
T421X2A	Poisoning by iminostilbenes, intentional self-harm, init
T421X2D	Poisoning by iminostilbenes, intentional self-harm, subs
T423X2A	Poisoning by barbiturates, intentional self-harm, init
T424X2A	Poisoning by benzodiazepines, intentional self-harm, init
T424X2D	Poisoning by benzodiazepines, intentional self-harm, subs
T424X2S	Poisoning by benzodiazepines, intentional self-harm, sequela
T426X2A	Poisn by oth antieplptc and sed-hypntc drugs, slf-hrm, init
T426X2D	Poisn by oth antieplptc and sed-hypntc drugs, slf-hrm, subs
T4272XA	Poisn by unsp antieplptc and sed-hypntc drugs, slf-hrm, init
T4272XD	Poisn by unsp antieplptc and sed-hypntc drugs, slf-hrm, subs
T428X2A	Poisn by antiparkns drug/centr musc-tone depr, slf-hrm, init
T428X2D	Poisn by antiparkns drug/centr musc-tone depr, slf-hrm, subs
T43012A	Poisoning by tricyclic antidepressants, self-harm, init
T43012D	Poisoning by tricyclic antidepressants, self-harm, subs
T43022A	Poisoning by tetracyclic antidepressants, self-harm, init
T43202A	Poisoning by unsp antidepressants, self-harm, init
T43212A	Poisn by slctv seroton/norepineph reup inhibtr,slf-hrm, init
T43212D	Poisn by slctv seroton/norepineph reup inhibtr,slf-hrm, subs
T43222A	Poisn by slctv serotonin reuptake inhibtr, self-harm, init
T43292A	Poisoning by oth antidepressants, self-harm, init
T433X2A	Poisn by phenothiaz antipsychot/neurolept, self-harm, init
T434X2A	Poisn by butyrophen/thiothixen neuroleptc, self-harm, init

ICD-10 Code	Description
T43502A	Poisoning by unsp antipsychot/neurolept, self-harm, init
T43502S	Poisoning by unsp antipsychot/neurolept, self-harm, sequela
T43592A	Poisoning by oth antipsychot/neurolept, self-harm, init
T43592D	Poisoning by oth antipsychot/neurolept, self-harm, subs
T43602A	Poisoning by unsp psychostimulants, self-harm, init
T43612A	Poisoning by caffeine, intentional self-harm, init encntr
T43622A	Poisoning by amphetamines, intentional self-harm, init
T43632A	Poisoning by methylphenidate, intentional self-harm, init
T43642A	Poisoning by ecstasy, self-harm, initial encounter
T438X2A	Poisoning by oth psychotropic drugs, self-harm, init
T4392XA	Poisoning by unsp psychotropic drug, self-harm, init
T440X2A	Poisoning by anticholinesterase agents, self-harm, init
T441X2A	Poisoning by oth parasympathomimetics, self-harm, init
T443X2A	Poisn by oth parasympath and spasmolytics, self-harm, init
T444X2A	Poisn by predom alpha-adrenocpt agonists, self-harm, init
T445X2A	Poisoning by predom beta-adrenocpt agonists, self-harm, init
T446X2A	Poisoning by alpha-adrenocpt antagonists, self-harm, init
T447X2A	Poisoning by beta-adrenocpt antagonists, self-harm, init
T448X2A	Poisn by centr-acting/adren-neurn-block agnt, slf-hrm, init
T44902A	Poisn by unsp drugs aff the autonm nrv sys, slf-hrm, init
T450X2A	Poisoning by antiallerg/antiemetic, self-harm, init
T450X2D	Poisoning by antiallerg/antiemetic, self-harm, subs
T451X2A	Poisoning by antineopl and immunosup drugs, self-harm, init
T452X2A	Poisoning by vitamins, intentional self-harm, init encntr
T454X2A	Poisoning by iron and its compounds, self-harm, init
T45512A	Poisoning by anticoagulants, intentional self-harm, init
T45522A	Poisoning by antithrombotic drugs, self-harm, init
T457X2A	Poisn by anticoag antag, vit K and oth coag, slf-hrm, init
T460X2A	Poisn by cardi-stim glycos/drug simlar act, self-harm, init
T461X2A	Poisoning by calcium-channel blockers, self-harm, init
T461X2D	Poisoning by calcium-channel blockers, self-harm, subs

ICD-10 Code	Description
T463X2A	Poisoning by coronary vasodilators, self-harm, init
T464X2A	Poisn by angiotens-convert-enzyme inhibtr, self-harm, init
T465X2A	Poisoning by oth antihypertensive drugs, self-harm, init
T465X2D	Poisoning by oth antihypertensive drugs, self-harm, subs
T465X2S	Poisoning by oth antihypertensive drugs, self-harm, sequela
T466X2A	Poisn by antihyperlip and antiarterio drugs, self-harm, init
T467X2A	Poisoning by peripheral vasodilators, self-harm, init
T467X2D	Poisoning by peripheral vasodilators, self-harm, subs
T46902A	Poisn by unsp agents aff the cardiovasc sys, self-harm, init
T470X2A	Poisoning by histamine H2-receptor blockers, self-harm, init
T471X2A	Poisn by oth antacids & anti-gstrc-sec drugs, slf-hrm, init
T472X2A	Poisoning by stimulant laxatives, self-harm, init
T476X2A	Poisoning by antidiarrheal drugs, self-harm, init
T481X2A	Poisoning by skeletal muscle relaxants, self-harm, init
T48202A	Poisoning by unsp drugs acting on muscles, self-harm, init
T483X2A	Poisoning by antitussives, intentional self-harm, init
T484X2A	Poisoning by expectorants, intentional self-harm, init
T485X2A	Poisoning by oth anti-common-cold drugs, self-harm, init
T486X2A	Poisoning by antiasthmatics, intentional self-harm, init
T490X2A	Poisn by local antifung/infect/inflamm drugs, slf-hrm, init
T492X2A	Poisoning by local astringents/detergents, self-harm, init
T496X2A	Poisoning by otorhino drugs and prep, self-harm, init
T500X2A	Poisoning by mineralocorticoids and antag, self-harm, init
T502X2A	Poisn by crbnc-anhydr inhibtr,benzo/oth diuretc,slf-hrm,init
T502X2D	Poisn by crbnc-anhydr inhibtr,benzo/oth diuretc,slf-hrm,subs
T502X2S	Poisn by crbnc-anhydr inhibtr,benzo/oth diuretc,slf-hrm,sqla
T503X2A	Poisn by electrolytic/caloric/wtr-bal agnt, self-harm, init
T506X2A	Poisoning by antidotes and chelating agents, self-harm, init
T507X2A	Poisn by analeptics and opioid receptor antag, slf-hrm, init
T50902A	Poisoning by unsp drug/meds/biol subst, self-harm, init
T50902D	Poisoning by unsp drug/meds/biol subst, self-harm, subs

ICD-10 Code	Description
T50902S	Poisoning by unsp drug/meds/biol subst, self-harm, sequela
T50912A	Poisn by multiple unsp drug/meds/biol subst, self-harm, init
T50912D	Poisn by multiple unsp drug/meds/biol subst, self-harm, subs
T50912S	Poisn by mult unsp drug/meds/biol subst, slf-hrm, sequela
T50992A	Poisoning by oth drug/meds/biol subst, self-harm, init
T50992D	Poisoning by oth drug/meds/biol subst, self-harm, subs
T510X2A	Toxic effect of ethanol, intentional self-harm, init encntr
T511X2A	Toxic effect of methanol, intentional self-harm, init encntr
T512X2A	Toxic effect of 2-Propanol, intentional self-harm, init
T513X2A	Toxic effect of fusel oil, intentional self-harm, init
T518X2A	Toxic effect of oth alcohols, intentional self-harm, init
T518X2D	Toxic effect of oth alcohols, intentional self-harm, subs
T5192XA	Toxic effect of unsp alcohol, intentional self-harm, init
T520X2A	Toxic effect of petroleum products, self-harm, init
T520X2S	Toxic effect of petroleum products, self-harm, sequela
T528X2A	Toxic effect of organic solvents, self-harm, init
T528X2S	Toxic effect of organic solvents, self-harm, sequela
T541X2A	Toxic effect of corrosive organic compounds, self-harm, init
T542X2A	Tox eff of corrosv acids & acid-like substnc, slf-hrm, init
T543X2A	Tox eff of corrosv alkalis & alk-like substnc, slf-hrm, init
T5492XA	Toxic effect of unsp corrosive substance, self-harm, init
T550X2A	Toxic effect of soaps, intentional self-harm, init encntr
T551X2A	Toxic effect of detergents, intentional self-harm, init
T560X2D	Toxic effect of lead and its compounds, self-harm, subs
T56892A	Toxic effect of oth metals, intentional self-harm, init
T578X2A	Toxic effect of inorganic substances, self-harm, init
T5792XA	Toxic effect of unsp inorganic substance, self-harm, init
T5802XA	Toxic eff of carb monx from mtr veh exhaust, slf-hrm, init
T5812XA	Toxic effect of carb monx from utility gas, self-harm, init
T588X2A	Toxic effect of carb monx from oth source, self-harm, init
T5892XA	Toxic effect of carb monx from unsp source, self-harm, init

ICD-10 Code	Description
T5892XD	Toxic effect of carb monx from unsp source, self-harm, subs
T5892XS	Toxic effect of carb monx from unsp source, slf-hrm, sequela
T59812A	Toxic effect of smoke, intentional self-harm, init encntr
T59892A	Toxic effect of gases, fumes and vapors, self-harm, init
T5992XA	Toxic effect of unsp gases, fumes and vapors, slf-hrm, init
T620X2A	Toxic effect of ingested mushrooms, self-harm, init
T622X2A	Toxic effect of ingested (parts of) plant(s), slf-hrm, init
T63462A	Toxic effect of venom of wasps, intentional self-harm, init
T65222A	Toxic effect of tobacco cigarettes, self-harm, init
T65222D	Toxic effect of tobacco cigarettes, self-harm, subs
T65292A	Toxic effect of tobacco and nicotine, self-harm, init
T65292S	Toxic effect of tobacco and nicotine, self-harm, sequela
T65892A	Toxic effect of oth substances, intentional self-harm, init
T6592XA	Toxic effect of unsp substance, intentional self-harm, init
T6592XD	Toxic effect of unsp substance, intentional self-harm, subs
T6592XS	Toxic effect of unsp substance, self-harm, sequela
T71122A	Asphyxiation due to plastic bag, intentional self-harm, init
T71162A	Asphyxiation due to hanging, intentional self-harm, init
T71162D	Asphyxiation due to hanging, intentional self-harm, subs
T71162S	Asphyxiation due to hanging, intentional self-harm, sequela
T71192A	Asphyx d/t mech thrt to breathe d/t oth cause, slf-hrm, init
X730XXA	Intentional self-harm by shotgun discharge, init encntr
X780XXA	Intentional self-harm by sharp glass, initial encounter
X781XXA	Intentional self-harm by knife, initial encounter
X781XXD	Intentional self-harm by knife, subsequent encounter
X788XXA	Intentional self-harm by other sharp object, init encntr
X788XXD	Intentional self-harm by other sharp object, subs encntr
X789XXA	Intentional self-harm by unsp sharp object, init encntr
X789XXD	Intentional self-harm by unsp sharp object, subs encntr
X838XXA	Intentional self-harm by other specified means, init encntr
Z7141	Alcohol abuse counseling and surveillance of alcoholic

ICD-10 Code	Description
Z7151	Drug abuse counseling and surveillance of drug abuser
Z8651	Personal history of combat and operational stress reaction
Z8659	Personal history of other mental and behavioral disorders

Behavioral Health Care Provider Type Taxonomy Codes and Description Included in Behavioral Health Care Definition

Taxonomy	Taxonomy Classification/Specialization
101Y00000X	Counselor,
101YA0400X	Counselor, Addiction (Substance Use Disorder)
101YM0800X	Counselor, Mental Health
101YP1600X	Counselor, Pastoral
101YP2500X	Counselor, Professional
101YS0200X	Counselor, School
103T00000X	Psychologist,
103TA0400X	Psychologist, Addiction (Substance Use Disorder)
103TA0700X	Psychologist, Adult Development & Aging
103TB0200X	Psychologist, Cognitive & Behavioral
103TC0700X	Psychologist, Clinical
103TC1900X	Psychologist, Counseling
103TF0000X	Psychologist, Family
103TH0100	Psychologist, Health Service
103TP0016X	Psychologist, Prescribing (Medical)
103TP0814X	Psychologist, Psychoanalysis
103TP2701X	Psychologist, Group Psychotherapy
104100000X	Social Worker,
1041C0700X	Social Worker, Clinical
1041S0200X	Social Worker, School
106E00000X**	Assistant Behavior Analyst
106H00000X	Marriage & Family Therapist
133VN1006X	Dietitian, Registered, Nutrition, Metabolic
163WA0400X	Registered Nurse, Addiction (Substance Use Disorder)
163WP0807X	Registered Nurse, Psychiatric/Mental Health, Child & Adolescent

Taxonomy	Taxonomy Classification/Specialization
163WP0808X	Registered Nurse, Psychiatric/Mental Health
163WP0809X	Registered Nurse, Psychiatric/Mental Health, Adult
172V00000X	Community Health Worker
175T00000X	Peer Specialist
207PP0204X**	Emergency Medicine, Pediatric Emergency Medicine
207QA0401X	Family Medicine, Addiction Medicine
2083A0300X**	Preventive Medicine, Addiction Medicine
2084A0401X	Psychiatry & Neurology, Addiction Medicine
2084F0202X	Psychiatry & Neurology, Forensic Psychiatry
2084P0015X	Psychiatry & Neurology, Psychosomatic Medicine
2084P0800X	Psychiatry & Neurology, Psychiatry
2084P0802X	Psychiatry & Neurology, Addiction Psychiatry
2084P0804X	Psychiatry & Neurology, Child & Adolescent Psychiatry
2084P0805X	Psychiatry & Neurology, Geriatric Psychiatry
221700000X	Art Therapist
222Q00000X	Developmental Therapist
225500000X	Specialist/Technologist
225600000X	Dance Therapist
225700000X**	Massage Therapist
251K00000X**	Public Health or Welfare
251S00000X	Community/Behavioral Health
251V00000X	Voluntary or Charitable
261QC1500X	Clilnic/Center, Community Health
261QM0801X	Clinic/Center, Mental Health (Including Community Mental Health Center)
261QM0850X	Clinic/Center, Adult Mental Health
261QM0855X	Clinic/Center, Adolescent and Children Mental Health
261QM2800X	Clinic/Center, Methadone
261QR0405X	Clinic/Center, Rehabilitation, Substance Use Disorder
273R00000X**	Psychiatric Unit
276400000X	Rehabilitation, Substance Use Disorder Unit
283Q00000X	Psychiatric Hospital

Taxonomy	Taxonomy Classification/Specialization
3104A0625X*	Assisted Living Facility, Assisted Living (Mental Illness)
310500000X*,**	Intermediate Care Facility, Mental Illness
311Z00000X*,**	Custodial Care Facility
320600000X	Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities
320800000X	Community Based Residential Treatment Facility, Mental Illness
322D00000X	Residential Treatment Facility, Emotionally Disturbed Children
323P00000X	Psychiatric Residential Treatment Facility
324500000X	Substance Abuse Rehabilitation Facility
3245S0500X	Substance Abuse Rehabilitation Facility, Substance Abuse Treatment, Children
363LP0808X	Nurse Practitioner, Psychiatric/Mental Health
364SC1501X**	Clinical Nurse Specialist – Community Health/Public Health
364SF0001X	Clinical Nurse Specialist, Family Health
364S00000X	Clinical Nurse Specialist
364SP0807X	Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Adolescent
364SP0808X	Clinical Nurse Specialist, Psychiatric/Mental Health
364SP0809X	Clinical Nurse Specialist, Psychiatric/Mental Health, Adult
405300000X	Prevention Professional

* Non-LTSS Related Services
** MaineCare only

HCPCS Codes to Identify Crisis Services

HCPCS Codes	Description
S9485	Crisis intervention mental health services, per diem
S9484	Crisis intervention mental health services, per hour
H2011	Crisis intervention service, per 15 minutes
H0018	Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem
G0017	Psychotherapy for crisis furnished in any place of service, other than the office setting); first 60 minutes
G0018	Psychotherapy for crisis furnished in any place of service, other than the office setting); each additional 30 minutes
H0007	Alcohol and/or drug services; crisis intervention (outpatient)
T2034	Crisis intervention, waiver; per diem

Codes Included in the Healthcare Setting Analysis

For Telehealth setting – see Procedure Codes Included in Telehealth Analysis below

Setting	Place of Service	Revenue Code	Type of Bill Code
IP Acute	21		11, 12, 18
IP Residential	51		21, 86
ED	20, 23	450-459, 981	
FQHC/RHC	50, 72		71, 73, 77
OP	POS codes not included in categories above		

Procedure Codes Included in Telehealth Analysis

Procedure Codes***	Description
2 (Place of Service)	Health services are received through Telecommunications technology
10 (Place of Service)	Telehealth Place of Service Code
FR (Modifier)	Procedure modifier
FQ (Modifier)	Procedure modifier
GT (Modifier)	Via interactive audio and video telecommunication systems
G0 (Modifier)	Procedure modifier
GQ (Modifier)	Procedure modifier
93 (Modifier)	Procedure modifier
95 (Modifier)	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
98966-98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment
99421-99423	Online Digital Evaluation and Management Services
98970 - 98972	Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days
98980	Remote monitoring PLUS interacting with patient
98981	Addl time
99441-99443	Telephone E/M service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment
99446-99449	Interprofessional Telephone/Internet/Electronic Health Record Consultations
99451-99452	Interprofessional Telephone/Internet/Electronic Health Record Consultations
99457	QHP service; 20 minutes of Non F2F and F2F time spent in analysis and via synchronous communication with patient the findings or care plan

Procedure Codes***	Description
99458	Add-on code; full additional 20 minutes for services described in 99457
0188T-0189T	Remote Real-Time Interactive Video-conferenced Critical Care Services
G0071	Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a rural health clinic (rhc) or federally qualified health center (fqhc) practitioner and rhc or fqhc patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an rhc or fqhc practitioner, occurring in lieu of an office visit; rhc or fqhc only
G0181	Physician or allowed practitioner supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician or allowed practitioner development and/or revision of care plans
G0182	Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more
G0406-G0408	Follow-up inpatient consultation, limited, physicians typically spend [15, 25, 35] minutes communicating with the patient via telehealth
G0425-G0427	Telehealth consultation, emergency department or initial inpatient, typically [30, 50, 70] minutes communicating with the patient via telehealth
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
G0508-G0509	Telehealth consultation, critical care
G2010	Remote evaluation of recorded video and/or images submitted by an established patient, including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment
G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report e/m services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
G2025	Payment for a telehealth distant site service furnished by a rural health clinic (rhc) or federally qualified health center (fqhc) only
G2061-G2063	Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; [5-10, 11-20, 21+] minutes
G2252	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 11–20 minutes of medical discussion

Procedure Codes***	Description
Q3014	Telehealth originating site facility fee
S9110	Telemonitoring of patient in their home, including all necessary equipment; computer system, connections, and software; maintenance; patient education and support; per month
T1014	Telehealth transmission, per minute, professional services bill separately

***Most codes used a Modifier.

Attachment F - Endnotes

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3. Maine Health Data Organization. Rule Chapter 247: Uniform Reporting System for Non-Claims-Based Payments. Adopted December 12, 2021. https://mhdo.maine.gov/_finalStatutesRules/Chapter%20247%20Non-Claims%20Data_211212.pdf.
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