



PENNSYLVANIA

HealthChoices

Program Audit Guide
Behavioral Health

for the
2012
Program Year

DEPARTMENT OF PUBLIC WELFARE

**COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE**

**HEALTHCHOICES AUDIT GUIDE
BEHAVIORAL HEALTH**

For the 2012 Program Year

**DEPARTMENT OF PUBLIC WELFARE
HEALTHCHOICES AUDIT GUIDE
BEHAVIORAL HEALTH**

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HEALTHCHOICES AUDIT GUIDE
BEHAVIORAL HEALTH**

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BEHAVIORAL HEALTH

INTRODUCTION

INTRODUCTION

Points of Contact

Questions or comments related to the Audit Guide should be submitted to:

Paul Waznik
Bureau of Audits
Forum Place
555 Walnut Street – 8th Floor
Harrisburg, Pennsylvania 17101
(717) 703-3954
pwaznik@pa.gov

Questions related to the examination should be submitted to:

Kimberly Butsch
Office of Mental Health & Substance Abuse Services
DGS Annex Complex
Shamrock Hall, Bldg. #31, 1st Floor
P.O. Box 2675
Harrisburg, PA 17105-2675
(717) 346-1097
kbutsch@pa.gov

Confirmation of Schedules to be Examined

Contractors submit electronic reports to the Department of Public Welfare (DPW) in compliance with the Behavioral HealthChoices Electronic Financial Data Submission Reporting Specifications Manual. Various reports are cumulative and year-to-date and/or contract-to-date amounts are calculated based on prior submissions. The Independent Public Accountants (IPA) must confirm that the reports they are examining represent the data received electronically by DPW on or prior to the submission deadline.

At such time as DPW receives the contract year-end submissions, the Office of Mental Health and Substance Abuse Services (OMHSAS) will forward an electronic copy of the reports to be examined to the IPA. It is the responsibility of the IPA to determine if the reports to be examined provided by the OMHSAS correspond to the reports to be examined provided by the contractor and to report any variances as examination adjustments.

Confirmation of Payments

Confirmation of payments received directly from DPW is available from the Comptroller Operations, Bureau of Payable Services, which processes all requests for confirmation. Such requests should always include the number of the contract and or Medical Assistance (MA) Provider Identification number/Location number as well as the name of the program (i.e. HealthChoices). Requests must include the type of payments to be confirmed, the time period to be confirmed for each type of payment, as well as the total of the payments per type (e.g., capitation, pay for performance). Amounts to be confirmed should consist of capitation payments (without sanctions deducted). The amount to be confirmed should not be reduced by the amount of the Gross Receipts Tax.

When requesting confirmation of capitation payments where a delay exists, the amounts must be based on the date of service. For example, if the request is for dates of service within fiscal year ended (FYE) June 30, 2012, the confirmation would be based on the actual month of service regardless of payment date (e.g., June 30, 2012 dates of service pay in August 2012; the Bureau of Payable Services, would confirm June's amount as part of the (FYE) June 30, 2012 confirmation).

Confirmation requests should be **emailed** to Tracy Steele at the following email address: tsteele@pa.gov.

Email is the preferred option for requesting confirmations; however, if mailing hard copy requests, use the following address:

Comptroller Operations, Bureau of Payable Services
Attn: Tracy Steele
Forum Place
555 Walnut Street, 9th Floor
Harrisburg, Pennsylvania 17101
Telephone: (717) 425-6869

Engagement Requirement

A bound report package on the IPA's examination of the Contractor's HealthChoices Behavioral Health Program performed in accordance with this Audit Guide, the provisions of Appendix W of the HealthChoices Behavioral Health Program Standards and Requirements, as well as Section 2.0, page 3 of the FRR is required to be submitted to the Commonwealth by:

- ♦ May 15, 2013 for the Southeast and Southwest Zones
- ♦ November 15, 2013 for the Lehigh Capital, Northeast, North Central State Option, and North Central County Option Zones.

If a management letter has been issued as a result of the IPA's examination, copies of this letter must be submitted with, but not necessarily part of the bound report on the IPA's examination.

Distribution:

The Bureau of Audits (BOA) requires the examination reports to be submitted electronically. The reports can be submitted to the following resource account:

RA-BOAHealthChoices@pa.gov.

The BOA will still accept a hard copy report if an electronic copy cannot be sent. The copy can be sent to the following address:

Pennsylvania Office of the Budget
Bureau of Audits
Forum Place
555 Walnut Street – 9th Floor
Harrisburg, Pennsylvania 17101
Attn: Paul Waznik

The OMHSAS will continue to receive hard copies of the report.

2 Copies If by regular mail to:

Ms. Terry Mardis
Department of Public Welfare
Office of Mental Health & Substance Abuse Services
DGS Annex Complex
Shamrock Hall, Bldg. #31, 1st Floor
P.O. Box 2675
Harrisburg, PA 17105

If by overnight courier to:

Ms. Terry Mardis
Department of Public Welfare
Bureau of Financial Management and Administration
Division of Medicaid Finance
DGS Annex Complex
Shamrock Hall, Bldg. #31, Room 116
112 East Azalea Drive
Harrisburg, PA 17110-3594
Telephone: (717) 772-7433

The DGS Annex Complex address is to be used for overnight courier delivery only. The P.O. Box must be used for U.S. Postal Service. They do not deliver to the DGS Annex Complex address.

NOTE: Copies sent directly to the Program Office (OMHSAS) should be clearly marked “**DPW Copy**”. **Hard copies sent to the Bureau of Audits (BOA) should be clearly marked “BOA Copy”**

Resolution:

Upon receipt of the report package, OMHSAS conducts a technical review of the submission and determines whether the report package meets the requirements as specified in the HealthChoices Audit Guide. **The Contractor and the IPA of record may be contacted during the resolution process by OMHSAS or BOA.**

Background of the Audit Guide

In February 1997, the Commonwealth of Pennsylvania, Department of Public Welfare (DPW) implemented a mandatory Behavioral Health Managed Care Program for Medical Assistance (MA) recipients, called the HealthChoices Behavioral Health Program. The program was designed to introduce an integrated and coordinated health care delivery system to serve MA recipients requiring medical, psychiatric and substance abuse services through a capitated, mandatory managed care program. The program has been gradually implemented across the Commonwealth over a period of several years. Attachment 1 to this Introduction provides information on this implementation.

As DPW transitioned its MA program in Pennsylvania from a fee-for-service environment to a managed care environment, it also fundamentally transformed the

focus of its operations. DPW moved away from an insurance environment in which it was concerned primarily with setting provider rates, authorizing services, and paying claims submitted by individual providers. DPW moved toward an environment in which it acts as a prudent purchaser of managed care services from a limited number of Contractors who assume the responsibility for providing a defined set of health care and supporting services to Medicaid beneficiaries for a set, pre-paid fee.

This fundamental shift in DPW's approach to providing care for MA recipients, created a corresponding shift in its audit approach, away from individual service providers, to managed care organizations (MCOs) and their compliance with financial, regulatory, and programmatic requirements. In addition, the inclusion of County governments as well as licensed health maintenance organizations (HMO) and preferred provider organizations (PPO) as sub-contractors in the Behavioral Health program added another layer of complexity to the audit process.

To effectively address this added level of complexity, DPW has developed a system of controls to ensure that Contractors participating in the HealthChoices Behavioral Health program are complying with the Commonwealth's requirements to deliver accessible, high quality, affordable health care services to eligible MA recipients, in accordance with the Commonwealth's managerial and regulatory requirements. These controls include:

- ♦ Monitor Contractors to ensure they have the resources to meet the requirements of the program.
- ♦ Complete an on-site review of each plan to assess its compliance with contract requirements.
- ♦ Review MCO subcontracts to assess compliance with Commonwealth requirements.
- ♦ Review and compare encounter data with medical records documentation for accuracy and validity.
- ♦ Monitor financial viability of Contractors.
- ♦ Analyze appropriateness of Contractors' Utilization Management targets.
- ♦ Monitor compliance with data format standards and timely receipt of on-line encounter data transfers.
- ♦ Review provider networks to ensure that adequate resources are available to meet Commonwealth access and medical management standards/medical necessity criteria.
- ♦ Review Quality Assurance and Improvement plans, structures, organizations and ongoing activities.
- ♦ Monitor adherence to notification requirements to DPW regarding formularies, prior authorization procedures, etc.
- ♦ Review utilization data to identify potential instances of under-utilization of services.
- ♦ Survey members for satisfaction with access and quality of services.

- ◆ Conduct random tests of plan member service and help lines and appointment systems for adherence to Commonwealth requirements.

Despite the existence of this extensive system of monitoring controls and activities, DPW recognized that there are risk areas that may need additional review. Therefore, it took steps to develop an audit guide that would address these risk areas. The resulting HealthChoices Audit Guide for Behavioral Health was developed to supplement the Commonwealth's monitoring efforts and yield a framework of controls to oversee the local operations of the HealthChoices program. The Audit Guide provides assurances relative to each Contractor's compliance with certain financial, administrative, and operational requirements of the HealthChoices program.

Purpose of the Audit Guide

The Audit Guide provides a consistent framework to be used by IPAs as they address the risk areas identified while conducting their annual contract-specific examinations. It was developed to supplement the Commonwealth's extensive monitoring efforts.

The Compliance Requirements of the Audit Guide are divided into the following four sections:

- ◆ Claims Processing
- ◆ MIS/Encounter Data Reporting
- ◆ Health Service Delivery System/MCO/MCO Subcontractor/ASO Incentive Arrangements
- ◆ Financial Management

Each section begins with an explanation of the objective of the compliance area. Next, the Audit Guide describes the compliance requirements to be tested and suggested procedures to be used in that testing. Finally, the Audit Guide provides the IPA with sources of information pertinent to specific requirements, such as, the HealthChoices Behavioral Health Program Standards and Requirements, the contract between the Commonwealth and the Contractors, their subcontracts with MCOs, the Behavioral Health Financial Reporting Requirements (FRR), and the Code of Federal Regulations (CFR).

The Audit Guide is designed to be used in conjunction with Generally Accepted Government Auditing Standards contained within Government Auditing Standards (commonly referred to as the Yellow Book) issued by the Comptroller General of the United States and audit/attest guidance issued by the AICPA. It provides guidance such as questions to ask and areas to explore. It is important to remember that an IPA may discover information that will lead him to seek answers to other questions or follow

additional procedures that are not in the Audit Guide in order to fully examine the risks in a specific compliance area.

The Audit Guide provides the minimum procedures the IPA should perform. Neither the list of compliance issues to be tested nor the suggested procedures in this Audit Guide are meant to be all-inclusive. The IPA is responsible to determine the nature, timing, and extent of the procedures to be performed based on the IPA's professional judgment.

Finally, it is important to note that despite extensive monitoring and control activities, examinations of Medicaid managed care organizations are still evolving. Therefore, this HealthChoices Program Audit Guide for Behavioral Health will be reviewed and amended on an annual basis.

Understanding the Functional Organization of HealthChoices Programs

The IPA must determine the primary and secondary sites where relevant data is processed and should have a clear understanding of the administrative and management structure utilized by the Contractor in executing the HealthChoices Behavioral Health contract. Attachments 2 and 3 to this Introduction detail the contractual relationships that exist in the Counties where HealthChoices has been implemented.

The following terms are essential to understanding the administration and management of the contract:

Contractor – an entity that contracts directly with the Department of Public Welfare to administer the HealthChoices Behavioral Health Program in a County (see Attachments 2 and 3 to this Introduction). This term is synonymous with Primary Contractor.

Managed Care Organization (MCO) - An entity which manages the purchase and provision of physical or behavioral health services under the HealthChoices Program.

MCO Subcontractor - a provider, practitioner, or vendor/supplier under subcontract with a County or an MCO pursuant to which services are provided under the HealthChoices Behavioral Health Program contract (see Attachments 2 and 3 to this Introduction).

Administrative Services Organization (ASO) - an independent organization (e.g., private for-profit managed care organization, insurance carrier) under contract to provide administrative services for a managed care plan in exchange for a fee. ASO services may include claims processing, actuarial support, benefit plan design, financial advice, medical management, preparation of data for reports to governmental units and other administrative functions.

Determining the Location of Functions to be Examined

The IPA is required to examine at the level where the functions/activities described in the Audit Guide take place unless other procedures can be appropriately relied upon to satisfy the requirements of this Audit Guide.

To meet the requirements of this audit guide, the IPA must determine: (1) the location of the various functions and activities which require examination coverage under this audit guide (i.e., the organizational and physical location(s) of files, processes and systems needed to perform under the contract); (2) whether any existing audit/examination coverage of such functions or activities is adequate to satisfy the requirements of this guide; and (3) if such coverage can be relied upon in accordance with AICPA's attestation standards and Government Auditing Standards, or whether such functions or activities must be examined.

Audits/Examinations Conducted by the Commonwealth

The IPA is instructed to inquire of management whether any audits, examinations, and/or technical reviews have been conducted by DPW, Comptroller Operations – Bureau of Audits, Department of Insurance (DOI), and/or the Department of the Auditor General and to consider the results of any such audits, examinations, and/or technical reviews while planning and performing this engagement.

Examination Adjustments

Examination adjustments should be determined based on materiality at the financial schedule level. Various financial schedules (Appendix I) require that examination adjustments result in the submission of revised schedules with detailed explanations included in the footnotes. Other financial schedules (Appendix I) contain an adjustment column where the examination adjustments must be listed and an adjusted balance column to reflect their impact. **These columns must be used;** however, if no adjustments are required, a definitive statement to that effect should be included on the schedule in question. Examination adjustments specified in the schedules must be explained in sufficient detail in the footnotes by rating group and category of service (where applicable).

A **Summary of Unadjusted Differences** should be maintained as part of the examination documentation. AICPA's attestation standards require the IPA to consider whether aggregated uncorrected misstatements materially affect the financial statements taken as a whole. Since materiality for the HealthChoices contract examinations is to be considered at the financial schedule level, a listing of accumulated unrecorded examination differences should be maintained as part of the examination documentation.

Notes to the Financial Schedules

The Notes to the Financial Schedules are an integral part of the financial schedules and are essential to understanding the underlying content of the financial schedules. The "Notes to the Financial Schedules" should contain, at a minimum, the notes listed in Appendix I of this Audit Guide. Additional notes should be added as warranted. In those instances where any of the minimum required notes are non-existent or immaterial, the issue should be reported as such within the Notes to the Financial Schedules.

Footnotes

The term "footnote" refers to explanations of examination adjustments expected to appear on the schedule itself. Notes to the Financial Schedules are a separate document.

Materiality

Materiality should be measured at the financial schedule level when determining examination adjustments to the financial schedules. Materiality should be based on the IPA's professional judgment.

Updates

Updates in the form of amendments to the Financial Reporting Requirements (FRR), policy statements, and contract, etc. may be issued in the future or during the examination period. This Audit Guide will cover an expanded time frame in order to include all HealthChoices Zones. Changes will be made to the FRRs during this time frame. It is the responsibility of the IPA to inquire of management if any updates subsequent to the issuance of the Audit Guide have been issued by DPW that may affect the contract examination.

Independent Accountant's Reports

The following reports are considered an integral part of the IPA's report package required to be submitted by this Audit Guide. The entire IPA's report package should be bound and include the Independent Accountant's Attestation Examination Report on Financial Schedules, the Financial Schedules, the Notes to the Financial Schedules, the Independent Accountant's Compliance Attestation Examination Report on Management's Assertions and Management's Assertion Letter.

References to Government Auditing Standards in the Attestation Examination Reports can be made based upon Generally Accepted Government Auditing Standards (GAGAS). This establishes the Reporting Standards for Attestation Engagements.

Independent Accountant's Attestation Examination Report on Financial Schedules

A separate attestation examination report should be issued to address the following Financial Management Compliance Requirements contained in the Program Compliance portion of this Audit Guide:

- A. Report #2, Primary Contractor Summary of Transactions
- B. Report #3, Subcontractor Summary of Transactions
- C. Report #4, Related Party Transactions and Obligations
- D. Report #6, Claims Payable (RBUCs and IBNRs)

- E. Report #7, Lag Reports
- F. Report #9, Analysis of Revenues and Expenses
- G. Report #12, Reinvestment Report
- H. Report #13, Balance Sheet/Statement of Net Assets

This attestation examination report should be prepared in accordance with GAGAS and with Standards for Attestation Engagements at AT Section 101. Appendix I provides the suggested language for the IPA's examination report.

The examination should be performed in accordance with attestation standards established by the American Institute of Certified Public Accountants, and the standards applicable to attestation engagements contained in Government Auditing Standards, issued by the Comptroller General of the United States, and should follow guidance provided in the HealthChoices Audit Guide for Behavioral Health and in Appendix W of the HealthChoices Program Standards and Requirements. The financial schedules should be prepared in conformity with the DPW's Behavioral Health Financial Reporting Requirements (FRR) for the period in question (Appendix III). Materiality is required to be at the financial schedule level. The basis of accounting and allocation methodology should be identified in the Notes to the Financial Schedules. Also, see the guidance on Examination Adjustments listed above and the required Notes to the Financial Schedules listed in Appendix I of this Audit Guide. The suggested language for this report and the financial schedules that should result from the engagement are provided in Appendix I.

Independent Accountant's Compliance Attestation Examination Report on Management's Assertions

A separate compliance attestation examination report on management's assertions should be issued to address the following sections contained in the Program Compliance portion of this Audit Guide:

- ◆ Management Information System/Encounter Data Reporting
- ◆ Health Service Delivery System/MCO/MCO Subcontractor Incentive Arrangements
- ◆ Claims Processing
- ◆ Financial Management Compliance Requirement I, Report #17 Contract Reserves Compliance
- ◆ Financial Management Compliance Requirement J, Accountability of Revenues and Expenses
- ◆ Financial Management Compliance Requirement K, Co-Mingling of Funds
- ◆ Financial Management Compliance Requirement L, Parental Guaranty

Management's assertions should be prepared and reported on as a separate document and included with the Accountant's Compliance Attestation Examination Report.

Management's assertions should be presented on management's letterhead, signed by a responsible primary contractor official, and dated. Report #17 should be attached. See Statements on Standards for Attestation Engagements, AT Section 601 - Compliance Attestation. Appendix II provides the suggested language for Management's Assertion.

This compliance attestation examination report should be submitted concurrently with the annual HealthChoices Behavioral Health financial schedule examination. It should be prepared in accordance with GAGAS and with Statements on Standards for Attestation Engagements, AT Section 601. Appendix II provides the suggested language for the practitioner's examination report.

HealthChoices Behavioral Health Program Implementation Summary

<u>Zone/Counties</u>	<u>Implementation Date</u>
Southeast Zone Bucks Chester Delaware Montgomery Philadelphia	February 1997
Southwest Zone Allegheny Armstrong Beaver Butler Fayette Greene Indiana Lawrence Washington Westmoreland	January 1999
Lehigh Capital Zone Adams Berks Cumberland Dauphin Lancaster Lebanon Lehigh Northampton Perry York	October 2001
Northeast Zone Lackawanna Luzerne Susquehanna Wyoming	July 2006

HealthChoices Behavioral Health Program Implementation Summary

Zone/Counties

Implementation Date

North Central State Option

January 2007

Bradford
Cameron
Centre
Clarion
Clearfield
Columbia
Elk
Forest
Huntingdon
Jefferson
Juniata
McKean
Mifflin
Montour
Northumberland
Potter
Schuylkill
Snyder
Sullivan
Tioga
Union
Warren
Wayne

North Central County Option

July 2007

Bedford
Blair
Cambria
Carbon
Clinton
Crawford
Erie
Franklin
Fulton
Lycoming
Mercer
Monroe
Pike
Somerset
Venango

HealthChoices Behavioral Health Program Defined Entities

Southeast Zone

Contractor	MCO	MCO Subcontractor
Bucks	Magellan Behavioral Health of PA, Inc. (MBH-PA)	N/A
Chester	Community Care Behavioral Health Organization, Inc. (CCBHO)	N/A
Delaware	Magellan Behavioral Health of PA, Inc. (MBH-PA)	N/A
Montgomery	Magellan Behavioral Health of PA, Inc. (MBH-PA)	N/A
Philadelphia	N/A	Community Behavioral Health, Inc. (CBH)

Southwest Zone

Contractor	MCO	MCO Subcontractor
Allegheny	Community Care Behavioral Health Organization, Inc. (CCBHO)	N/A
Armstrong/Indiana Behavioral & Developmental Health Program	Value Behavioral Health of PA (VBH-PA)	N/A
Beaver ¹	N/A	N/A
Butler	Value Behavioral Health of PA (VBH-PA)	N/A
Fayette ¹	N/A	N/A
VBH of PA (Greene) ²	N/A	N/A
Lawrence	Value Behavioral Health of PA (VBH-PA)	N/A
Washington	Value Behavioral Health of PA (VBH-PA)	N/A
Westmoreland	Value Behavioral Health of PA (VBH-PA)	N/A

¹ These Contractors subcontract with VBH-PA as an Administrative Service Organization (ASO) only.

² Greene County opted not to exercise its right of first opportunity; DPW contracted with VBH-PA directly for the provision of services to county recipients.

HealthChoices Behavioral Health Program Defined Entities

Lehigh Capital Zone

Contractor	MCO	MCO Subcontractor
Adams	Community Care Behavioral Health Organization, Inc. (CCBHO)	N/A
Berks	Community Care Behavioral Health Organization, Inc. (CCBHO)	N/A
Cumberland ¹	N/A	N/A
Dauphin ¹	N/A	N/A
Lancaster ¹	N/A	N/A
Lebanon ¹	N/A	N/A
Lehigh	Magellan Behavioral Health of PA, Inc. (MBH-PA)	N/A
Northampton	Magellan Behavioral Health of PA, Inc. (MBH-PA)	N/A
Perry ¹	N/A	N/A
York	Community Care Behavioral Health Organization, Inc. (CCBHO)	N/A

¹ These Contractors subcontract with Community Behavioral HealthCare Network of PA (CBHNP) as an Administrative Service Organization (ASO) only.

Northeast Zone

Contractor	MCO	MCO Subcontractor
Northeast Behavioral Health Care Consortium (NBHCC) ¹ (Lackawanna, Luzerne, Susquehanna and Wyoming)	N/A	N/A

¹ This Contractor subcontracts with CCBHO as an Administrative Service Organization (ASO) only.

HealthChoices Behavioral Health Program Defined Entities

North Central State Option

Contractor	MCO	MCO Subcontractor
Community Care Behavioral Health Organization, Inc. (CCBHO) (Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren and Wayne)	N/A	N/A

HealthChoices Behavioral Health Program Defined Entities

North Central County Option

Contractor	MCO	MCO Subcontractor
Behavioral Health Services of Somerset & Bedford Counties (Bedford/Somerset)	CBHNP Services, Inc. (CSI)	N/A
Central PA Behavioral Health Collaborative (Blair)	CBHNP Services, Inc. (CSI)	N/A
Cambria	Value Behavioral Health of PA (VBH-PA)	N/A
CMP Joinder Board (Carbon/Monroe/Pike)	Community Care Behavioral Health Organization, Inc. (CCBHO)	N/A
Erie County	Community Care Behavioral Health Organization, Inc. (CCBHO)	N/A
Lycoming/Clinton Joinder Board	CBHNP Services, Inc. (CSI)	N/A
Northwest Behavioral Health Partnership (Crawford/Mercer/Venango)	Value Behavioral Health of PA (VBH-PA)	N/A
Tuscarora Managed Care Alliance ¹ (Franklin/Fulton)	N/A	N/A

¹ This Contractor subcontracts with Community Behavioral HealthCare Network of PA (CBHNP) as an Administrative Service Organization (ASO) only.

HealthChoices Behavioral Health Program Contract Management/Funding Summary

Southeast Zone

Contractor	Joinder	Management Corporation ³	MCO	MCO Subcontractor
Bucks	N/A	N/A	Magellan Behavioral Health of PA, Inc. (MBH-PA)	N/A
Chester	N/A	N/A	Community Care Behavioral Health Organization, Inc. (CCBHO)	N/A
Delaware	N/A	N/A	Magellan Behavioral Health of PA, Inc. (MBH-PA)	N/A
Montgomery	N/A	Montgomery County Behavioral Health, Inc. (MCBH)	Magellan Behavioral Health of PA, Inc. (MBH-PA)	N/A
Philadelphia	N/A	N/A	N/A	Community Behavioral Health (CBH)

Southwest Zone

Contractor	Joinder	Management Corporation ³	MCO	MCO Subcontractor
Allegheny	N/A	Allegheny HealthChoices, Inc. (AHC)	Community Care Behavioral Health Organization, Inc. (CCBHO)	N/A
Armstrong-Indiana Behavioral & Developmental Health Program	N/A	Southwest Behavioral Health Management, Inc. (SBHM)	Value Behavioral Health of PA (VBH-PA)	N/A
Beaver ¹	N/A	N/A	N/A	N/A
Butler	N/A	Southwest Behavioral Health Management, Inc. (SBHM)	Value Behavioral Health of PA (VBH-PA)	N/A
Fayette ¹	N/A	N/A	N/A	N/A
VBH of PA (Greene) ²	N/A	N/A	N/A	N/A
Lawrence	N/A	Southwest Behavioral Health Management, Inc. (SBHM)	Value Behavioral Health of PA (VBH-PA)	N/A
Washington	N/A	Southwest Behavioral Health Management, Inc. (SBHM)	Value Behavioral Health of PA (VBH-PA)	N/A
Westmoreland	N/A	Southwest Behavioral Health Management, Inc. (SBHM)	Value Behavioral Health of PA (VBH-PA)	N/A

1. These Contractors subcontract with VBH-PA as an Administrative Service Organization (ASO) only.
2. Greene County opted not to exercise its right of first opportunity; DPW contracted with VBH-PA directly for the provision of services to County recipients.
3. A Management Corporation is a subcontractor that administers management services related to the fiscal and programmatic oversight of a Primary Contractor's subcontract with a MCO.

HealthChoices Behavioral Health Program Contract Management/Funding Summary Lehigh Capital Zone

Contractor	Joinder	Management Corporation ¹	MCO	MCO Subcontractor
Adams	York-Adams MH/MR Program	N/A	Community Care Behavioral Health Organization, Inc. (CCBHO)	N/A
Berks	N/A	N/A	Community Care Behavioral Health Organization, Inc. (CCBHO)	N/A
Cumberland ²	Cumberland-Perry MH/IDD Program	Capital Area Behavioral Health Collaborative, Inc. (CABHC)	N/A	N/A
Dauphin ²	N/A	Capital Area Behavioral Health Collaborative, Inc. (CABHC)	N/A	N/A
Lancaster ²	N/A	Capital Area Behavioral Health Collaborative, Inc. (CABHC)	N/A	N/A
Lebanon ²	N/A	Capital Area Behavioral Health Collaborative, Inc. (CABHC)	N/A	N/A
Lehigh	N/A	N/A	Magellan Behavioral Health of PA, Inc. (MBH-PA)	N/A
Northampton	N/A	N/A	Magellan Behavioral Health of PA, Inc. (MBH-PA)	N/A
Perry ²	Cumberland-Perry MH/IDD Program	Capital Area Behavioral Health Collaborative, Inc. (CABHC)	N/A	N/A
York	York-Adams MH/MR Program	N/A	Community Care Behavioral Health Organization, Inc. (CCBHO)	N/A

1. A Management Corporation is a subcontractor that administers management services related to the fiscal and programmatic oversight of a Primary Contractor's subcontract with a MCO.
2. These Contractors subcontract with Community Behavioral HealthCare Network of PA (CBHNP) as an Administrative Service Organization (ASO) only.

HealthChoices Behavioral Health Program Contract Management/Funding Summary

Northeast Zone

Contractor	Joinder	Management Corporation ²	MCO	MCO Subcontractor
Northeast Behavioral Health Care Consortium (NBHCC) ¹	Lackawanna-Susquehanna Luzerne-Wyoming	N/A	N/A	N/A

North Central State Option

Contractor	Joinder	Management Corporation ²	MCO	MCO Subcontractor
Community Care Behavioral Health Organization, Inc. (CCBHO) (Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren and Wayne)	N/A	N/A	N/A	N/A

1. This Contractor subcontracts with CCBHO as an Administrative Service Organization (ASO) only.
2. A Management Corporation is a subcontractor that administers management services related to the fiscal and programmatic oversight of a Primary Contractor's subcontract with an MCO.

HealthChoices Behavioral Health Program Contract Management/Funding Summary

North Central County Option

Contractor	Joinder	Management Corporation ¹	MCO	MCO Subcontractor
Behavioral Health Services of Somerset & Bedford Counties	Bedford/Somerset MH/MR Program	N/A	CBHNP Services, Inc. (CSI)	N/A
Central PA Behavioral Health Collaborative d/b/a Blair HealthChoices	N/A	N/A	CBHNP Services, Inc. (CSI)	N/A
Cambria	N/A	Behavioral Health of Cambria County	Value Behavioral Health of PA (VBH-PA)	N/A
CMP Joinder Board	N/A	N/A	Community Care Behavioral Health Organization, Inc. (CCBHO)	N/A
Erie	N/A	N/A	Community Care Behavioral Health Organization, Inc. (CCBHO)	N/A
Lycoming/Clinton Joinder Board	N/A	N/A	CBHNP Services, Inc. (CSI)	N/A
Northwest Behavioral Health Partnership	N/A	Southwest Behavioral Health Management, Inc. (SBHM)	Value Behavioral Health of PA (VBH-PA)	N/A
Tuscarora Managed Care Alliance ²	<i>Franklin/Fulton MH/ID/EI Program</i>	N/A	N/A	N/A

1. A Management Corporation is a subcontractor that administers management services related to the fiscal and programmatic oversight of a Primary Contractor's subcontract with a MCO.
2. This Contractor subcontracts with Community Behavioral HealthCare Network of PA (CBHNP) as an Administrative Service Organization (ASO) only.

**BEHAVIORAL HEALTH
PROGRAM COMPLIANCE**

CLAIMS PROCESSING

I. Requirement Objectives

The purpose of a claims processing system is to:

- ♦ arrange for and reimburse in-network health care providers accurately and timely for covered services rendered, and non-participating or unauthorized health care providers for any appropriate out-of-plan services,
- ♦ enable the Contractor to accept encounters from in-network health care providers accurately and timely for covered services rendered,
- ♦ enable the Contractor to identify liable third parties for services rendered to recipients, avoid payments where a third party is responsible as appropriate, and recover payments when a third party is subsequently identified,
- ♦ enable the Contractor to support data reporting requirements defined in the HealthChoices contracts, and generate data necessary for financial and program evaluation, both at the Contractor and Commonwealth level,
- ♦ detect suspected instances of recipient and provider fraud and abuse, and
- ♦ maintain current member data files including a capability to receive on-line data transfers of member enrollment/disenrollment information. Data files must provide accurate information on dates of Managed Care coverage for each recipient. (Member enrollment/disenrollment information may be maintained on a system separate from the claims processing system.)

Adequate and timely payment procedures for non-participating providers ensures appropriate use of HealthChoices program funds and assures enrollees and providers that appropriate services are accessible.

NOTE: To meet the requirements of this audit guide, the IPA must first determine the location of the various functions and activities which require coverage in this section, (i.e., the organizational and physical location(s) of files, processes and systems needed to perform under the contract). Such functions and activities may occur at the Contractor, MCO, MCO Subcontractor, joiner, management corporation, or administrative services organization as explained in the Introduction section of this audit guide, or at a third party administrator or third party processor. The term "Contractor" is used throughout this section to refer to the entity where the functions or activities are performed, regardless of whether the function is performed at a third party.

Behavioral Health Contract Requirements

The Contractor must provide DPW with accurate reports on provider payments and claims processing.

The Contractor must have appropriate procedures to pay for or deny provider claims. Claims reviewed and denied should be communicated appropriately to the health care provider with opportunity given to appeal denied claims within time frames established in the HealthChoices contract.

The Contractor must have procedures and reporting mechanisms to accurately identify liable third parties, to avoid and recover costs as appropriate, and to make a payment where a third party has made a partial payment for a service.

NOTE: The Contractor is required to process and pay Behavioral Health Rehabilitation Services for Children and Adolescents (BHRS) claims prior to initiating any cost recovery procedures.

The Contractor must have a strategy to detect and report recipient and health care provider fraud and abuse. Suspected and substantiated fraud and abuse must be reported to the Department of Public Welfare, Office of Medical Assistance Programs (OMAP), Bureau of Program Integrity (BPI).

With respect to member enrollment/disenrollment, the Contractor must have in effect written administrative policies and procedures which direct the receipt, update and testing of on-line transfers of member data from DPW. DPW will provide the Contractor with enrollment information for its members including the beginning and ending effective dates of enrollment. The data provided will include new enrollments, disenrollments and demographic changes. It is the responsibility of the Contractor to take necessary administrative steps consistent with dates established by the DPW.

Autism Insurance Act (Act 62)

Most sections of the Autism Insurance Act (Act 62) went into effect July 1, 2009. Broadly speaking, Act 62 has three primary requirements:

- It requires many private insurers to begin covering the costs of diagnostic assessments for autism and of services for individuals with autism who are under the age of 21, up to \$36,000 per year. The maximum benefit is adjusted to \$37,080 for policies issued or renewed in calendar year 2013.
- It requires DPW to cover those costs for eligible individuals who have no private insurance coverage, or for individuals whose costs exceed

\$36,000 that year, or \$37,080 for policies issued or renewed in calendar year 2013; and

- It requires the Pennsylvania Department of State to license professional behavior specialists and to establish minimum licensure qualifications for them.

We expect that affected claims may require additional processing time, therefore, the DPW is extending the time period to 180 days for processing Act 62 claims. It should be verified that Act 62 is acknowledged and that appropriate policies and procedures are in place. In addition, any deficiencies related to Act 62 should be identified in the attest documentation.

II. Compliance Requirements and Suggested Procedures

A. Compliance Requirement

The Contractor must have a claims processing system and MIS sufficient to support the provider payment and data reporting requirements specified in Part II-7, Section M of the HealthChoices Program Standards and Requirements.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

The adequacy of the claims processing information systems when processed in-house or outsourced to a third party processor can be assessed through an examination of independent third party reviews of the controls built into the claims processing application, general MIS internal control structure, and general information technology control structure.

The IPA is expected to perform sufficient testing and procedures to express an opinion on whether the compliance processing system is in conformity with the aforementioned Program Standards and Requirements. If the IPA relies on an independent third party review, such as a service organization controls report, the IPA is expected to determine that the third party review included the same sufficient testing and procedures to express such an opinion.

If an independent third party review has been performed for the engagement period, complete steps 1 through 5.

1. Examine the engagement letter and/or agreement requesting the third party review.

2. Evaluate the reputation of the independent third party.
3. Examine the report issued by the third party reviewer.
 - a. Identify the standards the report was issued under. Evaluate whether the planned reliance on the type of report is appropriate.
4. Identify the time period addressed by the third party review.
5. Assess whether the information in the third party review is relevant with respect to the Contractor's information systems and staff in place at the time of the audit and/or audit period.

Steps 6 through 10 must be completed for all engagements.

6. Obtain an inventory of all hardware and software applications.
7. Specifically identify the applications used to process, store and report encounter, enrollment and claim data, the age of these applications, the type of processing performed by these applications (batch vs. on-line), the interfaces between these applications, and whether the application was purchased or developed internally.
8. Obtain and review the policies and procedures related to the application requirements defined in the HealthChoices Program Standards and Requirements. Verify that specific requirements address the completeness, timeliness, and accuracy of claim data and standing reference (i.e., diagnosis codes, pricing, effective dates, DPW-assigned codes, HCPCS codes, etc.) data input for processing, the on-going control and maintenance of this data, and the payment of claims. Testing for completeness, timeliness, and accuracy of claims should include, but is not limited to, the following verifications:
 - a. Universe of Behavioral Health claims for the period of the engagement is complete.
 - b. Sample selected is representative of the Universe
 - 1) A portion of the claims tested must be adjusted claims and manually entered claims. These adjusted claims should be further tested to determine that the adjustment process defined in Appendix M of the HealthChoices Program Standards and Requirements have been followed and that the adjusted claims contain the necessary information to link the adjusted claims with the original claims.

- c. Both the HIPAA standard data element code sets that are submitted on electronic claims and the data element code sets that are submitted on manual claims can be successfully cross-walked to the codes that are acceptable on DPW encounter records.
 - d. The claim reference information on the claim form can be linked with the Encounter Claim Reference Number.
 - e. The information on the original, adjusted, and encounters can be matched for accuracy and completeness to the encounters.
 - f. The recipient identification number agrees with, or can be crosswalked to, the DPW's Recipient CIS Number.
 - g. The recipient is eligible for service on the date(s) service is provided.
 - h. The recipient is eligible for the type of service provided.
 - i. If the claim does not indicate other insurance or Medicare as a third party payer, ensure that the file does not include information that the recipient is covered by other insurance or Medicare on the date(s) service is provided. If the claim does indicate other insurance or Medicare as a third party payer, ensure that the amount paid is calculated correctly.
 - j. The provider identification number agrees with, or can be crosswalked to, the DPW's MA Provider Number.
 - k. The amount paid to the provider by the Contractor is in accordance with the HealthChoices contract and the provider agreement.
 - l. Where the claims information is manually input, the information on the system regarding the diagnosis code, type of service, procedure code, revenue code, units of service and dates of service agrees with information on the input document.
9. Through the review of Contractor policies and procedures and organization charts, report on significant deficiencies and material weaknesses in internal control. Specifically address the appropriateness of the MIS organizational structure for segregating responsibilities and controlling employee and vendor/subcontractor activities, human resources policies and procedures, system development policies and procedures, training plans and internal audit

activities, and reporting. Testing of these controls should include, but is not limited to, the following verifications:

- a. Documentation must be complete and comprehensive, fully documenting the following:
 - 1) system design
 - 2) programming
 - 3) computer operations
 - 4) user procedures
- b. Programmers are restricted from changing/updating production programs and operators are restricted from changing/updating actual program code. Testing should include the selection of specific programmers and operators to ensure that they cannot change/update production programs or program code.
- c. A system development life cycle methodology has been documented and implemented to guide and control the development/maintenance of programs.
- d. Hiring and human resource policies and procedures governing the minimum skills and education for each position exist and are used to ensure only qualified individuals, or properly supervised entry level individuals are employed. Policies and procedures should also address employee development and training.

10. Through the review of Contractor's policies and procedures and organization charts, evaluate the controls at the Contractor. Specifically, the adequacy of controls over new program development and implementation, program maintenance, physical and logical security, computer operations, disaster recovery planning, and capacity planning. Also, ensure that the Contractor has issued a data confidentiality policy to all employees with access to the various applications and data. Testing of the controls should include, but is not limited to, the following verifications:

- a. Physical and logical security controls have been implemented to ensure individuals are properly restricted to only those functions and data required by their job. Testing should include the selection of specific individuals to ensure that they are restricted from those functions not required by their job.

- b. A disaster recovery plan exists and has been tested, to ensure the continued processing of data and delivery of services in the event of an unexpected disaster.
- c. Computer operations schedules and program documentation exist to guide the operators through daily processing and ensure that all jobs run on time and in the correct order.
- d. Users are involved in the design, testing and approval of all program changes/implementations. Documentation of user requests and approvals should be reviewed.
- e. Determine that a data confidentiality policy has been issued to all employees with access to the various applications and data, and that this data confidentiality policy is enforced.

B. Compliance Requirement

Under Section 1902(a)(25) of the Social Security Act, DPW is required to take all reasonable measures to identify legally liable third parties and treat verified Third Party Liability (TPL) as a resource of the MA recipient. Under the HealthChoices Program, TPL activities will be shared between DPW's TPL Section and the Contractor as described in Part II-7, Section J. of the HealthChoices Program Standards and Requirements.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

1. Determine the methods used to identify third party payers that are not known to the Contractor or DPW. If the Contractor identified third party resources that do not appear on the DPW database, verify that such resources were supplied by the Contractor to DPW.
2. Determine if adequate policies and procedures are in place for the payment of claims with health-related insurance (i.e. cost avoidance through the identification of liable third parties). Test a sample of these claims to ensure the claim was processed correctly (paid accurately or denied correctly). Verify these claims have been sent and received by DPW as an encounter. The information on the claims can be matched for accuracy and completeness to the encounters.
3. Determine if adequate policies and procedures are in place for the collection and receipt of encounters with health-related insurance. Test a sample of these encounters to ensure the claim was processed

correctly. Verify that these encounters have been sent and received by DPW as an encounter. The information of the encounters can be matched for accuracy and completeness to the encounters.

4. Determine if adequate policies and procedures are in place for the payment of accident/injury claims (i.e. the contractor is responsible for payment of accident/injury claims and reporting accident/injury claims to DPW for recovery of identified liable third parties). Test a sample of these claims to ensure the claim was processed correctly (paid accurately or denied correctly). Verify that these claims have been sent and received by DPW as an encounter. The information on the claims can be matched for accuracy and completeness to the encounters.
5. Determine if adequate policies and procedures are in place for the recovery of claims when health-related insurance is identified after a claim is paid. Test a sample of these claims to ensure the claim was processed correctly (paid accurately or denied correctly). Verify that these claims have been sent and received by DPW as an encounter. The information on the claims can be matched for accuracy and completeness to the encounters.
6. Determine if adequate policies and procedures are in place to process claims when the recipient is retroactively identified to have other insurance or Medicare coverage and adequately address the 6-month/9-month window of opportunity for recovery. Test a sample of these recipients to ensure the claims or encounters are reprocessed correctly. Verify that these claims or encounters have been sent and received by DPW as an encounter. The information on the claims can be matched for accuracy and completeness to the encounters.
7. Evaluate the policies and procedures for reporting Coordination of Benefits/Third Party Liability (COB/TPL) Financial Reports (Report 11 A-C) to DPW.
8. Determine if the policies and procedures ensure that the required information is reported timely and accurately to DPW.

C. Compliance Requirement

The MCO/MCO subcontractor must establish a mandatory compliance plan designed to guard against fraud and abuse as described in Appendix F of the HealthChoices Program Standards and Requirements.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

1. Obtain the contractor's compliance plan to ensure that they have written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all Federal and State standards related to Medicaid managed care organizations.
2. Ensure that they have identified a compliance officer and a compliance committee accountable to senior management.
3. Ensure the plan includes provisions for effective training and education for the compliance officer and MCO employees, and effective lines of communication between the compliance officer and MCO employees.
4. Ensure the plan includes provisions for enforcement of standards through well-publicized disciplinary guidelines and provisions for internal monitoring and auditing.
5. Ensure the plan has provisions for prompt responses to detected offenses and for the development of corrective action initiatives.

D. Compliance Requirement

As described in Appendix F of the HealthChoices Program Standards and Requirements & Policy Clarification 06-09, the Contractor shall maintain and comply with written policies and procedures for the prevention, detection and reporting of suspected fraud and abuse. These policies and procedures are subject to the approval of DPW's Bureau of Program Integrity.

One of these required policies and procedures is a method for verifying with a portion of recipients whether services billed by providers were received.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

1. For the policies and procedures covering the prevention, detection and reporting of suspected fraud and abuse, verify that any revisions were submitted to DPW's Bureau of Program Integrity for approval.
2. Review examples of the Contractor's verification with recipients that services billed by providers were received.
 - a. Confirm the verification took place during the program year.
 - b. Verify the recipient was enrolled in HealthChoices at the time of service.

E. Compliance Requirement

As described in Policy Clarification 06-09, the Contractor must immediately notify DPW's, Bureau of Program Integrity, when a provider has disclosed information regarding a criminal conviction related to Medicare, Medicaid, or Title XX when making application to be credentialed as a BH-MCO network provider or upon renewal of their credentialing. The Contractor shall also notify DPW's Bureau of Program Integrity of an adverse action, such as convictions, exclusions, revocations, and suspensions taken on provider applications including denial of initial enrollment.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

1. Determine if the Contractor has adequate policies and procedures for notifying DPW when a provider has disclosed information regarding a criminal conviction related to Medicare, Medicaid, or Title XX.
2. Confirm the Contractor requires providers to disclose information regarding a criminal conviction related to Medicare, Medicaid, or Title XX when making application to be credentialed as a BH-MCO network provider or upon renewal of their credentialing.
3. Determine if the Contractor has adequate policies and procedures for notifying DPW of any adverse actions.

F. Compliance Requirement

1. The Contractor must have access for on-line inquiries and file transfers as specified in Appendices M and O of the HealthChoices Program Standards and Requirements.
2. The Contractor accesses the following files as required by any relevant Departmental communications.
 - a. Client Information System/Eligibility Verification System
 - b. Procedure Code Reference File
 - c. Provider File
 - d. Third Party Liability File
 - e. Diagnosis File
3. The Contractor receives and processes in house, the following files:
 - a. 834 Daily Enrollment/Disenrollment File
 - b. 834 Monthly Enrollment/Disenrollment File
 - c. Payment Reconciliation File (Monthly)
 - d. MCO Payment Summary File (Monthly)
 - e. Procedure Code Extract File (Monthly)
 - f. Reference Diagnosis Code File (Monthly)
 - g. MA Provider File (Monthly)
 - h. ARM568 Report File (Monthly)
 - i. 820 Capitation File (Monthly)
 - j. TPL File (Monthly)

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

1. Obtain and review the Contractor's policies and procedures related to accessing and retrieving DPW files as specified in the PS&R. Ensure the policies and procedures identify each of the files listed above.
2. Request a demonstration of the access of DPW files by the Contractor. Through the demonstration verify the Contractor is knowledgeable of the files to be accessed and the use of the file access system.
3. Review the Contractor's computer system daily logs for evidence of the connection and file transfer and timely update of the Contractor's files.

III. Applicable Regulations/Procedures and References

A. HealthChoices Behavioral Health Program Standards and Requirements

Part II-7, Section M.

Part II-7, Section J.

Appendices M and O.

B. GAGAS

MIS/ENCOUNTER DATA REPORTING

I. Requirement Objective

The Contractor, MCO, MCO Subcontractor, and Administrative Services Organization (ASO) must have effective procedures to compile, analyze, evaluate, and report data critical to the operations of the HealthChoices program managed care product, including encounter data. Encounter data or other appropriate information can assist to determine how and when Plan services are being utilized, to set future rates, to determine program effectiveness, and to evaluate performance management.

NOTE: To meet the requirements of this audit guide, the IPA must first determine the location of the various functions and activities which require coverage in this section (i.e., the organizational and physical location(s) of files, processes, and systems needed to perform under the contract). Such functions and activities may occur at the Contractor, MCO, MCO Subcontractor, joinder, management corporation, or ASO as explained in the Introduction to this Audit Guide, or at a third party administrator or third party processor. **The term "Contractor" is used throughout this section to refer to the entity where the functions or activities are performed, regardless of whether the function is performed at a third party.**

MIS is a critical area for any managed care organization to understand and monitor the financing, delivery, and effectiveness of the health care. It is only through information collection, reporting, and analysis that a contractor will be able to determine, in a managed care environment, how services are being delivered and whether adequate resources are available.

II. Compliance Requirements and Suggested Procedures

A. Compliance Requirement

The Contractor shall be responsible for maintaining appropriate systems and mechanisms to obtain all necessary data from its health care providers to ensure its ability to comply with the encounter data reporting requirements as required by Appendices M and O of the HealthChoices Program Standards and Requirements.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

To evaluate the adequacy of the encounter reporting application system and its compliance with the requirements outlined in A., above, perform the following procedures:

1. Obtain and review the Contractor's procedures related to the input of claims and encounters data submitted (consider paper and/or electronic submissions) by the provider. Ensure the procedures address manual steps and/or electronic edits designed to ensure the complete and accurate input of the data. Specifically, identify the process for resolving missing, incomplete, or invalid claims and encounters data received from the health care provider.
2. Obtain and review the Contractor's procedures related to monitoring the continued completeness and accuracy of the claims and encounters data once input and residing on a standing data file. The procedures should address run-to-run balancing routines and programmer and user access restrictions to the data files.
3. Obtain a sample (representative of the Universe) of individual encounters as submitted by the Contractor to DPW throughout the period under review. A portion of the encounters tested must be adjusted encounters. Ensure that the Contractor's procedures related to converting the claim or encounter to the 837I and 837P record format required by DPW are complete and accurate.
 - a. Evaluate the percentage of claims that met a 90-day length of time (or other contractual requirements) between the date of service and the date of its posting to the contractor's system.
 - b. Compare the sample encounter records to the claims and encounters submitted by health care providers to the Contractor for accuracy of recipient identification, procedure coding, category of service coding, amount paid, service date, units of service delivered, TPL/COB information, and date of receipt by the Contractor.
 - c. Compare the sample encounter records to the electronic and manual claims submitted by health care providers to the Contractor for accuracy of procedure codes, procedure code modifiers, place of service, and diagnosis. The comparison should consider any differences in converting the HIPAA standard data element code

sets that are submitted on electronic claims and the data element code sets that are submitted on manual claims to the DPW required codes for encounter reporting.

4. Review the Contractor's documentation of its capabilities to transfer files.
5. Determine whether the Contractor has issued a data confidentiality policy to all employees with access to the various applications and data, and verify that this data confidentiality policy is enforced.

NOTE: Claims and encounters codes may have to be cross-walked to the codes required by DPW for encounter reporting.

To evaluate the adequacy of the information systems and staff, determine whether the Contractor has or has not obtained an independent third party review of its general MIS internal control structure, specific program changes, and network communication controls.

The IPA is expected to perform sufficient testing and procedures to express an opinion on whether the compliance processing system is in conformity with the aforementioned Program Standards and Requirements. If the IPA relies on an independent third party review, such as a service organization controls report, the IPA is expected to determine that the third party review included the same sufficient testing and procedures to express such an opinion.

If an independent third party review has been performed for the engagement period, complete steps 1 through 5.

1. Examine the engagement letter and/or agreement requesting the third party review.
2. Evaluate the reputation of the independent third party.
3. Examine the report issued by the third party reviewer.
 - a. Identify the standards the report was issued under. Evaluate whether the planned reliance on the type of report is appropriate.
4. Identify the time period addressed by the third party review.

5. Assess whether the information in the third party review is relevant with respect to the Contractor's information systems and staff in place at the time of the audit and/or audit period.

Steps 6 through 9 must be completed for all engagements.

6. Obtain an inventory of all hardware and software applications.
7. Specifically identify the applications used to process, store and report encounter, enrollment, and claim data, the age of these applications, the type of processing performed by these applications (batch vs. on-line), the interfaces between these applications, and whether the application was purchased or developed internally.
8. Through the review of Contractor policies and procedures and organization charts, evaluate the appropriateness of the MIS organizational structure for segregating responsibilities and controlling employee and vendor/subcontractor activities, human resources policies and procedures, system development policies and procedures, training plans and internal audit activities, and reporting. Testing of these controls should include, but is not limited to, the following verifications:
 - a. Documentation must be complete and comprehensive for the following:
 - 1) system design
 - 2) programming
 - 3) computer operations
 - 4) user procedures
 - b. Programmers are restricted from changing/updating production programs and operators are restricted from changing/updating actual program code. Testing should include the selection of specific programmers and operators to ensure that they cannot change/update production programs or program code.
 - c. A system development life cycle methodology has been documented and implemented to guide and control the development/maintenance of programs.
 - d. Hiring and human resource policies and procedures governing the minimum skills and education for each position exist and are used

to ensure only qualified individuals, or properly supervised entry level individuals are employed. Policies and procedures should also address employee development, training, and termination.

9. Through the review of Contractor policies and procedures and organization charts, evaluate the controls over new program development and implementation, program maintenance, physical and logical security, computer operations, disaster recovery planning, and capacity planning. Testing of the controls should include, but is not limited to, the following verifications:
 - a. Physical and logical security controls have been implemented to ensure individuals are properly restricted to only those functions and data required by their job. Testing should include the selection of specific individuals to ensure that they are restricted from those functions not required by their job.
 - b. A disaster recovery plan exists and has been tested, to ensure the continued processing of data and delivery of services in the event of an unexpected disaster.
 - c. Computer operations schedules and program documentation exist to guide the operators through daily processing and ensure that all jobs run on time and in the correct order.
 - d. Users are involved in the design, testing and approval of all program changes/implementations. Documentation of user requests and approvals should be reviewed.

B. Compliance Requirement

The Contractor must submit encounter data reports in accordance with the requirements as set forth in Part II-7, Section K. (3) of the HealthChoices Program Standards and Requirements, and in the time and manner prescribed by the Department. (An encounter must be submitted and pass PROMISE edits on or before the last calendar day of the third month after the Primary Contractor paid/adjudicated the encounter.)

The Contractor shall be responsible for maintaining appropriate systems and mechanisms to obtain all necessary data from its subcontractors to ensure its ability to comply with the encounter data reporting requirements. The failure of a MCO, MCO Subcontractor, or ASO to

provide the Contractor with necessary encounter data shall not excuse the Contractor's compliance with this requirement.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

1. Determine that the Contractor has adequate procedures in place to ensure compliance with DPW's encounter reporting requirements, including timeliness and the encounter data element requirements, as defined by DPW.
2. Obtain a sample (representative of the Universe) of individual encounters as submitted by the Contractor to DPW throughout the period under review to ensure the encounters were submitted timely. NOTE: The timeliness requirements only apply to encounters using established procedure codes as shown on the Behavioral Health Services Reporting Classification Chart. The requirements do not apply to encounters for newly developed or allowed services which have recently been added, or have not yet been added to the Behavioral Health Services Reporting Classification Chart.

Waivers that impact timeliness requirements

Due to the Commonwealth's implementation process for the new HIPAA-compliant v5010 transactions and the 2013 Current Procedural Terminology (CPT) codes, DPW has established the following waivers:

- With respect to the HIPAA-compliant v5010 transactions, there was a period of time when HealthChoices Behavioral Health Primary Contractors were unable to comply with this requirement with respect to the timeliness of encounter data submissions. As a result, DPW is waiving this requirement with respect to ensuring encounters were submitted timely to OMHSAS for the period January 1, 2012 through March 31, 2012.
- With respect to the CPT codes, there will be a period of time where HealthChoices Behavioral Health Primary Contractors will be unable to fully meet the Department of Public Welfare's (DPW) expected requirements regarding the timeliness of encounter data submissions. For those psychotherapy and psychiatry-related 2013 CPT codes only, DPW is waiving the SFY 2012/2013 HealthChoices Audit Guide, MIS/Encounter

Data Reporting, Compliance Requirement II.B.2. for ensuring encounters were submitted timely to DPW for the period of January 01, 2013 through June 30, 2013. Additionally, Compliance Requirement II.B.2. is NOT being waived for encounters where the procedure codes are not affected by the implementation of the 2013 CPT codes.

Please note that for both of these waivers, Compliance Requirement II.B.1 is NOT being waived. The Contractor must continue to have adequate procedures in place to ensure compliance with DPW's encounter reporting requirements.

C. Compliance Requirement

DPW requires the Contractor to submit a separate record or "encounter" each time a member has an encounter with a provider.

Person-Level Record The person level record must include, at a minimum, the data elements as required for a HIPAA compliant 837 transaction.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

1. Compare a sample of the encounters data received by the Contractor from the provider with the records submitted in the Encounter file to ensure that the Contractors are reporting all encounters as person-level Encounter records. Rating Group should be determined in accordance with the Managed Care Payment System Table (Appendix IV) and category of service should be determined in accordance with the HealthChoices Behavioral Health Services Reporting and Classification Chart (Appendix V).
2. Compare a sample of payments made to the providers for any payment agreements other than fee-for-service; i.e., Alternative Payment Arrangement (APA) retainer, case rates, bundled case rates, etc.; with the Financial APA records to ensure that all provider payments are being reported completely and accurately to DPW.
3. Verify that the Alternative Payment Arrangement has been approved by DPW.

III. Applicable Regulations/Procedures & References

- A.** HealthChoices Program Standards and Requirements
Part II-7, Section K. (3).
Appendices M and O.
- B.** Appendix IV –Managed Care Payment System Table.
- C.** GAGAS.

HEALTH SERVICE DELIVERY SYSTEM/ MCO/MCO SUBCONTRACTOR/ASO INCENTIVE

I. Requirement Objective

The Commonwealth has offered Counties the right of first opportunity to administer the HealthChoices program in order to better coordinate behavioral health services provided under medical assistance with other publicly funded behavioral health and human services. The Commonwealth wishes to ensure that contractual incentive arrangements between the Counties and their MCO/MCO Subcontractor/ASO are appropriate and that amounts due to/from the MCO/MCO Subcontractor/ASO and the Counties are accurately calculated. Errors in calculations may result in inaccurate amounts being reported for reinvestment plans, or amounts required to be returned to the Counties or the Commonwealth. The Commonwealth also wishes to ensure that the Counties' policies and procedures for oversight and monitoring of any incentive arrangements are complete and effective.

Additionally, in subsequent years of the HealthChoices program, the Commonwealth will audit the provider incentive arrangements between the Contractor and its providers, and/or the County's MCO/MCO Subcontractor/ASO and its providers, if such arrangements exist.

The Commonwealth will pay the Contractors a capitation payment for in-plan services. The Contractors are at full risk for providing services and the Commonwealth must be assured that the Contractors do not inappropriately motivate their MCO/MCO Subcontractor/ASO.

II. Compliance Requirements and Suggested Procedures

A. Compliance Requirement

The contractual arrangement, and any contract amendments between the Contractors and their MCO/MCO Subcontractor/ASO, should define the financial incentive plan and any related objective benchmarks.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

Examine the contracts between the Contractors and the MCO/MCO Subcontractor/ASO for the financial incentive provision.

1. Review the financial incentive provision in the contract, and any contract amendments.
2. Assure that the provision is clear; by defining the benchmarks the MCO/MCO Subcontractor/ASO must attain to receive the incentive.
3. Ensure that the benchmarks are reasonable and do not create a disincentive for the MCO/MCO Subcontractor/ASO to provide proper care or utilize medically necessary services.
4. Determine if the MCO/MCO Subcontractor/ASO is responsible for attaining savings on behavioral health services or administrative services in order to achieve the incentive payment.

B. Compliance Requirement

The Contractors must have control procedures in place to determine whether the MCO/MCO Subcontractor/ASO is eligible for an incentive payment, the amount of the payment, and the timing of the payment. These controls will be related to the policies and procedures of the Contractor.

Subcontracts may contain provisions requiring MCO/MCO Subcontractor/ASO to have audits of the incentive payment calculations. Where such provisions exist, the County should have in place procedures to ensure that such audit reports are both submitted and reviewed timely, and that needed adjustments are made.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

1. Review the Contractor's policies and procedures relating to the collection of necessary financial and program information for purposes of monitoring and assuring the appropriateness of the calculation, amount, and timing of the incentive payment. Review any quarterly or annual reports submitted in accordance with contractual or Contractor - directed requirements.
2. If the MCO/MCO Subcontractor/ASO is eligible for an incentive payment, determine that the amount of incentive payment calculated

meets all of the contractual requirements and does not exceed the amount set aside for this purpose.

- a. The amount available for the incentive payment is held by the Primary Contractor. This amount should agree with the amount on the Annual Counterpart Report #2, Line 6, plus any accrued interest or other increases/decreases indicated in the contracts or amendments.
 - b. If the amount available for the incentive payment is held by the Subcontractor, this amount should agree with the amount on the Annual Counterpart Report #3, Line 6, plus any accrued interest or other increases/decreases indicated in the contracts or amendments.
3. Where Contractor subcontracts contain provisions requiring MCO/MCO Subcontractor/ASO to have audits of the incentive payment calculations, determine that procedures are in effect to obtain and review such audit reports, and to make needed adjustments.

III. Applicable Regulations/Procedures and References

- A.** Refer to the appropriate sections in the subcontracts between the Contractor and MCO/MCO Subcontractor/ASO.
- B.** GAGAS.

FINANCIAL MANAGEMENT

I. Requirement Objective

Each participating Contractor, at its expense, is required to provide to DPW an annual HealthChoices Behavioral Health contract examination prepared by an Independent Public Accountant (IPA). This examination must include the specific financial schedules described in Table 1, below, along with accompanying Notes to the Financial Schedules. These Notes must contain descriptions of methodologies regarding revenue and expense allocation used in preparing the financial schedules.

NOTE: The IPA should also see related guidance in the Introduction and in the Notes to the Financial Schedules in Appendix I.

The formats for the contract examination financial schedules are included in Appendix I.

- Reports #2, #3, #4 and #9 are the annual counterparts to reports submitted periodically throughout the program year and should reflect the sum of the reports submitted throughout the year to DPW.
- Reports #6, #7, #12, and #13 are reports that reflect balances at the end of the reporting period.

All reports submitted as part of the IPA's report package should be completed using the same guidelines applied throughout the reporting period (i.e. FRR, Contract Amendments, etc.) Each DPW financial schedule should contain information applicable to the contract year or year ending account balances as of the last day of the contract year, as appropriate. The financial schedules provide the framework for the independent examination and will be further utilized to present the nature and magnitude of all material adjustments required as a result of the contract examination. The OMHSAS will forward the confirmed schedules to the IPAs as the schedules to be examined. It is then the responsibility of the IPA to determine if these reports correspond to the reports provided by the contractor to be examined and to report any variances as an adjustment.

Various financial schedules (Appendix I) require that adjustments result in the submission of revised schedules with detailed explanations included in the footnotes. Other financial schedules (Appendix I) contain an adjustment column where the adjustments must be listed and an adjusted balance column to reflect their impact. These columns must be used; however, if no adjustments are required, a definitive statement to that effect should be included on the schedule

in question. Adjustments specified in the schedules must be explained in sufficient detail in the footnotes. Adjustments should be determined based on materiality at the financial schedule level. A Summary of Unadjusted Differences should be maintained as part of the examination documentation.

NOTE: Medical or service expenses should not be reported via an allocation method, as in the case of some administrative expenses, but as actually incurred or expected to be incurred, by rating group and category of service. Medical or service expenses, for purposes of Reports #2, #3 and #9, should include only claims or service costs.

Table 1

Report #	Name	Description	Required by:
2	Primary Contractor Summary of Transactions	Report containing all capitation, investment and other revenue received during the year, as well as disposition of these funds.	ALL
3	Subcontractor Summary of Transactions	Report containing Subcontractor receipt of capitation revenues from the Contractor and investment and other revenues earned during the year, as well as disposition of these funds.	NA for Beaver, Fayette, VBH of PA, Inc. (Greene County), Cumberland, Dauphin, Lancaster, Lebanon, Perry, NBHCC, North Central State Option, <i>Tuscarora Managed Care Alliance</i>
4	Related Party Transactions and Obligations	Report that provides for the proper disclosure of all related party transactions, including the description of relationship, types of transactions conducted during the past year, and the resultant revenue and/or expense generated by each transaction. It should be further noted that the Contractor and the MCO/MCO Subcontractor are required to submit separate reports.	ALL
6	Claims Payable (RBUCs and IBNRs)	Report presenting RBUC and IBNR balances at year end.	ALL
7	LAG Reports	Report containing historical payment patterns.	ALL
9	Analysis of Revenues & Expenses	Presents an analysis of revenues and expenses, by category of service and rating group.	ALL
12	Reinvestment Report	Reports expenditures for approved reinvestment plans, by contract year.	N/A for VBH of PA (Greene County)
13	Balance Sheet/Statement of Net Assets	Reports assets and liabilities of Enterprise/Special Revenue Fund for the reporting period.	Philadelphia, Beaver, Fayette, NBHCC, TMCA and any Primary Contractor, who is not a private-sector BH-MCO, with a Risk and Contingency fund

Behavioral Health Contract Requirements

Financial Schedules

Each Contractor will provide a Report on the Examination of Financial Schedules. Along with the applicable financial schedules, this package should include a report of independent accountants on financial schedules #2, #3, #4, #6, #7, #9, and #12. Additionally, Beaver, Fayette, Philadelphia, NBHCC, TMCA and any Primary Contractor, who is not a private-sector BH-MCO, with a Risk and Contingency Fund should include Report #13 in their reports. All report packages should include accompanying Notes to the Financial Schedules. The bound report packages are required to be submitted to the Commonwealth by

- ♦ May 15, 2013 for the Southeast and Southwest Zones
- ♦ November 15, 2013 for the North Central State Option, Lehigh Capital, Northeast, and North Central County Option Zones.

Note: The IPA is no longer required to opine on Report #17 as a part of the Independent Accountant's Attestation Examination Report on the Financial Schedules. The IPA will now be required to report on the compliance requirements of Report #17 as a part of the Independent Accountant's Compliance Attestation Examination Report. Report #17 should be included with Management's Assertions as an attachment.

Accountability of Revenue and Expenses

The HealthChoices Contractors and their MCO/MCO Subcontractors are required to have separate bank accounts for all HealthChoices transactions.

Co-Mingling of Funds

The HealthChoices Counties are prohibited from using state and federal funds allocated to the County's mental health and/or drug and alcohol programs to fund the HealthChoices Program.

Parental Guaranty

Many contractors use a Parental Guaranty as a method of meeting the Insolvency Requirement. As a condition of accepting the Parental Guaranty, DPW requires quarterly monitoring of the parents financial condition by either the Primary Contractor or the BH-MCO.

II. Compliance Requirements and Suggested Procedures

A. Compliance Requirement - Report #2 Primary Contractor Summary of Transactions

This report should be accurately compiled in accordance with instructions included in the FRR. A copy of the FRR is included in Appendix III of this Guide.

The objective of Report #2 is to assist the Commonwealth in understanding the **current year** costs incurred at the Contractor level to administer the HealthChoices program; to provide assurance as to the completeness of revenue reporting and to be assured that financial subcontractual arrangements are in accordance with contract terms.

The Contractor must report all capitation revenue, as well as investment or other revenue related to the HealthChoices contract (excluding reinvestment account investment income), received during the contract period, and the disposition of these funds, in this report.

The Contractor should report actual HealthChoices administrative expenses on Report #2. It is to the advantage of the County to show these actual costs correctly because any possible future increases in rates for administrative expenses cannot be justified without showing that actual expenses exceeded the amounts received under the administrative portion of the capitation.

1. Report #2 is to show only actual HealthChoices transactions (i.e., no funds other than HealthChoices should be included on this report). Since this report is not based on GAAP, it is acceptable to show expenses greater than revenues.

In addition, Report #2 reflects revenues and expenditures received/incurred by jointers: Cumberland/Perry MH/MR Program on behalf of Cumberland and Perry Counties; York/Adams MH/MR Program on behalf of York and Adams Counties; Bedford/Somerset MH/MR Program on behalf of Bedford and Somerset Counties and Franklin/Fulton MH/MR Program on behalf of Franklin and Fulton Counties. These Counties must submit two separate Reports #2: one listing total county revenue and expenses and one listing only revenue and expenses related to the jointer.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

1. The contract with any subcontractor should be reviewed to recalculate distributions to subcontractor amounts and distributions to management corporation/ASO amounts.
2. All current year revenues and expenses should be classified accurately by rating group (column). Detailed amounts should be tested to substantiate proper classification and accuracy of amounts.
3. Detailed records should be tested to ascertain completeness, accuracy, cutoff, existence, and appropriateness of revenues and expenses included on the schedule. Revenues and expenses should be tested for appropriateness pertaining to the HealthChoices contract.
4. Amounts, where appropriate, should be recalculated to assess the accuracy and completeness of amounts included in each schedule.
5. Schedules and detailed records should be verified for mathematical accuracy.
6. Expense allocations used in preparing the report should be verified for reasonableness and accuracy. Amounts should be agreed to appropriate supporting documentation with recalculations performed, where necessary. Methodologies for allocation should be verified with acceptable methodologies, if any, contained in the contract.
7. Administrative Expenses should be tested to ensure that the costs reported reflect expenses incurred for purposes of administering the HealthChoices Behavioral Health Program **only**.
8. Administrative Expenses should be tested to determine accuracy. This should include ensuring separate reporting of Clinical Care/Medical Management expenses as described in the FRR, Section 3.3, instructions. Attachment F of the FRR, "Administrative Overhead and Clinical Care/Medical Management Cost Definitions", should be applied in determining which costs are clinical care/medical management or which costs are administrative overhead for DPW reporting purposes. Indirect overhead and administrative costs should **not** be included in Clinical Care/Medical Management costs.

9. If the County's administrative expenses are equal to either the amount withheld for county administration or the amount withheld for county administration plus investment income earned, additional testing may be required to ensure that the amounts are complete and accurate.
10. NOTE: This suggested procedure only applies to the Northeast and North Central zones.

Determine if start up costs, incurred prior to implementation, are included as part of administrative costs. If so, determine whether the start up costs are separately identified on the report so that they can be excluded from the administrative cost base for rate setting projections.

NOTE: Adjustments should result in submission of a revised Report #2 with the notation made in the "Revised Report, see Adjustment List" block on the face of the report. **It is important that adjustments be explained in sufficient detail in the footnotes by rating group. DPW will use the revised report to make adjustments to their financial database. The IPA should consider including a separate page showing adjustments only.**

**B. Compliance Requirement - Report #3
Subcontractor Summary of Transactions**

This report should be accurately compiled in accordance with instructions included in the FRR. A copy of the FRR is included in Appendix III of this guide.

The objective of Report #3 is to assist the Commonwealth in understanding the current year revenues and expenditures being incurred at the MCO/MCO Subcontractor level to administer the HealthChoices program; to provide assurance as to the completeness of revenue reporting; and to be assured that financial subcontractual arrangements are in accordance with contract terms.

The MCO/MCO Subcontractor must report all capitation revenue received from the Contractor, as well as investment or other revenue related to the HealthChoices contract (excluding reinvestment account investment income), received during the contract period, and the disposition of these funds, in this report.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

1. All current year revenues and expenses should be classified accurately by rating group (column). Detailed amounts should be tested to substantiate proper classification and accuracy of amounts.
2. Detailed records should be tested to ascertain completeness, accuracy, cutoff, existence, and appropriateness of revenues and expenses included on the schedule. Revenues and expenses should be tested for appropriateness pertaining to the HealthChoices contract.
3. Amounts, where appropriate, should be recalculated to assess the accuracy and completeness of amounts included in the schedule in accordance with subcontractor/agreements/contracts.
4. Schedules and detailed records should be verified for mathematical accuracy.
5. Expense allocations used in preparing the report should be verified for reasonableness and accuracy. Amounts should be agreed to appropriate supporting documentation with recalculations performed, where necessary. Methodologies for allocation should be verified with acceptable methodologies, if any, contained in the contract.
6. Administrative Expenses should be tested to determine accuracy. This should include ensuring separate reporting of Clinical Care/Medical Management expenses as described in the FRR, section 3.4, instructions. Attachment F of the FRR, "Administrative Overhead and Clinical Care/Medical Management Cost Definitions," should be applied in determining which costs are clinical care/medical management or which costs are administrative overhead for DPW reporting purposes. Indirect overhead and administrative costs should **not** be included in Clinical Care/Medical Management costs.

NOTE: Adjustments should result in submission of a revised Report #3 with the notation made in the "Revised Report, see Adjustment List" block on the face of the report. **It is important that adjustments be explained in sufficient detail in the footnotes by rating group. DPW will use the revised report to make adjustments to their financial database. The IPA should consider including a separate page showing adjustments only.**

**C. Compliance Requirement - Report #4
Related Party Transactions and Obligations**

This report should be accurately compiled in accordance with instructions included in the FRR. A copy of the FRR is included in Appendix III of this Guide.

The objective of Report #4 is to provide the Commonwealth with information regarding costs being incurred via transactions and obligations with related parties or affiliates, particularly those transactions that are not pre-approved by the Pennsylvania Insurance Department for licensed entities.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

1. Test the completeness of Report #4 - Related Party Transactions to ascertain that all related parties and affiliates, as defined by the contract, are listed on the report by performing procedures such as a review of Board minutes, reviewing prior year examination documentation for names of known related parties, reviewing filings with other regulatory/authoritative bodies, and inquiry of management to assist in determining completeness. (An additional source of information for determining completeness of related party transactions is Schedule Y, of the Contractor's annual statement submitted to the Pennsylvania Insurance Department. Schedule Y is entitled "Summary of the Insurer's Transactions with any Affiliates.")
2. Detailed tests of transactions and balances should include steps to ascertain the completeness of the related party and affiliate transactions.
3. Confirmation of account balances (including loans receivable and payable), paying particular attention to transactions recognized at or near the end of the period should be performed. The confirmation process should be supplemented with a review of accounting records for evidence of loan guarantees, large, unusual and/or nonrecurring transactions with officers, directors, and affiliated companies.
4. The "Transaction Code" column data should be traced and agreed to the specific transaction contained within that respective row to ensure the accuracy of transaction codes included in the report.

NOTE: Adjustments should result in submission of a revised Report #4 with the notation made in the “Revised Report, see Adjustment List” block on the face of the report. Adjustments should be explained in sufficient detail in the footnotes.

**D. Compliance Requirements - Report #6
Claims Payable (RBUCs and IBNRs)**

This report should be accurately compiled in accordance with instructions included in the FRR. A copy of the FRR is included in Appendix III of this Guide. Please note the Behavioral Health FRR Section 3.7 states that claim liabilities should not include the administrative portion of claim settlement expenses. Any liability for future claim settlement expense must be disclosed separately from the unpaid claim liability.

The objective of Report #6 is to provide information to the Commonwealth on the claims liability each Contractor is experiencing; to be assured that the Contractor has an adequate claims and accrual system in place; to ensure that the methodology being used is adequate; and to ensure that the Contractor is reviewing the liability on a timely basis, particularly for Contractors who have no historical data/experience on which to base their estimates.

The Contractor or its MCO/MCO Subcontractor/ASO is required to report Received But Unpaid Claims (RBUCs) and Incurred But Not Reported (IBNR) claims payable, by category of service.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

1. RBUCs aging should be tested and evaluated to ensure the accuracy as included on the report by Service Group and Days.
2. IBNRs should be tested and evaluated to ensure the accuracy as included on the report.
3. Items included in the report should be tested and agreed to detailed records to ensure completeness, accuracy, cut off, and existence of information.
4. Detailed listings should be scanned for unusual items.

5. Determine that appropriate adjustments to IBNR amounts are made where there is a nonroutine delay in the notification of claims, a significant volume of unprocessed claims, or a change in the date of closing records.
6. Determine that any claim settlement administrative expenses are reported separately as required in the FRR.
7. Amounts, where appropriate, should be recalculated to assess the accuracy of amounts included in the schedule.
8. Consider the need to have an actuary involved to perform a reserve analysis to ensure the proper valuation of the claims payable. Compare information contained in the actuary's analysis to detailed claim files, as appropriate, to verify the accuracy, completeness, cutoff, and existence of detailed claim information reviewed by the actuary.

NOTE: Adjustments should result in submission of a revised Report #6 with the notation made in the “Revised Report, see Adjustment List” block on the face of the report. **It is important that adjustments be explained in sufficient detail in the footnotes by category of service. DPW will use the revised report to make adjustments to their financial database. The IPA should consider including a separate page showing adjustments only.**

E. Compliance Requirement - Report #7 Lag Reports

This report should be accurately compiled in accordance with the **detailed** instructions included in the FRR. A copy of the FRR is included in Appendix III of this Guide. Materiality should be determined at each financial schedule level for Report #7.

The objective of Report #7 is to provide information to the Commonwealth on the historical payment patterns being experienced. Since this data provides a basis for IBNR estimates, it is essential that the lag tables are being developed properly.

The Contractor or its MCO/MCO Subcontractor/ASO is required to report its Lag Tables monthly, by category of service.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

1. Claims payments should be tested and evaluated to ensure the accuracy and completeness as included on the report for correct service grouping, month of payment, and month of service provided.
2. Claim files and IBNR amounts should be tested and agreed to detailed records and to the report to ensure completeness, accuracy, cutoff, and existence of information.
3. Detailed listings should be scanned for unusual items.
4. Determine that appropriate adjustments to IBNR amounts are made where there is a nonroutine delay in the notification of claims, a significant volume of unprocessed claims, or a change in the date of closing records.
5. Amounts, where appropriate, should be recalculated to assess the accuracy of amounts included in the schedule.
6. Consider the need to have an actuary involved to perform a reserve analysis to ensure the proper valuation of the IBNR claims estimate. Compare information contained in the actuary's analysis to detailed claim files, as appropriate, to verify the accuracy, completeness, cutoff, and existence of detailed claim information reviewed by the actuary.
7. Assess lag technique methodologies for reasonableness.

NOTE: Adjustments should result in submission of a revised Report #7 with the notation made in the “Revised Report, see Adjustment List” block on the face of the report. **It is important that adjustments be explained in sufficient detail in the footnotes by category of service. DPW will use the revised report to make adjustments to their financial database. The IPA should consider including a separate page showing adjustments only.**

The amount in the 24th & prior column on the confirmation schedules will only reflect activity in the 24th prior month. For report purposes, the IPA may identify either the 24th prior month or cumulative data for the 24th & prior months. In either case, the report does not have to be marked “Revised Report” unless other changes have been made to the report.

F. Compliance Requirement - Report #9 Analysis of Revenues and Expenses

This report should be accurately compiled in accordance with instructions included in the FRR. A copy of the FRR is included in Appendix III of this Guide. For purposes of the engagement, monthly Reports #9, Part A and Part B have been combined. Report #9, for the report package, contains a PMPM column in lieu of the complete monthly Report #9, Part B. The PMPM column should be completed in accordance with the FRR instructions for Report #9, Part B.

The objective of Report #9 is to provide the Commonwealth with information on combined Contractor and MCO/MCO Subcontractor **current year** revenues and expenditures for the HealthChoices Behavioral Health program. The rating groups and categories of service crosswalk to the rating groups and service categories contained in the Behavioral Health Data Book and the Contractors' cost proposals.

For purposes of Report #9, all "Other" revenue reported on Report #2 and Report #3 that represents a transfer of funds between entities should **not** be included on Report #9 (i.e., sanctions imposed by the County on the BH-MCO or a transfer of medical management funds.) See Line 3, Section 3.10, page 22, of the FRR.

For purposes of Report #9, individual stop loss reinsurance premiums should be reported on line 15a). Reinsurance Recoveries should be reported in the appropriate category of service and rating group. See FRR Section 3.1 for specific instructions for reporting additional amounts as "Other" on Line 15b). (Section 3.10, pages 22 and 23 of the FRR)

For purposes of Report #9, costs must be properly classified as "medical" or "administrative." "Medical costs," for this report, means those costs that represent claims or service costs, which will also have an encounter record, and reinsurance premiums and reinsurance recoveries. All other costs should be classified as "administrative." Medical costs should be classified by rating group and category of service, as incurred. Administrative costs may be allocated based on an appropriate allocation method, such as the applicable percentage of capitation revenue. Refer to Section 3.10 of the FRR for guidelines for allocating administrative expense amounts. Clinical Care/Medical Management expenses should be reported separately from other administrative costs. Attachment F of the FRR provides a chart to assist in identifying these costs. Refer to revised expense reporting requirements in Section 3.10, pages 22 and 23

of the FRR. **ALL** “Other Medical Services” should be disclosed within the footnotes to Report #9 **by amount, type of service and procedure code** as discussed in Section 3.1, page 6 of the FRR. Additionally, Section 3.1, page 7 of the FRR discusses the reporting of sanctions.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

1. All current year revenues and expenses should be classified accurately by both category of service (row) and rating group (column). Detailed amounts should be tested to substantiate proper classification and accuracy of amounts. Rating Group should be determined in accordance with the Managed Care Payment System Table (Appendix IV).
2. Detailed records should be tested to ascertain completeness, accuracy, cutoff, existence, and appropriateness of revenues and expenses by rating group and category of service included on the schedule. Revenues and expenses should be tested for appropriateness pertaining to the HealthChoices contract. Amounts, where appropriate, should be recalculated to assess the accuracy of amounts included in the schedule. For example, Line #10, BHRS and Line #12, RTF Non-Accredited, should be tested to ascertain that treatment and room and board costs are accurately reported.
3. Schedules and detailed records should be verified for mathematical accuracy.
4. Expense allocations used in preparing the report should be verified for reasonableness and accuracy. Amounts should agree with appropriate supporting documentation and recalculations performed where necessary. Methodologies for allocation should be verified with acceptable methodologies, if any, contained in the contract.
5. IBNR accrual allocations to the various rating groups should be verified for reasonableness and accuracy. Amounts should agree with appropriate supporting documentation and recalculations performed where necessary.
6. Administrative Expenses should be tested to determine accuracy. This should include ensuring separate reporting of Clinical Care/Medical Management expenses as described in the FRR, section 3.10, instructions. Attachment F of the FRR, “Administrative Overhead and

Clinical Care/Medical Management Cost Definitions,” should be applied in determining which costs are clinical care/medical management or which costs are administrative overhead for DPW reporting purposes. Indirect overhead and administrative costs should **not** be included in Clinical Care/Medical Management costs.

7. NOTE: This suggested procedure only applies to the North Central State Option Zone.

Determine if start up costs, incurred prior to implementation, are included as part of administrative costs. If so, determine whether the start up costs are separately identified on the report so that they can be excluded from the administrative cost base for rate setting projections.

NOTE: Adjustments should result in submission of a revised Report #9 with the notation made in the “Revised Report, see Adjustment List” block on the face of the report. **It is important that adjustments be explained in sufficient detail in the footnotes by rating group and category of service. DPW will use the revised report to make adjustments to their financial database. The IPA should consider including a separate page showing adjustments only.**

ALL ‘Other Medical Services’ should be disclosed within the footnotes to Report #9 **by amount, type of service, and procedure code** as discussed in Section 3.1, page 6 of the FRR.

G. Compliance Requirement – Report #12 Reinvestment Report

This report should be accurately compiled in accordance with instructions included in the FRR. A copy of the FRR is included in Appendix III of this Guide.

The objective of Report #12 is to assist the Commonwealth in tracking expenditures resulting from DPW-approved Reinvestment Plan(s); to provide assurance as to the completeness of expenditure reporting; and to provide assurance that financial information is being reported in accordance with contract and FRR requirements.

The Contractor must report all reinvestment account revenue and expenditures (on a cash basis), as well as other revenue, allocations or

contributions, related to the Reinvestment account, in this report. The amounts reported on Report #12 must be segregated and reported by contract year. One report is required for each year and each rating group only if funds are allocated to or used from an approved Reinvestment Plan year.

For the SE/SW Primary Contractors, effective January 1, 2012, the Department will recoup any reinvestment savings in excess of 3% of total HealthChoices Behavioral Health revenue, net of Gross Receipts Tax, in accordance with Appendix 1, Reinvestment Sharing Arrangement, of the January 1, 2012 contract amendment.

For the LC/NE/NC SO/NC CO Primary Contractors, effective July 1, 2011, the Department will recoup any reinvestment savings in excess of 3% of total HealthChoices Behavioral Health revenue, net of Gross Receipts Tax, in accordance with Appendix 1, Reinvestment Sharing Arrangement, of the LC/NC SO and Appendix 5 of the NE/NC CO July 1, 2011 contract amendment.

The notes to the financial schedules MUST include a calculation of estimated funds identified as being available for reinvestment from the year being examined. Refer to the suggested format for calculating excess funds available for reinvestment on page I-17 of Appendix I.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

1. Reinvestment funds must be maintained in a separate reinvestment bank account.
2. Revenues and expenditures should be tested to substantiate proper classification by contract year and rating group.
3. Estimated funds available for reinvestment from the current year should be calculated in accordance with the contracts and subcontracts between DPW and the counties and/or the counties and the BH-MCO as applicable.
4. Reinvestment expenditures are only permitted for initiatives contained in DPW-approved reinvestment plans. All expenditures on Report #12 should be compared to the appropriate plan for accuracy of initiative amounts and to substantiate proper classification by plan.

5. Detailed records should be tested to ascertain completeness, accuracy, cutoff, existence, and appropriateness of revenues and expenses included on the schedule. Revenues and expenses should be tested for appropriateness pertaining to the HealthChoices contract, FRR, and DPW-approved Reinvestment Plan. Verify beginning balance agrees with ending balance of prior year (NOTE: Beginning balance for the first year of participation is 0).
6. Schedules and detailed records should be verified for mathematical accuracy.
7. Expense allocations used in preparing the report should be verified for reasonableness and accuracy. Amounts should be agreed to appropriate supporting documentation with recalculations performed, where necessary. Methodologies for allocation should be verified with acceptable methodologies, if any, contained in the FRR or Reinvestment Plan.
8. The IPA must examine each year the approved Reinvestment Plan incurred expenditures and include all years in the contract report package. For instance, contract year 2004 reinvestment funds spent in 2009 must be reported in the report package for 2009. This is also true for any other contract year reinvestment funds since Report #12 is on a cash basis.

NOTE: Adjustments should result in submission of a revised Report #12 with the notation made in the “Revised Report, see Adjustment List” block on the face of the report. **It is important that adjustments be explained in sufficient detail in the footnotes by rating group and DPW-approved service. DPW will use the revised report to make adjustments to their financial database. The IPA should consider including a separate page showing adjustments only.**

H. Compliance Requirement - Report #13 Balance Sheet/Statement of Net Assets

(Applies to Philadelphia, Beaver, Fayette, NBHCC, TMCA and any Primary Contractor who is not a private-sector BH-MCO with a Risk and Contingency Fund.)

The purpose of the requirement for an examined Balance Sheet/Statement of Net Assets is to ensure the Commonwealth that as of the last day of the contract year under examination:

1. the assets and liabilities of the Enterprise/Special Revenue Fund were in existence.
2. recorded transactions actually occurred during the contract year.
3. all transactions and accounts that should be presented are properly included.
4. the Contractor had actual ownership of the assets as presented.
5. assets and liabilities were included at the appropriate amounts.
6. assets and liabilities are properly classified, described, and disclosed.

This report should include all HealthChoices Behavioral Health contract assets and liabilities. (NOTE: IBNRs and RBUCs should be reported separately.) The Balance Sheet/Statement of Net Assets should be broken out, at a minimum, into current and non-current assets and liabilities. If any single balance sheet/statement of net assets item classified under "Other" Current Asset/Liability or Non-current Asset/Liability is ≥ 5 percent (5%) of the total for that section, provide an itemized list and dollar amount for that item.

All cash assets **must** be broken down into sufficient detail to report the purpose of the cash accounts (i.e. risk and contingency amounts, reinvestment amounts, in particular, must be reported separately).

To clarify the FRR instructions for reporting a claims payable amount on the Balance Sheet/Statement of Net Assets that ties into Report #6 (Claims Payable) and Report #7 (Lag Report): Tie-in's to Reports #6 and #7 are specific to those entities that have an Enterprise Fund or non-governmental entities that contract directly with DPW.

NOTE: There is no standard format for Report #13.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

1. Obtain year-end bank statements.
2. Obtain, directly from the bank, “cut-off statements” subsequent to the end of the contract year.
3. Obtain and review confirmations at the end of the contract period concerning account balances, interest rates on interest-bearing accounts and information on direct indebtedness to financial institutions.
4. Perform tests of bank reconciliations to verify that the recorded cash balance agrees with the actual cash in bank.
5. Prepare an interbank transfer schedule to ascertain the possibility of double counting of cash, kiting, etc.
6. Ensure claims liability for RBUCs and IBNRs agree with Report #6 and Report #7.
7. Make inquiries concerning contingencies.
8. Confirm that any risk and contingency fund is included as a separate line item and the fund is in conformance with contract requirements. See Section II-7, G of the HealthChoices Program Standards and Requirements.
9. Observe inventories and gain satisfaction as to prior inventory counts.
10. Inspect securities or obtain written confirmation from custodian.
11. Apply analytical procedures to financial and non-financial data.

NOTE: Adjustments are to be made in the column “ADJUSTMENT” with a corrected total in the column “BALANCE.” All adjustments should be explained in detail in a separate listing included with the Balance Sheet/Statement of Net Assets.

**I. Compliance Requirement – Report #17
Contract Reserves Compliance**

The HealthChoices Contractors, and/or their MCO/MCO Subcontractors, must meet and maintain certain equity and reserve requirements as specified in Part II-7, Sections A. 4) and 5) of the HealthChoices Program Standards and Requirements and Section 6.1 D of the HealthChoices Behavioral Health contracts. DPW requires assurance that the equity and reserve balances are properly reported.

All Contractors must submit a report in accordance with the FRR (see Appendix III to this Audit Guide) detailing the calculation used to

determine its compliance with the equity requirement. This report is known as Report #17 and should be accurately compiled in accordance with the guidance referenced above.

All HealthChoices capitation revenues, net of MCO Assessment and Gross Receipts Tax, must be included in the calculation for the reserve requirement. If there is a lack of compliance, the report must include an analysis of the fiscal status of the contract and the steps for fiscal improvement that management plans to take.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

1. Confirm the “Capitation Payments for Applicable Period” paid to the Primary Contractor(s) on Report #17 as of the end of the last quarter of the contract year being examined by sending a confirmation request to Comptroller Operations, Bureau of Payable Services at the email address at the top of page 2. (The confirmation request should include a request for capitation revenue for each county/contract included in Report #17.) The amount to be confirmed as Capitation Payments should not be reduced by the amount of the MCO Assessment or Gross Receipts Tax. However, the MCO Assessment and Gross Receipts Tax must be deducted prior to calculating the equity requirement.
2. Verify that the “Required % of Capitation Payments” for each Primary Contractor is accurate based on the applicable DPW/Primary Contractor Agreement. (The required % is the minimum equity defined as a percentage of annual capitation revenue.)
3. Verify that the sum of each Primary Contractor’s “Required % of Capitation Payments” equals the Managed Care Organization’s Total “Equity Reserve Requirement.”
4. Confirm that “Total Equity,” per Report #17, agrees with the Total Equity reported by the MCO on the applicable Department of Insurance (DOI) annual/quarterly filing or annual audit. This confirmation should include inquiry as to any amended DOI filings that may exist for the applicable quarter.
5. Verify the sum of the Managed Care Organization’s “Total Equity” is equal to or greater than the sum of the Primary Contractors’ “Equity/Reserve Requirement.”

6. If there is a lack of compliance, review the analysis of the fiscal status of the situation and steps for fiscal improvement that management planned to take. Confirm that the steps for fiscal improvement were taken.
7. Confirm that the Primary Contractor's policies and procedures regarding monitoring MCO's equity are in place and are being performed in accordance with said policies and procedures.
8. Verify that the financial condition of related parties will not impact the MCO as a going concern.

NOTE: Adjustments are to be made in an "ADJUSTMENT" column with a corrected total in an "ADJUSTED BALANCE" column. Adjustments should be explained in sufficient detail in the footnotes.

Reporting Requirement

This compliance requirement should be addressed in the Compliance Attestation Examination Report described in the Introduction, Independent Accountant's Report Section. Report #17 should be included in the contract report package as an attachment to the Management Assertion Letter. (See Appendix II)

J. Compliance Requirements - Accountability of Revenues and Expenses

The HealthChoices Contractors, and their MCO/MCO Subcontractors, are required to have contract specific bank accounts for 1) HealthChoices capitation transactions, 2) reinvestment transactions, 3) restricted reserve funds, where applicable, and 4) risk and contingency funds. The Contractors, and their MCO/MCO Subcontractors, must also have procedures for accurately recording, tracking, monitoring, and reporting HealthChoices revenues and expenses separately from any non-HealthChoices revenues and expenses. In addition, Contractors and MCO/MCO Subcontractors who operate in more than one County, must have procedures for accurately recording, tracking, monitoring, and reporting HealthChoices revenues and expenses by individual County as stated in Part II-7, Sections A. 7 of the HealthChoices Program Standards and Requirements and the HealthChoices Behavioral Health contracts Section 6.1; Section 7.1 for Philadelphia.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

1. Verify that the bank accounts utilized by the Contractors and the MCO/MCO Subcontractors are designated specifically for HealthChoices for the four areas listed above.
2. Verify that all HealthChoices transactions flow through these accounts, and that there are no non-HealthChoices transactions occurring within the accounts.
3. Identify reinvestment plans approved by OMHSAS during the engagement period. Verify that the Contractor deposited Reinvestment Funds in a restricted account within 30 days of the OMHSAS written approval of the reinvestment plan(s).
4. Review procedures of the Contractors and their MCO/MCO Subcontractors to determine that only HealthChoices revenue and expenses are tracked, monitored, and reported separately from all non-HealthChoices revenue and expenses.
5. Verify that the Contractor, MCO/MCO Subcontractors and Management Corporations have a process in place to record staff time spent on HealthChoices duties separate from non-HealthChoices duties. Also, verify that MCO/MCO Subcontractors and Management Corporations with multiple contracts have a process in place to allocate staff time by contract. Expense allocations charged to HealthChoices based on time studies should be verified for reasonableness and accuracy. Amounts should be agreed to supporting documentation with recalculations performed, where necessary.

Reporting Requirement

This compliance requirement should be addressed in the Compliance Attestation Examination Report described in the Introduction, Independent Accountant's Report Section.

K. Compliance Requirements - Co-Mingling of Funds

The HealthChoices Counties must maintain separate fiscal accountability for Medicaid funding under the HealthChoices waiver apart from mental health and substance abuse programs funded by State, County, and/or other Federal program monies.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

1. Verify that the County has maintained separate fiscal accountability for Medicaid funding under the HealthChoices waiver apart from mental health and substance abuse programs funded by State, County, and/or other Federal program monies.
2. Verify the utilization of State and Federal funds allocated to the County's mental health and/or drug and alcohol programs to determine that these funds were not used for in-plan services by examining payments for these services and bank statements to determine that co-mingling did not occur.

Reporting Requirement

This compliance requirement should be addressed in the Compliance Attestation Examination Report described in the Introduction, Independent Accountant's Report Section.

L. Compliance Requirements – Parental Guaranty

Each HealthChoices Contractor must submit a plan to provide for payment to Providers by a secondary liable party after a default in payment to Providers resulting from bankruptcy or insolvency. The arrangement must be, at a minimum, the equivalent of two months' worth of paid claims, when determinable, or two months of expected capitation revenue.

One method of meeting this requirement is through a guaranty from an entity, acceptable to DPW, with sufficient financial strength and credit worthiness to assume the payment obligations, as specified in Part II-7, Section A. 3) c. of the HealthChoices Program Standards and Requirements.

Many contractors are using a Parental Guaranty as a method of meeting the Insolvency Requirement. As a condition of accepting the Parental Guaranty, DPW requires quarterly monitoring of the parents financial condition by either the Primary Contractor or the BH-MCO.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS.

1. Determine whether the Contractor has entered into a Parental Guaranty agreement in order to meet the insolvency requirement.

If a Parental Guaranty is not in place, no further testing is necessary. If a Parental Guaranty agreement exists, continue with the following suggested procedures:

2. Verify that the Primary Contractor has policies and procedures in place for quarterly monitoring of the parent's financial condition, and that the procedures are being performed in accordance with the policy.
3. Verify timeliness of financial monitoring and submission of reports and results to DPW.
4. Determine whether the quarterly monitoring identified financial concerns. If so, verify that the contractor took appropriate steps in accordance with the policies and procedures. These steps may include notification to DPW, development of a corrective action plan, or arrangements for other insolvency protection.

Reporting Requirement

This compliance requirement should be addressed in the Compliance Attestation Examination Report described in the Introduction, Independent Accountant's Report Section.

III. Applicable Regulations/Procedures and References

- A.** Appendix III - Behavioral Health Financial Reporting Requirements.
- B.** HealthChoices Behavioral Health contract,
 - Section 4.8 Section 5.8 for Philadelphia
 - Section 6.1 Section 7.1 for Philadelphia
 - Section 7 Section 8 for Philadelphia
- C.** HealthChoices Behavioral Health Program Standards and Requirements
Part II-7, Sections A. 3), 4), 5) and 7).
- D.** Appendix IV – Managed Care Payment System Table.
- E.** GAGAS.

**BEHAVIORAL HEALTH
APPENDIX I**

Financial Schedules Examination Report

NOTE: The following is suggested language for the Independent Accountant’s Attestation Examination Report on Financial Schedules specified in Table 1 of the Financial Management Section of the Audit Guide.

Independent Accountant’s Report

To the County Commissioners
ABC County
Anywhere, PA

We have examined the accompanying schedules of [insert a list of the financial schedules specified in Table 1 of the Financial Management Section of the HealthChoices Audit Guide for the Behavioral Health Program] of ABC’s HealthChoices Behavioral Health program for the period ended (December 31, [SE/SW]/ June 30, [NE LC, and NC Options]) 20XX. These schedules are the responsibility of ABC’s management. Our responsibility is to express an opinion on these financial schedules based upon our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants and the standards applicable to attestation engagements contained in Government Auditing Standards, issued by the Comptroller General of the United States and, accordingly, included examining, on a test basis, evidence supporting ABC’s HealthChoices Behavioral Health program’s financial schedules as listed above and performing such other procedures as we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion.

The accompanying financial schedules were prepared for the purposes of complying with the HealthChoices Behavioral Health program requirements of the Pennsylvania Department of Public Welfare (DPW) pursuant to the contract described in Note X and are not intended to be a complete presentation of ABC’s revenues and expenses.

In our opinion, the schedules referred to above present fairly, in all material respects, [insert a list of the financial schedules specified in Table 1 of the Financial Management Section of the HealthChoices Audit Guide for the Behavioral Health Program] of ABC’s HealthChoices Behavioral Health program for the period ended (December 31, [SE/SW]/ June 30, [NE, LC, and NC Options]) 20XX, in conformity with DPW’s Behavioral Health Financial Reporting R equirements as described in Note “X”.

Suggested Language (continued)

[When any of the matters set forth in of GAGAS have been identified the following paragraph would be added.]

In accordance with Government Auditing Standards, we are required to report findings of deficiencies in internal control, violations of provisions of contracts or grant agreements, and abuse that are material to ABC's HealthChoices Behavioral Health program's financial schedules as listed above, and any fraud and illegal acts that are more than inconsequential that come to our attention during our examination. We are also required to obtain the views of management on those matters. We performed our examination to express an opinion on whether ABC's HealthChoices Behavioral Health program's financial schedules as listed above are presented in accordance with the criteria described above and not for the purpose of expressing an opinion on the internal control over ABC's HealthChoices Behavioral Health program's financial schedules as listed above or on compliance and other matters; accordingly, we express no such opinions. Our examination disclosed certain findings that are required to be reported under Government Auditing Standards and those findings, along with the views of management, are described in the attached Schedule of Findings.

[If a management letter has been issued, the following paragraph should be included.]

In accordance with Government Auditing Standards, we also noted other matters which we have reported to management of ABC in a separate letter dated Month Day, 20XX.

The purpose of this *[report, letter, presentation, or communication]* is solely to *[describe the purpose of the auditor's written communication, such as to describe the scope of our testing of internal control over financial reporting and compliance, and the result of that testing, and not to provide an opinion on the effectiveness of the entity's internal control over financial reporting or on compliance]*. This *[report, letter, presentation, or communication]* is an integral part of an audit performed in accordance with Government Auditing Standards in considering *[describe the results that are being assessed, such as the entity's internal control over financial reporting and compliance]*. Accordingly, this *[report, letter, presentation, or communication]* is not suitable for any other purpose.

Signature
Month, Day, 20XX

If a management letter has been issued as a result of the IPA's examination, copies of this letter must be submitted with, but not necessarily part of the bound report on the IPA's examination.

NOTE: The IPA should refer to GAGAS and Statements on Standards for Attestation Engagements for guidance on the issuance of this report.

Behavioral Health Schedule - Report 2 Primary Contractor Summary of Transactions

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

Revenues/Expenses	TANF	Healthy Beginnings	SSI and Healthy Horizons w/ Medicare	SSI and Healthy Horizons w/o Medicare	Federal GA	Categorically Needy State Only GA	Medically Needy State Only GA	TOTAL
1) Beginning Balance								
Revenue:								
a) Capitation Revenue								
b) Investment Revenue								
c) Other (Identify)								
2) Revenue Total								
Distributions:								
Distributions to Subcontractor:								
a) Medical Services								
b) Administration								
c) Profit								
d) Reinvestment								
e) Other (Identify)								
3) Total Distributions to Subcontractor								

Please refer to instructions for this report for guidelines on allocating expenses among the seven behavioral health rating groups.

- Revised Report, see Adjustment List
 Original Report without adjustments

Behavioral Health Schedule - Report 2 (continued) Primary Contractor Summary of Transactions

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

Revenues/Expenses	TANF	Healthy Beginnings	SSI and Healthy Horizons w/ Medicare	SSI and Healthy Horizons w/o Medicare	Federal GA	Categorically Needy State Only GA	Medically Needy State Only GA	TOTAL
Distributions for:								
4) Reserves								
5) Reinvestment								
6) Incentive/Risk Pools								
7) Medical Expenses								
8) Other (Identify)								
Administrative Expenses:								
a) Compensation								
b) Interest Expense								
c) Occupancy, Depreciation & Amortization								
d) Gross Receipts Tax								
e) Distributions to Management Corporation/ASO								
f) Clinical Care/Medical Management								
g) Other (Identify)								
9) Administrative Expense Total								
10) Total Distributions (Lines 3 through 9)								
Balance (Line 1 + Line 2 - Line 10)								

Please refer to instructions for this report for guidelines on allocating expenses among the seven behavioral health rating groups.

Revenue and Expenses are Reported as: 100% actual amounts
 allocated amounts have been attributed to one or more of the 7 rating groups as described in Note ____ of the Financial Schedules

Behavioral Health Schedule - Report 3 Subcontractor Summary of Transactions

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

Revenues/Expenses	TANF	Healthy Beginnings	SSI and Healthy Horizons w/ Medicare	SSI and Healthy Horizons w/o Medicare	Federal GA	Categorically Needy State Only GA	Medically Needy State Only GA	TOTAL
1) Beginning Balance								
Revenue:								
a) Capitation Revenue								
b) Investment Revenue								
c) Other (Identify)								
2) Revenue Total								
Distributions:								
Distributions for:								
a) Medical Services								
b) Profit								
c) Reinvestment								
d) Other (Identify)								
3) Total Distributions								

Please refer to instructions for this report for guidelines on allocating expenses among the seven behavioral health rating groups.

- Revised Report, see Adjustment List**
 Original Report without adjustments

Behavioral Health Schedule - Report 3 (continued) Subcontractor Summary of Transactions

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

Revenues/Expenses	TANF	Healthy Beginnings	SSI and Healthy Horizons w/ Medicare	SSI and Healthy Horizons w/o Medicare	Federal GA	Categorically Needy State Only GA	Medically Needy State Only GA	TOTAL
Administration Expenses:								
a) Compensation								
b) Interest Expense								
c) Occupancy, Depreciation, & Amortization								
d) Gross Receipts Tax								
e) Clinical Care/Medical Management								
f) Other (Identify)								
4) Total Administration Expenses:								
5) Other (Identify)								
6) Incentive/Risk Pool(s)								
7) Reinvestment								
8) Total Distributions (Lines 3 through 7)								
Balance (Line 1 + Line 2 - Line 8)								

Please refer to FRR instructions for this report for guidelines on allocating expenses among the seven behavioral health rating groups.

Revenue and Expenses are Reported as: 100% actual amounts
 allocated amounts have been attributed to one or more of the 7 rating groups as described in Note _____ of the Financial Schedules

Behavioral Health Schedule - Report 6 Claims Payable (RBUCs and IBNRs)

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

CATEGORY OF SERVICE	Received But Unpaid Claims (RBUCs)					IBNR	TOTAL RBUCs & IBNRs
	1 - 30 Days	31 - 45 Days	46 - 90 Days	91+ Days	TOTAL RBUC		
Inpatient Psychiatric							
Inpatient D & A							
Non-Hospital D & A							
Outpatient Psych.							
Outpatient D & A							
B.H. Rehab. Services for Children & Adolescents							
RTF – Accredited							
RTF - Non-Accredited							
Ancillary Support							
Community Support							
Other							
TOTAL CLAIMS PAYABLE							

Method of estimation used to determine the amount of IBNRs is provided at Note ___ to the Financial Schedules

- Revised Report, see Adjustment List
- Original Report without Adjustments

Behavioral Health Schedule - Report 7

Lag Report _____ (Major Service Grouping)

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

(1)	(2)	(3)	(4)	(5) Month In Which Service Was Provided										
	Month of Payment	Current	1st Prior	2nd Prior	3rd Prior	4th Prior	5th Prior	6th Prior	7th Prior	8th Prior	9th Prior	10th Prior	11th Prior	
1	Current													
2	1st Prior													
3	2nd Prior													
4	3rd Prior													
5	4th Prior													
6	5th Prior													
7	6th Prior													
8	7th Prior													
9	8th Prior													
10	9th Prior													
11	10th Prior													
12	11th Prior													
13	12th Prior													
14	13th Prior													
15	14th Prior													
16	15th Prior													
17	16th Prior													
18	17th Prior													
19	18th Prior													
20	19th Prior													
21	20th Prior													
22	21st Prior													
23	22nd Prior													
24	23rd Prior													
25	24th Prior													
26	Totals													
27	Expense Reported													
28	Remaining Liability*													

See instructions before completing schedule.

Complete a separate form for EACH of the eleven behavioral health major service groupings and one for the total of all services.

- Revised Report, see Adjustment List
- Original Report without Adjustments

**Behavioral Health Schedule - Report 9
Analysis of Revenues & Expenses**

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

Revenues/Expenses	TANF	Healthy Beginnings	SSI and Healthy Horizons w/ Medicare	SSI and Healthy Horizons w/o Medicare	Federal GA	Categorically Needy State Only GA	Medically Needy State Only GA	TOTAL	PMPM*
MEMBER MONTH EQUIVALENTS									
REVENUES:									
1. Capitation									
2. Investment Income									
3. Other (Specify)									
4. TOTAL REVENUES (Lines 1 through 3)									
EXPENSES:									
5. Inpatient Psychiatric:									
a) Freestanding Psych Facilities (22-64)									
b) Other									
SUBTOTAL									
6. Inpatient D & A									
7. Non-Hospital D & A									
a) All Treatment									
b) Non-Accredited Room and Board (CISC)									
8. Outpatient Psychiatric									
9. Outpatient D & A									
10. BHRS									
a) All Treatment									
b) CRR Host Home Room and Board									
SUBTOTAL									
11. RTF – Accredited									
12. RTF – Non-Accredited									
a) Treatment									
b) Room & Board									
SUBTOTAL									

* The PMPM column is included here in lieu of requiring a full examination of Report 9B. This column should be completed in accordance with the FRR instructions for Report 9B. (See FRR - Appendix III)

- Revised Report, see Adjustment List
- Original Report without Adjustments

**Behavioral Health Schedule - Report 9 (continued)
Analysis of Revenues & Expenses**

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

Revenues/Expenses	TANF	Healthy Beginnings	SSI and Healthy Horizons w/ Medicare	SSI and Healthy Horizons w/o Medicare	Federal GA	Categorically Needy State Only GA	Medically Needy State Only GA	TOTAL	PMPM
13. Ancillary Support									
14. Community Support Services									
a) Crisis Intervention									
b) Family Based Services for Children & Adolescents									
c) Targeted MH Case Management									
SUBTOTAL									
15. Other									
a) Stop-Loss Reinsurance Premiums									
b) Other Medical Services									
SUBTOTAL									
TOTAL MEDICAL EXPENSES (lines 5 through 15)									
16. Administration									
a) Compensation									
b) Interest Expense									
c) Occupancy, Depreciation, & Amortization									
d) Gross Receipts Tax									
e) Distributions to Management Corporations/ASO/Subcontractor									
f) Clinical Care/Medical Management									
g) Other (Specify)									
TOTAL ADMINISTRATION									
17. TOTAL EXPENSES (Lines 5 through 16)									
18. INCOME (LOSS) FROM OPERATIONS									

See instructions before completing this line item.

19. Non-Accredited Room & Board C & Y Secondary Funding Sources									
--	--	--	--	--	--	--	--	--	--

Revenue and Expenses are Reported as: 100% actual amounts
 allocated amounts have been attributed to one or more of the 7 rating groups as described in Note ___ of the Financial Schedules

Behavioral Health Schedule - Report 13 Balance Sheet/STATEMENT OF NETS ASSETS

This Report is required for the Enterprise Fund of the Counties of Philadelphia, Beaver, and Fayette.

This report is also required for any Primary Contractor with a Risk and Contingency Fund who is not a private sector BH-MCO.

The purpose of the requirement for an examination of the Balance Sheet/Statement of Net Assets is to ensure the Commonwealth that as of the last day of the contract year under examination:

- the assets and liabilities of the Enterprise/Special Revenue Fund were in existence
- recorded transactions actually occurred during the contract year
- all transactions and accounts that should be presented are properly included
- the Counties had actual ownership of the assets as presented
- assets and liabilities were included at the appropriate amounts
- assets and liabilities are properly classified, described, and disclosed

This report should include all HealthChoices Behavioral Health contract assets and liabilities. (NOTE: IBNRs and RBUCs should be reported separately.) The Balance Sheet/Statements of Net Assets should be broken out, at a minimum, into current and non-current assets and liabilities. If any single balance sheet item classified under “Other” Current Asset/Liability or Non-current Asset/Liability is > 5 percent (5%) of the total for that section, provide an itemized list and dollar amount for that item.

All cash assets **must** be broken down into sufficient detail to report the purpose of the cash accounts (i.e. risk and contingency amounts, reinvestment amounts, in particular, must be reported separately).

There is no standard format for this report. Confirmation that the report provided is the correct report to examine should be requested through the single point of contact listed on page 1 of this Audit Guide.

NOTE: The IPA must provide for an adjustment column where adjustments should be listed and balance column to reflect their impact. These columns must be used; however, if no adjustments are required, a definitive statement to that effect should be included. All adjustments should be explained in detail in a separate listing included with the Balance Sheet/Statements of Net Assets.

Behavioral Health Schedule - Report 17 Contract Reserves Compliance Report

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

SOURCE OF EQUITY REPORTED _____								
DPW Capitation Payments								
	Contract A *	Contract B *	Contract C *	Contract D *	Contract E *	TOTAL	Adjustment	Adjusted Balance
Capitation Payments for Applicable Period								
Required % of Capitation Payments								
Equity/Reserve Requirement								
Total Equity								
Amount Over/(Under) Equity Requirement								

* Equity requirement to be calculated on all HealthChoices contracts for which the entity is responsible for meeting this requirement.

NOTES TO THE FINANCIAL SCHEDULES

The following Notes to the Financial Schedules **must** be included. In those instances where any of the issues addressed in the following notes are non-existent or immaterial, the issue should be reported as such within the Notes to the Financial Schedules:

- Basis of accounting
- Organizational structure for the administration of contracts of programs
(This should include all related organizations and economic dependencies)
- Description/basis of accruing health care costs
- Disclosure of significant business, management and provider contracts or arrangements
- Commitments and contingencies
- Information about restricted and reserve accounts
- Related party transactions
- Subsequent events
- Risks and uncertainties
- Information about reinsurance arrangements
- Estimation methodology used to determine the amount of IBNRs
- Methodologies used for allocation of all revenues and/or expenses attributed to various categories of aid
- Calculation of funds available for reinvestment from the year being examined.
See page I-17 for example of the suggested format for the reinvestment calculation.

Reinvestment Estimate
Suggested Format

	Current Year	1st Prior	2nd Prior
Capitation Revenue - Report #2			
Other Revenue			
Total Revenue	\$0	\$0	\$0

Claims Revenue:			
Medical Services Distribution/Claims Reserve			
Incentive Withhold			
Miscellaneous Claims Revenue			
Total Claims Revenue	\$0	\$0	\$0
Claims Expense:			
Claims Expense - Report #9			
Incentive accrued/paid			
Risk Corridor Recoupment			
Miscellaneous Claims Related Expense			
Total Claims Expense	\$0	\$0	\$0
Surplus/(Deficit)	\$0	\$0	\$0

Administrative Revenue			
County Interest Revenue			
Total County Revenue	\$0	\$0	\$0
County Administrative Expense (including MCO Assessment and Gross Receipts Tax)			
Administrative Distribution to Subcontractor			
Miscellaneous Expense/Reserve			
	\$0	\$0	\$0
Surplus/(Deficit)	\$0	\$0	\$0
Prior Year Adjustments made during Current Year		\$0	\$0
Estimated Excess Funds	\$0	\$0	\$0

The suggested format is only provided as an example. This example is not intended to specify a method of calculation for funds available for reinvestment. However, the calculation of funds available for reinvestment included in the notes to financial schedules should contain a level of detail similar to the example provided.

**BEHAVIORAL HEALTH
APPENDIX II**

**Compliance Attestation Examination Report
on
Management Information System/Encounter Data Reporting
Health Services Delivery System/MCO/MCO Subcontractor/ASO
Incentive Arrangements
Claims Processing
Financial Reporting Requirements I, J, K & L**

NOTE: The following is suggested language for the Independent Accountant's Compliance Attestation Examination Report on Management Information System/Encounter Data Reporting, Health Service Delivery System/MCO/MCO Subcontractor/ASO Incentive Arrangements, Claims Processing, and Financial Management Compliance Requirements I (Contract Reserves Compliance), J, K and L.

Independent Accountant's Report

To the County Commissioners
ABC County
Anywhere, PA

We have examined management's assertions*, included in the accompanying [insert title of management's report] that ABC County complied with [insert a list of the specific compliance requirements as set forth in the various sections of the HealthChoices Audit Guide for Behavioral Health with the exception of Sections A to H, inclusive, of the Financial Management Section of the HealthChoices Behavioral Health program contract during the period ended (December 31, 20XX for the Southeast/Southwest zones, June 30, 20XX for the Northeast zone, Lehigh Capital zone, and North Central zones.) Management is responsible for ABC County's compliance with these requirements. Our responsibility is to express an opinion on ABC County's compliance based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants, and the standards applicable to attestation engagements contained in Government Auditing Standards, issued by the Comptroller General of the United States, and, accordingly, included examining, on a test basis, evidence about ABC County's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion. Our examination does not provide a legal determination on ABC County's compliance with specific requirements.

In our opinion, management's assertion that (ABC County) complied with the aforementioned requirements for the period ended (December 31, 20XX for the Southeast/Southwest zones, June 30, 20XX for the Northeast zone, Lehigh Capital zone, and North Central zones), is fairly stated, in all material respects.

Suggested Language (continued)

[When any of the matters set forth in GAGAS have been identified the following paragraph would be added.]

In accordance with Government Auditing Standards, we are required to report findings of deficiencies in internal control, violations of provisions of contracts or grant agreements, and abuse that are material to ABC County's compliance with the above requirements, and any fraud and illegal acts that are more than inconsequential that come to our attention during our examination. We are also required to obtain the views of management on those matters. We performed our examination to express an opinion on management's assertion that ABC County complied with the above requirements and not for the purpose of expressing an opinion on the internal control over ABC County's compliance with those requirements or on other matters; accordingly, we express no such opinions. Our examination disclosed certain findings that are required to be reported under Government Auditing Standards and those findings, along with the views of management, are described in the attached Schedule of Findings.

[If a management letter has been issued, the following paragraph should be included.]

In accordance with Government Auditing Standards, we also noted other matters which we have reported to management of ABC County in a separate letter dated Month Day, 20XX.

The purpose of this *[report, letter, presentation, or communication]* is solely to *[describe the purpose of the auditor's written communication, such as to describe the scope of our testing of internal control over financial reporting and compliance, and the result of that testing, and not to provide an opinion on the effectiveness of the entity's internal control over financial reporting or on compliance]*. This *[report, letter, presentation, or communication]* is an integral part of an audit performed in accordance with Government Auditing Standards in considering *[describe the results that are being assessed, such as the entity's internal control over financial reporting and compliance]*. Accordingly, this *[report, letter, presentation, or communication]* is not suitable for any other purpose.

Signature
Month, Day, 20XX

If a management letter has been issued as a result of the IPA's examination, copies of this letter must be submitted with, but not necessarily part of the bound report on the IPA's examination.

- * Management's assertions should be prepared and reported on as a separate document and included with this report. Management's assertions should be presented on management's letterhead, signed by a responsible primary contractor official, and dated. See AT 601 - Compliance Attestation.

NOTE: The IPA should refer to GAGAS and Statements on Standards for Attestation Engagements for guidance on the issuance of this report.

Sample BH Management's Assertion Letter

NOTE: MANAGEMENT'S ASSERTIONS SHOULD BE PREPARED AND REPORTED ON A SEPARATE DOCUMENT AND INCLUDED WITH THE ACCOUNTANT'S COMPLIANCE ATTESTATION REPORT. MANAGEMENT'S ASSERTIONS SHOULD BE PRESENTED ON MANAGEMENT'S LETTERHEAD, SIGNED BY A RESPONSIBLE PRIMARY CONTRACTOR OFFICIAL, AND DATED. SEE GAGAS AND STATEMENTS ON STANDARDS FOR ATTESTATION ENGAGEMENTS. REPORT 17 SHOULD ACCOMPANY MANAGEMENT'S ASSERTIONS.

NOTE: THE FOLLOWING IS SUGGESTED LANGUAGE FOR MANAGEMENT'S REPORT ON COMPLIANCE AND SHOULD BE MODIFIED, AS CIRCUMSTANCES REQUIRE.

Report of Management on Compliance

We, as members of management of (County), are responsible for (a.) identifying applicable compliance requirements, (b.) establishing and maintaining internal controls over compliance and complying with the requirements specified in the Claims Processing, Management Information System/Encounter Data Reporting, Health Service Delivery System/MCO/MCO Subcontractor/ASO Incentive Arrangements, and Financial Management Compliance Requirements I (attached), J, K and L as specified in the HealthChoices Behavioral Health Program Audit Guide (the Guide) issued by the Commonwealth of Pennsylvania, Department of Public Welfare (DPW) for the period (Month, Day, 20XX) to (Month, Day, 20XX)¹, (c.) monitoring and evaluating compliance with these requirements, and (d.) specifying reports that satisfy contractual requirements. We have performed an evaluation of our compliance with the aforementioned requirements. Based on this evaluation, we assert that during the period ended (Month, Day, 20XX)², the (County) (has/has not) complied in all material respects as described in the following:

1. Claims Processing

Compliance Requirement A

- The Contractor has a claims processing system and management information systems sufficient to support the provider payment and data reporting requirements specified in Part II-7, Section M, of the HealthChoices Program Standards and Requirements, except for the following:
 - a) Reason a (if applicable)
 - b) Reason b (if applicable)

¹ January 1, 2012 to December 31, 2012 for Southeast/Southwest Zones

July 1, 2012 to June 30, 2013 for Lehigh Capital, Northeast, North Central State Option, and North Central County Option Zones

² December 31, 2012 for Southeast/Southwest Zones

June 30, 2013 for Lehigh Capital, Northeast, and North Central Zones

Sample BH Management's Assertion Letter

Compliance Requirement B

- The Contractor took all reasonable measures to identify legally liable third parties and treat verified Third Party Liability (TPL) as a resource of the Medicaid recipient except for the following:
 - a) Reason a (if applicable)
 - b) Reason b (if applicable)

Compliance Requirement C

- The Contractor established written policies and procedures for the detection and prevention of fraud and abuse by providers, recipients, or the employees as described in Part II-5, Section D. 5), of the HealthChoices Program Standards and Requirements, except for the following:
 - a) Reason a (if applicable)
 - b) Reason b (if applicable)

Compliance Requirement D

- The Contractor maintained and complied with written policies and procedures for the prevention, detection and reporting of suspected fraud and abuse as described in Appendix F of the HealthChoices Program Standards and Requirements & Policy Clarification 06-09, except for the following:
 - a) Reason a (if applicable)
 - b) Reason b (if applicable)

Compliance Requirement E

- The Contractor appropriately notify DPW's, Bureau of Program Integrity of criminal convictions disclosed during credentialing and of any adverse action taken on a provider's application as described in Policy Clarification 06-09, except for the following:
 - a) Reason a (if applicable)
 - b) Reason b (if applicable)

Compliance Requirement F

- The Contractor has access for on-line inquiries and file transfers as specified in Appendix M and O of the HealthChoices Program Standard and Requirements, except for the following:
 - a) Reason a (if applicable)
 - b) Reason b (if applicable)
- The Contractor (does/does not) access the following DPW files as specified by the RFP and any relevant Departmental communications.
 - a) Client Information Systems/Eligibility Verification System
 - b) Procedure Code Reference File
 - c) Provider File

Sample BH Management's Assertion Letter

- d) Third Party Liability File
- e) Diagnosis File
- The Contractor (does/does not) receive and process, in house, the following files transmitted by DPW.
 - a) 834 Daily Enrollment/Disenrollment File
 - b) 834 Monthly Enrollment/Disenrollment File
 - c) Payment Reconciliation File (Monthly)
 - d) MCO Payment Summary File (Monthly)
 - e) Procedure Code Extract File (Monthly)
 - f) Reference Diagnosis Code File (Monthly)
 - g) MA Provider File (Monthly)
 - h) ARM568 Report File (Monthly)
 - i) 820 Capitation File (Monthly)
 - j) TPL File (Monthly)

2. Management Information Systems/Encounter Data Reporting

Compliance Requirement A

- The Contractor maintained appropriate systems and mechanisms to obtain all necessary data from its health care providers to ensure its ability to comply with the encounter data reporting requirements as required by Appendices M and O of the HealthChoices Program Standards and Requirements, except for the following:
 - a) Reason a (if applicable)
 - b) Reason b (if applicable)

Compliance Requirement B

- The Contractor (does/does not) submit encounter data reports in accordance with the requirements as set forth in Part II-7, Section K. (3), pages 76-78 of the HealthChoices Program Standard and Requirements, and the HIPAA Implementation Guides and PROMiSe Companion Guides, and in the time and manner prescribed by DPW.

The Contractor (does/does not) maintain appropriate systems and mechanisms to obtain all necessary data from its subcontractors to ensure its ability to comply with the encounter data reporting requirements.

Compliance Requirement C

- A “encounter” records encounter data where no actual payment takes place. The Contractor (does/does not) submit a separate record or “encounter” each time a member has an encounter with a provider.

Sample BH Management's Assertion Letter

3. Health Service Delivery System/MCO/MCO Subcontractor/ASO Incentive Arrangements

Compliance Requirement A

- All contractual arrangements, and contract amendments between the Contractors and their MCO/MCO Subcontractor/ASO define the financial incentive plan and any related objective benchmarks except for the following:
 - a) Reason a (if applicable)
 - b) Reason b (if applicable)

If the above compliance requirement is not applicable, management should include a statement indicating the reason the specified requirement is not applicable.

Compliance Requirement B

- The Contractor has control procedures in place to determine whether the MCO/MCO Subcontractor/ASO is eligible for an incentive payment, the amount of the payment, and the timing of the payment, except for the following:
 - a) Reason a (if applicable)
 - b) Reason b (if applicable)

If the above compliance requirement is not applicable, management should include a statement indicating the reason the specified requirement is not applicable.

4. Financial Compliance Requirement I – Report 17 (Contract Reserves Compliance) (Attached)

Compliance Requirement I

- The Contractor (or MCO/MCO Subcontractor) (has/has not) met and maintained the equity and reserve requirements as specified in Part II-7, Sections A.4) and 5) of the HealthChoices Program Standards and Requirements.
- Report 17 is accurately compiled in accordance with the Financial Reporting Requirements.
 - All HealthChoices capitation revenues are included in the calculation for the reserve requirement in accordance with the FRR.
 - “Required % of Capitation Payments” for each Primary Contractor is accurate based on the applicable DPW/Primary Contractor Agreement.
 - Total Equity per Report #17 agrees with the Total Equity reported by the Primary Contractor on the applicable Department of Insurance (DOI) annual/quarterly filing or annual audit.

Sample BH Management's Assertion Letter

- If there is a lack of compliance, a plan for fiscal improvement is in place and is being implemented.
- The Primary Contractor's has policies and procedures regarding monitoring MCO's equity in place and they are being performed in accordance with said policies and procedures.
- The financial condition of related parties will not impact the MCO as a going concern.

5. Financial Management Compliance Requirements J - Accountability of Revenues and Expenses, K - Co-Mingling of Funds, and L – Parental Guaranty

Compliance Requirement J

- The Contractor and their MCO/MCO Subcontractors (do/do not) have contract specific bank accounts for 1) HealthChoices capitation transactions, 2) reinvestment transactions, 3) restricted reserve funds (Philadelphia, Beaver and Fayette only), and 4) risk and contingency funds. The Contractors and their MCO/MCO subcontractors (do/do not) have a process in place to record staff time spent on HealthChoices duties separate from non-HealthChoices duties and/or between HealthChoices contracts. The Contractors and their MCO/MCO subcontractors (do/do not) have procedures for accurately recording, tracking, monitoring and reporting HealthChoices revenues and expenses separately from any non-HealthChoices revenues and expenses and by County as stated in Part II-7, Sections A. 7 of the HealthChoices Program Standards and Requirements and the HealthChoices Behavioral Health contract Section 6.1; Section 7.1 for Philadelphia.
- The Contractor (has/has not) deposited Reinvestment Funds in a restricted account within 30 days of the OMHSAS written approval of the reinvestment plan(s).

Compliance Requirement K

- The Contractor (has/has not) maintained separate fiscal accountability for Medicaid funding under the HealthChoices waiver apart from mental health and substance abuse programs funded by State, County, and/or other Federal program monies.
- The Contractor (has/has not) used State and Federal funds allocated to the County's Mental Health and/or Drug and Alcohol programs pursuant to the 1966 MH/MR Act and the 1972 Drug and Alcohol Act to pay for in-plan services rendered to eligible HealthChoices recipients unless an exception was approved by DPW.

Sample BH Management's Assertion Letter

Compliance Requirement L

- The Contractor (has/has not) performed quarterly monitoring of the Parental Guaranty agreement in accordance with policies and procedures established for that purpose.
- The Contractor (has/has not) taken appropriate steps, as contained in the policies and procedures, to address issues of financial concern identified during the quarterly monitoring process.

If the above compliance requirement is not applicable, management should include a statement indicating the reason the specified requirement is not applicable.

Date

Signature

**BEHAVIORAL HEALTH
APPENDIX III**

**Financial Reporting Requirements and Attachments
For**

**HealthChoices Southeast/Southwest Zones
Reporting Period 01/01/12 through 12/31/12**

**HealthChoices Lehigh Capital, Northeast, North
Central State Option, and North Central County Option
Zones Reporting Period 07/01/12 through 06/30/13**

FINANCIAL REPORTING REQUIREMENTS

HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM

Southeast and Southwest Zones

Reporting Period 01/01/12 through 12/31/12

Lehigh Capital Zone
Northeast Zone
North Central State Option Zone
North Central County Option Zone

Reporting Period 07/01/12 through 06/30/13

July 1, 2012

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1.0 GLOSSARY OF TERMS

AFDC (Now referred to as TANF). Aid to Families with Dependent Children under Title IV-A of the Social Security Act, as amended.

Adjudicate. To pay or reject a claim.

ASO. Administrative Services Organization.

BH-MCO. Behavioral Health Managed Care Organization. An entity directly operated by county government or licensed by the Commonwealth as a Health Maintenance Organization or risk assuming Preferred Provider Organization, which manages the purchase and provision of behavioral health services.

BHRS. Behavioral Health Rehabilitation Services for Children and Adolescents.

C & Y. Office of Children & Youth.

CNO. Categorically Needy Only.

DOI. Pennsylvania Insurance Department.

DPW. Pennsylvania Department of Public Welfare.

EPSDT (now referred to as Behavioral Health Rehabilitation Services for Children and Adolescents). The Early and Periodic Screening, Diagnosis, and Treatment Program for persons under age 21.

Freestanding Psychiatric Facility (previously referred to as IMD). A freestanding hospital that provides inpatient psychiatric services.

FYE. Fiscal Year End.

GA. General Assistance.

GAAP. Generally Accepted Accounting Principles.

HMO. Health Maintenance Organization. A public or private entity organized under state law that is a federally qualified HMO; or meets the Medicaid state plan definition of an HMO.

IMD (now referred to as Freestanding Psychiatric Facility) - Institution for Mental Disease. An institution for mental disease is a hospital with a bed capacity greater than 16 beds that dedicates 50% or greater of its beds for psychiatric inpatient services.

IBNRs. Incurred But Not Reported Claims. Costs associated with health care services incurred prior to a financial reporting date but not reported to the health care organization until after the financial reporting date.

JCAHO. Joint Commission on Accreditation of Healthcare Organizations.

MA. Medicaid or Medical Assistance.

MNO. Medically Needy Only.

PCP. Primary Care Practitioner. A specific physician, physician group, or health center operating under the scope of individual licensure responsible for providing primary care services and locating, coordinating, and monitoring other medical care and rehabilitation services on behalf of a recipient.

PMPM. Per Member Per Month.

PSR. Program Standards and Requirements Document.

RBUCs. Received but Unpaid Claims. A claim is considered received the day it is physically received.

RTF. Residential Treatment Facility.

SAP. Statutory Accounting Principles.

SSI. Supplemental Security Income. Income under Title XVI of the Social Security Act, as amended.

TANF (Previously referred to as AFDC). Temporary Assistance to Needy Families.

2.0 FINANCIAL REPORTING REQUIREMENTS TABLE

Frequency	Due Date	Title	Report #
Q	15 th of the second month after period end i.e. – period ending 03/31/XX reports are due 5/15/XX	Enrollment Table	1
Q		Primary Contractor Summary of Transactions	2
Q		Subcontractor Summary of Transactions	3
Q		Related Party Transactions and Obligations	4
Q		Risk Pool Analysis	5
M		Claims Payable (RBUCs and IBNRs)	6
M		Lag Reports	7
M		Claims Processing Report	8
Q		Analysis of Revenues and Expenses	9
M		Coordination of Benefits Report	11
M		Reinvestment Report	12
M, Q, or A		Balance Sheet	13
M, Q, or A		Statement of Revenues, Expenses, and Changes in Retained Earnings (Deficit)/Fund Balance	14
M, Q, or A		Statement of Cash Flows	15
M		Federalized GA Report	16
Q		Contract Reserves Compliance Report	17
Q		Insurance Department Quarterly Filing	18
Q		15 th of the second month after period end	Adult Outpatient Services in Alternative Settings
A	LC/NE/NC – September 1 st SE/SW – March 1 st	Annual Counterpart Reports	20
A	LC/NE/NC – November 15 th SE/SW - May 15 th	Annual HealthChoices Behavioral Health Contract Audit	21
A	9 months after the County's audit year end	Audited General Purpose Financial Statements	22
A	180 days after FYE	Annual Entity-Wide Audit	23
A	March 1 st	Insurance Department Annual Filing	24
A	June 30 th	Insurance Department Annual Audited Financial Statements	26
A	Last date of the contract year	Physician Incentive Arrangement	
A	LC/NE/NC – May 15 th SE/SW – November 15 th	Equity Requirement	
A	LC/NE/NC – May 1 st SE/SW - November 1 st	Insolvency Protection Arrangement	
A	LC/NE/NC – May 1 st SE/SW - November 1 st	Risk Protection (Stop-Loss Reinsurance)	
A	LC/NE/NC–October 1 st SE/SW – April 1 st	Reinsurance Experience - Estimated	
A	LC/NE/NC – July 1 st SE/SW – January 2 nd	Reinsurance Experience - Actual	

Please refer to Attachment D for more information on which entities are required to submit the above reports.

If a due date falls on a weekend or state holiday, reports will be due the next state business day.

The Pennsylvania Department of Public Welfare may issue amendments and/or updates to the financial reporting requirements from time to time as deemed necessary by DPW.

Frequency Key: M = Monthly
 Q = Quarterly
 A = Annually

3.0 INSTRUCTIONS FOR THE COMPLETION OF REPORTING FORMS

This section contains the instructions for completing the required monthly, quarterly, and annual reports.

3.1 General Instructions

HOW TO REPORT:

The following are general instructions for completing the monthly, quarterly, and annual reports required to be submitted by the Primary Contractor and Subcontractors (as applicable, refer to Attachment D) to DPW. The primary objectives of these instructions are to promote uniformity in reporting and to ensure that the financial statements are prepared in accordance with Generally Accepted Accounting Principles (GAAP), except as otherwise noted in the instructions.

The heading of each report should contain the following fields:

Statement as of: This should be the month, quarter, or year-end date for the report.

County: This should be the name of the County for which the report is applicable.

Reported By: This should be the entity that collected the data and compiled the report. In instances where a report contains data from more than one entity, this field should name the primary contractor.

Line titles and columnar headings of the reports are, in general, self-explanatory and therefore constitute instructions. Specific instructions are provided for items about which there may be some question as to content. Any entry for which no specific instructions are included should be made in accordance with sound accounting principles and in a manner consistent with related items covered by specific instructions.

Always utilize predefined categories or classifications before reporting an amount as "Other". Provide detail for "Other Administrative Expenses" if the total amount reported is >5% of total administrative expense. At a minimum, the detail should list any item that composes an amount $\geq 1\%$ of total administrative expense. Items that are <1% of total administrative expense can be consolidated. For example: "Total Administrative Expenses is \$100,000 and total "Other Administrative Expenses" is \$5,500, which consists of Consulting Fees \$3,000; Legal Fees \$1,000; Telephone \$900; and Equipment \$600. The detail would include Consulting Fees \$3,000; Legal Fees \$1,000; and Other \$1,500. ALL "Other Medical Services" reported must be disclosed by local code and by national code and modifier combination, as well as a detailed description, regardless of materiality. ALL "Other Revenue", "Other Distributions to Subcontractors" and "Other Distributions" reported must be disclosed by source, regardless of materiality.

Only contract-related income and expenses should be reported in these reports. Charitable contributions, Federal Income taxes, State Income taxes and non-HC Program interest expense allocations are examples of expenses not directly related to the HC Program and therefore, should not be reported in these reports. **Expenditures included in the financial reports that are not directly related to the operation of the program, as well as expenditures that are considered one-time administrative costs or one-time provider rate increases will be removed from the base data for rate setting purposes.**

Any interest or penalties paid to providers as a result of not paying claims timely should not be included in these reports. For electronic filing, include disclosure information in the common text area.

Any adjustments to amounts already reported for any current year prior period should be made to the reports for the current period being reported. If an adjustment affects a line item amount being reported for the current period by >5%, provide an explanation of the amount and reason for the adjustment (i.e., if an expense for the current period would be \$100,000 without any adjustment and the adjustment causes the amount to be less than \$95,000 or greater than \$105,000, disclosure is necessary). The disclosure should indicate how the adjustment(s) should be applied over the prior periods(s), various categories of assistance, and/or various rating groups, if applicable. For purposes of these financial reports, the Department considers adjustments to be changes to estimated amounts **previously reported** due to the determination that the estimate was over/understated. The Department retains the right to impose sanctions if material adjustments are made after year-end, if Department staff raised concerns related to the adjusted items throughout the course of the contract year. Errors in the calculation of amounts previously reported are not considered adjustments. The Department reserves the right to require resubmission of reports that include incorrect amounts, depending on the materiality of the error. **The revision date must be indicated on all revised reports.**

Current year prior period information should be reported using the same criteria established for completing the current period information. Where the necessary detail does not exist to adequately report current year prior period information, this fact should be disclosed. When submitting paper copy reports, include the disclosure on paper. When reporting electronically, include the disclosure in the common text area. Ending balances from the last month of a contract year should not be carried over as the beginning balance of the next contract year, except for Reports 5A, 6, 7, 8, 12, 13, 14, and 15 (if applicable). **The financial reports should be prepared to reflect transactions related to the current contract year ONLY, except as otherwise noted in the instructions.**

Unanswered questions and blank lines or reports will not be considered properly completed. If no answers or entries are to be made, write "None", "Not Applicable" (N/A), or "-0-" in the space provided. For specific instructions on how to report blank lines or blank reports when filing electronically, please refer to the Requirements and Specifications Manual for Electronic Submission of Financial Data.

Amounts should be reported to the nearest dollar and should not include decimal places, except for per member per month (PMPM) amounts which should include two decimal places. **IMPORTANT:** When rounding or truncating numbers, do not perform rounding or truncation until arriving at the final amount. (Example: If calculation is $1.5892 \times 2.059 = 3.272163$, report final amount as 3.27; not $1.59 \times 2.06 = 3.28$.)

Sanctions imposed by DPW on the Primary Contractor must be reported as follows: Report #2, Capitation Revenue (Line 2a), should disclose the gross amount of capitation revenue. Other Revenue (Line 2c) should include an offsetting negative number in the amount of the sanction. Report #9, Other Revenue (Line 3), should also include the offsetting negative number in the amount of the sanction. If the Primary Contractor passes part or all of the sanctions on to the Subcontractor, follow the reporting instructions below for Sanctions imposed by the Primary Contractor. Sanctions must be disclosed in the footnotes to the reports.

Sanctions imposed by the Primary Contractor on the Subcontractor must be reported as follows: Report #2, Distributions to Subcontractor, Other (Line 3e), should disclose a negative

number in the amount of the sanction. Report #3, Capitation Revenue (Line 2a), should disclose the gross amount of capitation revenue. This amount should equal the sum of Report #2, Distributions to Subcontractor for Medical Services and Administration (Lines 3a and 3b). Also, on Report #3, Other Revenue (Line 2c), should include an offsetting negative number in the amount of the sanction. Sanctions imposed by the Primary Contractor should not be disclosed on Report #9. Sanctions must be disclosed in the footnotes to the reports.

Sanctions imposed by the Primary Contractor on an ASO must be reported on Report #2 as an offset to Other Administrative Expenses (Line 9g). Contact DPW for further reporting instructions if a different situation exists other than described in the preceding instructions.

All reports must be submitted via electronic files consistent with specifications provided by DPW, unless noted below. Refer to Attachment G for details on the Web-Based Submission Process.

The following reports must be submitted on paper. DPW may decide at a later date to require all or some of the following reports to be submitted electronically.

- Report #13 Balance Sheet (including the quarterly or annual actuarial certification reports required as part of Report #13)
- Report #14 Statement of Revenues, Expenses and Changes in Retained Earnings (Deficit)/Fund Balance
- Report #15 Statement of Cash Flows
- Report #17 Contract Reserves Compliance Report
- Report #18 Insurance Department Quarterly Filing
- Report #19 Adult Outpatient Services in Alternative Settings
- Report #21 Annual HealthChoices Behavioral Health Contract Audit
- Report #22 Comprehensive Annual Financial Report
- Report #23 Annual MCO Entity-Wide Audit
- Report #24 Insurance Department Annual Filing
- Report #26 Insurance Department Annual Audited Financial Statements
- No Report # Other Financial Requirements
- No Report # Financial Data Certification Form

Reports must be submitted as follows:

- (1) One copy of the monthly reports on paper until notified by DPW. Exception: Report #16 is only required in an electronic file format. Paper reports must utilize the format specified herein, but it is acceptable to submit computer-generated facsimiles. When filing paper reports, ALL reports must be submitted at one time, including the signed monthly or annual certification statement.
- (2) ASCII files containing the raw data that DPW will use to produce the financial reports. The File Specifications and Record Layouts will be provided to the Behavioral Health Contractors. When filing electronic reports, ALL reports must be transmitted at one time.

The ASCII files include record types to accommodate a common text area that should include footnotes and comments. A Y/N field is included in the record types associated with each report to indicate the presence of text in the common text area. The record

for common text will include fields for the report number and report part being referenced.

WHERE TO SEND REPORTS:

These reports require accounting of all capitation funds paid under a HealthChoices Behavioral Health contract. All reports are deemed received when they are actually received by the Department. Paper reports should be sent in one package via;

Regular mail to:

Department of Public Welfare
Office of Mental Health & Substance Abuse Services
Ms. Terry Mardis
DGS Annex Complex
Shamrock Hall, Bldg. #31, 1st Floor
P.O. Box 2675
Harrisburg, PA 17105

Or overnight courier to:

Ms. Terry Mardis
Department of Public Welfare
Bureau of Financial Management and Administration
Division of Medicaid Finance
DGS Annex Complex
Shamrock Hall, Bldg. #31, Room #116
112 East Azalea Drive
Harrisburg, PA 17110-3594

The Harrisburg State Hospital address is to be used for overnight courier delivery only. The U.S. Postal Service does not deliver to this address. Material revisions should be mailed to the address given for paper reports or faxed to Ms. Terry Mardis at (717) 705-8128. Prior telephonic communication of faxing of revisions must occur prior to fax transmission. The telephone number to call is (717) 772-7433.

The ASCII files containing the report data will be transferred via web submission to an address to be provided. The file transfer names will be included in the File Specifications and Record Layouts.

LATE REPORTING:

The Department has the right to impose sanctions, as defined in the contract with the Department of Public Welfare, for failure to submit, or late submission of, reports as contractually obligated. The Department may extend a report deadline if a request for an extension is communicated, in writing, and is received at least five (5) business days prior to the report deadlines as set forth in this document. Requests for extension must include the reason for the requested extension and the date by which the report will be filed. Requests for extensions will be reviewed and the requestor will be notified of the decision in writing.

REPORTING OF HEALTHCHOICES REVENUES AND EXPENSES:

For reference purposes, the eleven Behavioral Health Major Rate Code Service Groupings referred to throughout the financial reporting package are:

- Inpatient Psychiatric
- Inpatient D & A
- Non-Hospital D & A
- Outpatient Psychiatric
- Outpatient D & A
- Behavioral Health Rehabilitation Services for Children & Adolescents (BHRS)
- RTF - Accredited
- RTF - Non-Accredited
- Ancillary Support
- Community Support
- Other

For reference purposes, the seven Behavioral Health Rating Groups referred to throughout the financial reporting package are:

- Temporary Aid to Needy Families (TANF)
- Healthy Beginnings
- SSI & Healthy Horizons w/ Medicare
- SSI & Healthy Horizons w/o Medicare
- Federal GA
- Categorically Needy State-Only GA (CNO)
- Medically Needy State-Only GA (MNO)

The financial reports (Reports #2, #3, and #9, in particular) were modeled after the Capitation Rate Calculation Sheets (CRCS) and are to reflect costs in the same way.

For purposes of these financial reports, "medical" expenses should reflect only those costs that represent claims or service costs, with the addition of individual stop loss reinsurance premiums and recoveries. All other costs, including those incurred for Utilization Review, Quality Assurance, Medical Director, Member Services, aggregate reinsurance premiums and recoveries, and all other non-medical claim costs, are to be reported under the "Administrative Expense" sections of applicable reports. This will enable DPW and its contractors to compare costs actually being incurred to the costs included in each service group in the existing capitation rates. In addition, the Department and its contractors will also be utilizing these financial reports, along with the contractors' encounter data, to develop future capitation rates.

Exception: If a contractor/subcontractor is a staff model HMO (an HMO that directly employs physicians and other providers on its staff for the purpose of the direct delivery of services, as opposed to contracting with providers through a network), the above requirement may be waived. Each contractor will be evaluated on a case-by-case basis, and the decision of the Department will be final.

Additional instructions on the classification and allocation of revenues and expenses can be found in the specific instructions for the financial reports.

3.2 Report #1 - Enrollment Table

A member is a person who has been enrolled consistent with the DPW contract. This report discloses member month equivalents per month by behavioral health rating group.

Count of Members Enrolled on Last Day of Current Period - Report the number of people enrolled on the last day of the month for which the report is being prepared.

Member Month Equivalents - These columns disclose member month equivalents per month by behavioral health rating group. The member month equivalents should be reported by the behavioral health rating group as shown on the report. A member month is equivalent to one member for one entire month. Where eligibility is recognized for only part of a month for a given individual, a partial, pro-rated member month should be counted. A partial member month is pro-rated based on the actual number of days in a particular month.

Year-to-Date - The year-to-date column should equal the sum of as many months as have been completed through the month being reported. For example, after the first month, the year-to-date column will equal the first month's numbers, but after the second month, the year-to-date column will equal the sum of the first and each subsequent month columns.

Do not update member month counts provided for a prior month on a previous report. Adjustments to costs and populations reported for a previous month within the current year should be applied to current month information.

3.3 Report #2 - Primary Contractor Summary of Transactions

The Primary Contractor must report all capitation revenue received applicable to the current period, as well as the disposition of those funds, in this report.

Any funds being held by the Primary Contractor for future incentive payments to a subcontractor should be reported on Line 6, Incentive/Risk Pools. However, investment income earned on these funds should be reported on Line 2)b, Investment Revenue.

Incentive/Risk Pools: This line should include funds retained by the Primary Contractor for potential payment to the Subcontractor for excess medical expenses or incentives. Incentive payments made by the Primary Contractor to Providers should be reported as an Administrative Expense under "Other" and disclosed in the notes to the report.

Payment or accrual of Excess Medical/Incentive Funds and applicable interest:

If excess medical expense or incentive to be paid from funds reserved on Line 6, Incentive/Risk Pools, is known or can be reasonably estimated during the year in which they were earned or prior to submission of the annual contract audit, this amount should be reported on either Line 3a, Distributions to Subcontractor for Medical Services or Line 3e, Other, and an offsetting entry in the amount of the payment or accrual should be made to Line 6. If the payment or accrual includes interest earned on this account, an offsetting entry in the amount of the interest payment should be made to Line 2)b, Investment Revenue. If the amount to be paid for excess medical expenses or incentive funds is not known until after the annual counterpart report and/or contract audit have been submitted, that information should **not** be reflected on the current year's reports. Information pertaining to distributions from

funds reserved on Line 6 not reported on either the annual counterpart report or contract audit should be supplied to the Department as soon as it is available for adjustments to the prior year database.

Primary Contractor Medical Expenses: This line should be used to report medical claims expense incurred for the reporting period by the primary contractor. This does not include medical expenses incurred by any subcontractors.

Distributions to Management Corp/ASO: This line should be used to report the expense incurred for the reporting period as a result of a subcontract or management agreement with a Management Corporation or ASO. The amount should only reflect that portion of the expense that directly relates to the performance of administrative functions.

Distributions to a Joinder: Report these distributions as County Administrative Expenses under "Other." The amount of the distribution to the joinder must be specified in the footnotes to the report.

Clinical Care/Medical Management: All Clinical Care/Medical Management expenses should be reported on this line. The amounts reported on this line should not be duplicated in any other administrative expense line on this report. Compensation, interest expense, occupancy, depreciation, and amortization, and other administrative expense lines should include Administrative Overhead costs only. Refer to Attachment F to assist in the task of determining which costs are clinical care/medical management or administrative overhead for DPW reporting purposes.

IMPORTANT: For the purpose of allocating administrative expense amounts, use the following guidelines: 1) if the entire expense can be directly attributed to each behavioral health rating group, report exact dollar amounts for each behavioral health rating group; 2) if a portion of the expense can be directly attributed to one or more of the behavioral health rating groups, distribute only the remaining amounts based on the applicable percentage of capitation revenue; and 3) if no portion of the expense can be directly attributed to one or more of the behavioral health rating groups, distribute the entire expense amount proportionately based on the applicable percentage of capitation revenue. When submitting paper copy reports, include an explanation of the amount being allocated. When reporting electronically, include this explanation in the common text area.

3.4 Report #3 – Subcontractor Summary of Transactions

If the Department's primary contractor has subcontracted with an entity who will be subcapitated and whose subcapitation payment includes a medical claims cost component, the subcontracted entity must report all capitation revenue received during the period, as well as the disposition of those funds, in this report. If the Department's primary contractor has subcontracted with an entity for administrative services only, regardless of the type of payment arrangements, this report should not be filed.

Distribution at Subcontractor Level - These lines are for the subcontractor to report amounts that they paid directly from their capitation revenues for medical services, profit, reinvestment, and other.

Clinical Care/Medical Management: All Clinical Care/Medical Management expenses should be reported on this line. The amounts reported on this line should not be duplicated in any other administrative expense line on this report. Compensation, interest expense, occupancy, depreciation, and amortization, and other administrative expense lines should include Administrative Overhead costs only. Refer to Attachment F to assist in the task of determining which costs are clinical care/medical management or administrative overhead for DPW reporting purposes.

Incentive/Risk Pools: This line should include funds received from the Primary Contractor and reserved for potential payment to the Subcontractor for excess medical expenses or incentives. Incentive payments made by the Subcontractor to Providers should be reported as an Administrative Expense under "Other" and disclosed in the notes to the report.

IMPORTANT: For the purpose of allocating administrative expense amounts, use the following guidelines: 1) if the entire expense can be directly attributed to each behavioral health rating group, report exact dollar amounts for each behavioral health rating group; 2) if a portion of the expense can be directly attributed to one or more of the behavioral health rating groups, distribute only the remaining amounts based on the applicable percentage of capitation revenue; and 3) if no portion of the expense can be directly attributed to one or more of the behavioral health rating groups, distribute the entire expense amount proportionately based on the applicable percentage of capitation revenue. When submitting paper copy reports, include an explanation of the amount being allocated. When reporting electronically, include this explanation in the common text area.

3.5 Report #4 - Related Party Transactions and Obligations

Transactions with related parties/affiliates (as defined in the HealthChoices contract) may or may not be in the normal course of business. In the normal course of business, there may be numerous routine and recurring transactions with parties who meet the definition of a related party. Although each party may be appropriately pursuing its respective best interest, transactions between them must be disclosed to the Department.

Description of Relationship or Affiliation, Transaction Code, Income or Receipts, and Expense or Distributions - Report the total amount of each transaction code on a separate line for the current reporting period involving any individual or entity that meets the definition/description of a related party/affiliate as defined in the contract. For example, report all Inpatient Psychiatric Hospital expenses at an affiliated facility for the period, or all medical compensation expenses, including risk pool activity, to owners, medical directors, and/or board members. Other non-medical service transactions should also be reported on this schedule, such as allocation of overhead, rent or management fees to related parties, as well as any loans and/or distribution between related parties.

The transaction codes for this report are as follows:

- 01) Shareholder Dividends
- 02) Capital Contributions
- 03) Purchases, Sales or Exchanges of Loan Securities, Real Estate Mortgage Loans or Other Investments

- 04) Income/(Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)
- 05) Management Agreements, Service Contracts, including Contract for Services Provided by the primary contractor, or Purchased by the primary contractor (for the HealthChoices Program) from Other Affiliates, and Non-GAAP Cost Sharing Agreements
- 06) Income/(Disbursements) Incurred Under Reinsurance Agreements
- 07) Reinsurance Recoverable/(Payable) on Losses and/or Reserve Credit Taken/(Liability)
- 98) Other - include explanation in footnote or common text area.

Include transactions and obligations that are related to administrative costs associated with the HealthChoices contract. Transactions or obligations that are related to medical costs may be limited to those that are associated with the HealthChoices contract. It is acceptable to provide comprehensive information on qualifying transactions or obligations, without regard to whether they are related to this contract. If the latter option is selected, the reports must specify this in accompanying text.

Amount Due From/(To) Current & Amount Due From/(To) Noncurrent - List current and non-current amounts due from (to) related parties or affiliates. If a due from and due to exists for the same affiliate, the amounts should be netted together and reported as one net amount. However, current amounts should not be netted with non-current amounts.

Current assets or obligations are those expected to be used or satisfied within one year of the last day of the period being reported.

A separate report must be prepared for all entities identified in Attachment D.

3.6 Report #5 - Part A: Risk Pool Analysis

The purpose of this report is to monitor risk pool activity. All revenues and expenses allocated to the risk pool(s) are shown on this report along with risk pool adjustments and distributions.

Line 1 - Revenues Allocated to Risk Pool(s) - All amounts allocated to the risk pool(s) from which claims are to be paid should be reported (capitation, reinsurance, deferred liability and other revenue sources).

Lines 2 through 13 - Expenses Allocated to Risk Pool(s) - The expenses recognized in the risk pool(s) should be reported by expense category. Include provider capitation paid out of the pool(s).

Line 15 - Risk Pool Expense Adjustment(s) for the Period - The difference between the total revenue allocated to the risk pool less the total expenses allocated to the risk pool results in the net adjustment from the current period activity.

Line 16 - Risk Pool Balance(s) at the Beginning of the Period - The beginning risk pool balance should be the accrued risk pool payable from the prior period.

Line 18 - Risk Pool Distribution(s) - All risk pool distribution(s) during the period are to be recorded on Line 18. This amount should equal the ending balance in the Distributions/Contributions column on Report #5 - Part B.

Line 19 - Risk Pool Payable/(Receivable) - If a negative amount is not receivable in full, please provide an explanation on paper, when filing paper copy reports, and in common text area when filing electronically.

If a risk pool arrangement covers multiple levels of care, a proposal for the allocation of amounts across service groupings must be submitted BEFORE submission of the first monthly report. All risk pool arrangements should be reviewed for compliance with the federal requirements concerning physician incentive arrangements.

Part B: Risk Pool Listing by Participant - List all participants in the risk pool(s) on this schedule. Include all prior period risk pool balances along with any distributions to or contributions from these participants during the period. The ending balance for the total of all participants should tie to the last line on Report #5 - Part A.

Risk Pool Accounting - Risk pool contracting passes on some element of risk for members' medical expenses to the subcontracted providers participating in the risk pool. This contracting arrangement is useful as an incentive to maintain proper utilization of medical services. Many of the Counties and subcontractors may have risk sharing arrangements with some or all of their health care providers. For consistency in reporting among the Counties and MCO subcontractors, DPW has established the following suggested guidelines for risk pool accounting. The goal of accounting for risk pools is to identify revenues and expenses relating to providers who are part of a risk pool so that the net results of that activity can be reported in the risk pool expense adjustment accounts and the risk pool payable/receivable account on the financial statements. It is important to note that while only the net results are being reported in these accounts, the total of all revenues and expenditures must be accounted for on the financial statements. Specifically, all revenues and expenses are to be reported gross, not net, of risk pool activity.

As revenues are realized relating to members assigned to a risk pool, they are accounted for as any other revenues, crediting the appropriate account such as capitation, reinsurance, etc. while debiting either cash or receivables. After this accounting is done, the proper allocations are made to the risk pool accounts by debiting the risk pool expense adjustment account and crediting the risk pool payable/receivable account. Likewise, all expenses relating to members assigned to a risk pool are to be reported as debits to the appropriate expense category and credits to cash or claims liabilities. After these entries are made they should be reflected in the risk pool accounts by crediting risk pool expense adjustment and debiting risk pool payable/receivable.

Risk Pool Accounting Example - The following example will illustrate the accounting discussed above. Assume this County/BH-MCO has a risk pool arrangement with a group of primary care physicians whereby they are capitated for their services and all medical expenses relating to the risk pool members are paid out of the pool.

- A. The County/BH-MCO receives \$100,000 of capitation revenue from DPW that relates to members in the risk pool. The County/BH-MCO allocates 90% of all revenues to risk pools (\$100,000 x 90% = \$90,000).
- B. The County/BH-MCO capitates a group of PCPs \$20,000 for their services relating to the risk pool members for the period.
- C. During the period, the County/BH-MCO pays \$15,000 for hospitalization, \$5,000 for medical compensation, and \$5,000 for other medical services for members in the risk pool.
- D. During the period, the County/BH-MCO receives \$10,000 in supplemental revenue (risk pool allocation, \$10,000 x 90% = \$9,000) and recognizes \$5,000 in reinsurance revenue (risk pool allocation, \$5,000 x 90% = \$4,500) related to risk pool members.
- E. At the end of the period, the County/BH-MCO estimates unpaid liabilities relating to the risk pool members as follows: \$30,000 hospitalization, \$10,000 medical compensation, and \$10,000 other medical.
- F. The County/BH-MCO pays out the resulting risk pool payable of \$8,500.

3.7 Report #6 - Claims Payable (RBUCs and IBNRs)

A claim becomes a Received But Unpaid Claim (RBUC) the day it is received. Incurred But Not Reported (IBNR) claims should be reported in the second to last column by the appropriate Behavioral Health major service grouping.

This is a point-in-time report as of the last day of the month. There is no relationship between the report and service dates.

Show amounts for each Behavioral Health Major Rate Code Service Grouping, net of third party resources.

Claims Liability (Including Claim Estimations, RBUCs & IBNRs) - There are three primary components of claims expense:

- Paid claims.
- RBUCs. Note that a claim is considered an RBUC immediately upon receipt and should be tracked as such. Include, in the footnote to Report #6, the amount of RBUCs that is estimated (i.e., claims in-house but not yet entered on the system).
- IBNRs. **Claims liabilities should not include the administrative portion of claim settlement expenses. Any liability for future claim settlement expense must be disclosed separately from the unpaid claim liability. This may require a qualification to the actuarial certification.**

The first two components of claims expense are readily identifiable as part of the basic accounting systems being utilized. Since these components, along with a well-established prior authorization and referral system, form the basis for estimation of IBNRs, it is important to have adequate claims accrual and payment systems. These systems must be capable of reporting claims, by major rate code service groupings and by rating group on an incurred or date of service basis, have the capacity to highlight large outlier cases, possess sufficient internal controls to prevent and detect payment errors, and conform to regular payment patterns. Once IBNR estimates have been established, it is imperative that they be continually monitored with reference to reported and paid claims.

Claims expense cannot be properly evaluated without adequate consideration of current trends and conditions. The following summarizes claims environment factors that should be considered.

- Changes in policy, practice or coverage.
- Fluctuations in enrollment by behavioral health rating group.
- Expected inflationary trends.
- Trends in claims lag time.
- Trends in the length of hospital inpatient stay by behavioral health rating group.
- Changes in behavioral health rating group case mix.
- Changes in contractual agreements.

Elements of an IBNR System - IBNRs are difficult to estimate because the quantity of service and exact service cost are not always known until claims are actually received. Since medical claims are the major expenses incurred, it is extremely important to accurately identify costs for outstanding unbilled services. To accomplish this, a reliable claims system and logical IBNR methodology is required.

Selection of the most appropriate system for estimating IBNR claims expense requires judgement based on the circumstances, characteristics, and the availability and reliability of various data sources. Using a primary estimation methodology, along with supplementary analysis, usually produces the most accurate IBNR estimates. Other common elements needed for a successful IBNR system are:

1. IBNR systems must function as part of the overall financial management and claims system. These systems combine to collect, analyze and share claims data. They require effective referral, prior authorization, utilization review and discharge planning functions. In addition, a full accrual accounting system is necessary. Full accrual systems help properly identify and record the expense, together with the related liability, for all unpaid and unbilled medical services provided to members.
2. An effective IBNR system requires the development of reliable lag tables that identify length of time between provision of service, receipt of claims, and processing and payment of claims by behavioral health major service grouping. Reliable claims/cash disbursement systems generally produce most of the necessary data. Lag tables, and the projections developed from them, are most useful when there is sufficiently accurate claims history which shows stable claims lag patterns. Otherwise, the tables will need modification on a proforma basis to reflect corrections for known errors or skewed payment patterns. The data included in the lag schedules should include all information received to date in order to take advantage of all known amounts (i.e. RBUCs).
3. Accurate, complete and timely claims data should be monitored, collected, compiled and evaluated as early as possible. Whenever practical, claims data collection and analysis should begin before the service is provided (i.e. prior authorization records). This

prospective claims data, together with claims data collected as the services are provided, should be used to identify claims liabilities.

4. **Claims data should also be segregated to permit analysis by behavioral health rating group, behavioral health major service grouping, major provider, and county, if more than one county's membership is maintained on the system.**
5. Subcontractor agreements should clearly state each party's responsibility for claims/encounter submission, prior notification, authorization, and reimbursement rates. These agreements should be in writing, clearly understood and followed consistently by each party.
6. The individual IBNR amounts, once established, should be monitored for adequacy and adjusted as needed. If IBNR estimates are subsequently found to be significantly inaccurate, analysis should be performed to determine the reasons for the inaccuracy. Such an analysis should be used to refine an IBNR methodology, if applicable. **Material changes in estimates to an IBNR methodology must be reported to DPW in the period during which it occurs.**

IMPORTANT: There are several different methods that can be used to determine the amount of IBNRs. Employ the one that best meets your needs and accurately estimates the IBNRs. The IBNR methodology being utilized must be submitted to the Department. The IBNR methodology used must be evaluated by an independent accountant or actuary for reasonableness. An actuarial certification of claims liabilities shown on the Balance Sheet must accompany the Balance Sheet as required in the instructions for Report #13.

For further information concerning lag tables refer to the instructions for Report #7.

3.8 Report #7 - Lag Reports

Analyzing the accuracy of historical claims liability estimates is helpful in assessing the adequacy of current liabilities. This schedule provides the necessary information to make this analysis.

A separate form must be completed for each of the eleven behavioral health major service groupings, as well as a total page.

The schedules are arranged with dates of service horizontally and month of payment vertically. Therefore, payments made during the current month for services rendered during the current month would be reported in Line 1, Column 3, while payments made during the current month for services rendered in prior months would be reported on Line 1, Columns 4 through 27. Do not include risk pool distributions as payments in this schedule.

Line 27 - The expense reported to DPW on Report #9 for each behavioral health major service grouping in the current and previous months should be recorded, on Line 27 in the appropriate column.

Line 28 - "Remaining Liability", represents any remaining liability estimated for each month.

Only data applicable to the HealthChoices program is to be included in this report. The Lag

Report should not be adjusted for Reinsurance Recoveries.

Lag Tables - Lag tables are used to track historical payment patterns. When a sufficient history exists and a regular claims submission pattern has been established, this methodology can be employed. Lag information should be used as a validation test for accruals calculated using other methods if it is not the primary methodology employed. Typically, the information on the schedules is organized according to the month claims are incurred on one axis (horizontal) and the month claims are paid on the other axis (vertical). Specific information by Behavioral Health rating group, and by Behavioral Health major service grouping, must be tracked, as each population may have different characteristics.

Once a number of months become "fully developed" (i.e. claims submissions are thought to be complete for the month of service), the information can be utilized to effectively estimate IBNRs. This is done by computing the average period over which claims are submitted historically and applying this information to months that are not yet fully developed.

Lag Table Example - The following simple example demonstrates the lag table approach discussed above.

<u>Month Paid</u>	<u>January</u>	<u>February</u>	<u>March</u>	<u>Total</u>	<u>Percent of Total</u>	<u>Cumulative Percent</u>
Current	\$1,400	\$800	\$2,000	\$4,200	10.0%	10.0%
1 st Subsequent	\$8,200	\$8,750	\$8,500	\$25,450	60.6%	70.6%
2 nd Subsequent	\$3,700	\$2,800	\$3,750	\$10,250	24.4%	95.0%
3 rd Subsequent	\$700	\$650	\$750	\$2,100	5.0%	100.0%
TOTAL	\$14,000	\$13,000	\$15,000	\$42,000	100.0%	

This table indicates that 10% of all claims are reported and paid in the month services are rendered; in the next month, 60.6% of the claims are paid; and so on. In this example, all claims are shown to be paid within four months from the date of service (i.e. fully developed). This may be unrealistic but it satisfies the needs of this example. The above information can be used to calculate IBNRs by looking at claims payment experience for the three months prior to the balance sheet date.

By dividing claim payments to date by the decimal form of the cumulative percent developed from the fully developed table for the applicable month, an estimate is made of each month's total claims to be experienced for the period. Subtracting the total claims paid to date from this estimate yields the estimated claims accrual.

The following steps must be taken:

In order to estimate the total claims expense as of the end of June:

1. For each month not yet fully developed, the cumulative percentage (obtained from the fully developed table) should be divided into the total amount of claims paid to date for each month. The result will be the estimated total claims expense for each month.

2. Subtract all claims already paid or received (RBUCs) for that month from the estimated total claims expense for each month. The remainder represents your IBNR estimates.

<u>Month Paid</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>Total</u>
Current	\$ 1,600	\$ 1,900	\$1,600	\$ 5,100
1st Subsequent	\$ 9,700	\$10,600	\$-----	\$ 20,300
2nd Subsequent	\$ 3,800	\$-----	\$-----	\$ 3,800
3rd Subsequent	<u>\$-----</u>	<u>\$-----</u>	<u>\$-----</u>	<u>\$-----</u>
TOTAL	\$15,100	\$12,500	\$1,600	\$29,200
Divided by Cumulative Percent Paid	95.0%	70.6%	10.0%	N/A
Estimated Total Claims Expense	\$15,895	\$17,705	\$16,000	\$49,600
Less: Amount Paid to Date	(\$15,100)	(\$12,500)	(\$1,600)	(\$29,200)
Less RBUCs	(\$100)	(\$200)	(\$1,100)	(\$1,400)
Estimated Claims Accrual (IBNR)	\$695	\$ 5,005	\$13,300	\$19,000

It should be noted that the estimates developed by this lag technique should be monitored for reasonableness. This is especially true for the most recent months where the information is less developed than the older months. If the calculation is producing an unusually low or high total claims accrual for any particular month, it should be investigated for validity. An example of a possible solution is to override the skewed portion of the IBNR with an average monthly cost less the amount paid to date for that month.

3.9 Report #8 - Claims Processing Report

Refer to Attachment E for additional information on claims processing requirements.

This report should reflect the status of claims entered into the claims processing system as of the end of the month being reported.

Part A should reflect the number of claims. For purposes of this report, each claim line is counted as 1 claim.

Part B should reflect the dollar amount of claims.

- “#/\$ Amount of Claims Received” column includes all claims entered into the claims processing system with a receipt date prior to the end of the month being reported. Report

the dollar amount of the claim that is allowable/authorized by the County/BH-MCO. If the dollar amount cannot be determined, include the claim on Part A and report as \$0 dollars on Part B. However, if the claim is included as part of the RBUC estimate on Report #6, Claims Payable (RBUCs and IBNRs), the estimate must be included on Part B and adjusted when the dollar amount can be determined.

- “#/\$ Amount of Clean Claims” column should include the number or dollar amount of clean claims received. If efforts are made internally to procure the necessary information to adjudicate a pended claim, the claim should be moved from the “#/\$ Amount of Claims Not Adjudicated” column to the “#/\$ Amount of Clean Claims” column and either “Paid” or “Rejected” for the month received. However, if the claim is pended and later returned to the provider for further information, it should be removed from the “#/\$ Amount of Claims Not Adjudicated” column and shown as “Rejected” only.
- Clean Claim – A claim that can be processed without requiring additional information from the provider of the service or from a third party.
- A clean claim does not include: claims pended or rejected because they require additional information either from a provider or from internal sources (i.e. claims pended for an authorization number, etc.); a claim under review for medical necessity; or a claim submitted by a provider or contractor reported as being under investigation by a governmental agency.
- “#/\$ Amount of Claims Not Adjudicated” column should include **all** claims that have not been adjudicated. This includes approved but unpaid claims, as well as claims requiring additional information from the provider of the service and or from a third party.
- “Paid” column includes all claims for which a check has been created or an electronic payment has been transferred to the provider.
- “Clean Rejected” column includes all clean claims that have been returned to the provider or third party.
 - Clean Rejected Claim - A claim that is returned to the provider or third party due to ineligible recipient or service.
- “Unclean Rejected” column includes all unclean claims that have been returned to the provider or third party.
 - Unclean Rejected Claim - A claim that is returned to the provider or third party for additional information.

As claims are adjudicated, they should be reflected in the aging columns as either paid or rejected.

Part C - The Contractor must also include a listing of all clean claims currently in-house that have not yet been adjudicated within 45 days separated by the three categories of service below:

1. Inpatient Claims – Includes claims received for inpatient admissions (Psych and D&A) and RTFs;

2. Practitioner and Outpatient Claims – Includes claims for all outpatient services (Psych, D&A and Partial), Non-hospital D&A, Non-Accredited RTFs, and BHRS for children.
3. Other Claims – Includes claims for Ancillary or Community Support services, or claims received from any providers not included in category 1. or 2. above.

The listing should include both number of claims and dollar amount of claims. When the claim is adjudicated, it should no longer appear on this report.

Beginning with the first month of the second contract year, this report should reflect data for the 12 most recent months of the HealthChoices program. In the event that claims from 13 months prior or before are still not adjudicated, two versions of this report should be filed; one for the most recent 12 months; and one for the prior 12 month period.

Any interest or penalties paid to providers should not be included in this report.

3.10 Report #9 - Analysis of Revenues and Expenses

This report is meant to be an analysis of revenues and expenses. In Part A, information should be completed for each behavioral health rating group. Part B will sum the information shown on Part A.

Line 3 - Other Revenues - All “Other” revenue reported must be disclosed by source, regardless of materiality. Only contract-related revenue should be reported. “Other” Revenue reported on Report #2 and Report #3 that represents a transfer of funds between entities should **not** be included on Report #9 (i.e., sanctions imposed by the County on the BH-MCO or a transfer of medical management funds.)

Line 5 - Inpatient Psychiatric must be reported on Part A and Part B of the report by Freestanding Psychiatric Facility or Other. The Freestanding Psychiatric Facility line is only to be used for expenses related to persons between the ages of 22-64. Expenses for Freestanding Psychiatric Facilities that are related to persons not between the ages of 22-64 should be included in the Other line as well as all inpatient psychiatric expenses for facilities that are not Freestanding Psychiatric Facilities. A Freestanding Psychiatric Facility is largely defined as a hospital with a bed capacity greater than 16 beds that dedicates 50% or greater of its beds for psychiatric inpatient services. A listing of Freestanding Psychiatric Facilities is included as Attachment C.

Lines 6, 7, 9, & 12 - Refer to the OMHSAS and BDAP Medical Necessity Criteria Appendix of the HealthChoices Behavioral Health PSR effective 07/01/09 for details of items that should be included on these lines.

Line 7)b – Non-Hospital D&A Non- Accredited Room and Board (CISC) should include room and board expenses for children who are in substitute care placed in a non-accredited non-hospital D&A facility. These expenses are not MA reimbursable and are not included in the HealthChoices capitation rate base. Expenses related to the treatment component should be reported on Line 7)a.

Line 10)b – CRR Host Homes Room and Board should include room and board expenses for children who are **not** in substitute care placed in CRR Host Homes. These expenses are not MA

reimbursable and are not included in the HealthChoices capitation rate base. Expenses related to the treatment component should be reported on Line 10)a.

Line 12)b – RTF Non-Accredited Room & Board should include room and board paid to Children and Youth Licensed Group Homes with a Mental Health Treatment Component (formerly known as CRR Group Homes), as well as other Non-JCAHO RTF room & board paid for children who are **not** in substitute care. Expenses related to the treatment component should be reported on Line 12)a. Non-Accredited RTF room and board funded by Children and Youth should be reported on Line 19.

Line 15)a – Individual stop loss reinsurance premiums should be reported on this line as Medical Expense “Other”. Aggregate reinsurance premiums should be reported as Administrative “Other”. Reinsurance Recoveries should be reported in the appropriate category of service and rating group.

Line 15)b - See Section 3.1 for specific instructions for reporting additional amounts as "Other."

Line 16)f - Clinical Care/Medical Management: All Clinical Care/Medical Management expenses should be reported on this line. The amounts reported on this line should not be duplicated in any other administrative expense line on this report. Compensation, interest expense, occupancy, depreciation, and amortization, and other administrative expense lines should include Administrative Overhead costs only. Refer to Attachment F to assist in the task of determining which costs are clinical care/medical management or administrative overhead for DPW reporting purposes.

Line 19 - Both parts of the report also include Line 19 for the reporting of Non-Accredited, Room & Board expenses, Children and Youth Secondary Funding Sources. Information provided on this line must NOT include any funding included as part of the capitation. Funding is to include only other funding sources, such as from Children and Youth or other secondary sources. Amounts reported in this row must NOT be included within any of the capitation rows (1-15).

No Incentive Payment transactions to subcontractors (reserves or distributions) should be included in this report.

This report must be provided in two versions: Current period dollar amounts (Part A) and PMPM amounts (Part B). Part A should reflect dollar amounts for the current period. Part B should reflect the sum of all dollar amounts listed on Part A, YTD dollar amount, and PMPM amounts for both the current month and YTD dollar amounts.

Amounts should be net of third party resources collected.

IMPORTANT: For the purpose of allocating administrative expense amounts, use the following guidelines: 1) if the entire expense can be directly attributed to each behavioral health rating group, report exact dollar amounts for each behavioral health rating group; 2) if a portion of the expense can be directly attributed to one or more of the behavioral health rating groups, distribute only the remaining amounts based on the applicable percentage of capitation revenue; and 3) if no portion of the expense can be directly attributed to one or more of the behavioral health rating groups, distribute the entire expense amount proportionately based on the applicable percentage of capitation revenue. When submitting paper copy reports, include an explanation of the amount being allocated. When reporting electronically, include this explanation in the common text area.

3.11 Report # 11 (Behavioral Health) - Coordination of Benefits Reports

This report is used to capture the MCO's activities involving third party resources. The reporting is compiled using quarterly data. These reports will be submitted quarterly, however, each report contains three months of accumulated history. Each report is separated into the types of claims that the service represents. Each report is also divided by resource type, Commercial and Medicare. On each report, there are fields for the **Commercial Subtotal** and the **Medicare Subtotal**. The figures within each column should equal the resource subtotal. On each report, the final line is the combination of both the **Commercial** and **Medicare Subtotals** for all claim types.

NOTE: Report Hospital stay charges (i.e. the Room and Board) in the INPATIENT fields. Report physician, lab and any procedure charges associated with an inpatient stay in the OUTPATIENT/PROFESSIONAL fields.

REPORT 11A- CLAIMS COST AVOIDED: These are claims that the MCO **DENIES**, because a third party health insurance-related resource exists that may cover the service. A "cost avoidance" occurs when a provider submits a claim that has an identified TPL resource and the provider did not attach an Explanation of Benefits (EOB) indicating that Coordination of Benefits (COB) with the primary insurance carrier occurred and the amount paid by the other insurance.

NOTE: *Total number of claims processed (Column D) as identified below is the "Total" number of claims processed that had a TPL resource (either coordinated or denied) whether it was an initial submission, a corrected claim, or a resubmitted claim.*

Complete Report 11A as follows:

Step 1: The MCO must first identify whether this is a **COMMERCIAL** or a **MEDICARE** resource and the type of claim (Inpatient, Outpatient/Professional) as indicated in column A.

Step 2: Identify the total number of claims with COB processed with a known TPL resource and enter the number in the appropriate row in column B.

Step 3: Identify the total number of claims denied due to a known TPL resource submitted without an EOB attached and enter the number in the appropriate row in column C.

NOTE: *A claim is considered denied if the entire claim is denied. Partial coordination with another resource should be considered coordinated.*

Step 4: Identify the total number of claims with a TPL resource coordinated or denied by summing the totals of column B and column C and enter the number in the appropriate row in column D.

Step 5: Identify the percent of claims denied with a known TPL resource without an EOB attachment. Divide column C by column D and enter the percent in the appropriate row in column E.

Step 6: Identify the total number of unique members active with a TPL resource at the end of the quarterly reporting period (last day) and enter the total for Commercial, total for Medicare and the Total Commercial and Medicare in the appropriate row in column F. If a member has

BOTH Commercial and Medicare, report the member as having Medicare.

NOTE: *This is the total number of active members (count ONLY once) that have an identified TPL resource regardless if a claim was processed or not for the member.*

Report 11A

Column A	Column B	Column C	Column D	Column E	Column F
Type of Resource by Type of Claim	Total Number of Claims with Coordination of Benefits Processed with a Known TPL Resource	Total Number of Claims Denied Due to a Known TPL Resource without an EOB Attachment	Total Number of Claims with a TPL Resource Coordinated or Denied (Column B + Column C)	Percent of Claims Denied with a Known TPL Resource without an EOB Attachment (Column C Divided by Column D)	Total Number of Members Active with a TPL Resource at the End of the Reporting Period (Commercial, Medicare, Total Commercial and Medicare)

REPORT 11B- PROVIDER REPORTED: These are the **REPORTED** payments received by the provider from third party insurers after coordination of benefits has occurred. These amounts are reported by the provider in the **Other Insurance Paid** and the **Medicare Paid** fields on encounter data. The MCO should have an established process for collecting payments from third party insurers to effectively process a retroactive TPL resource or discovery of a missed coordination of benefits opportunity. These are the amounts collected from a Provider or a third party insurer **after** the MCO has already paid the Provider for the encounter/service. If the MCO initially pays a claim, discovers there is a liable third party insurer, or newly acquired coverage retroactive to the date of service, the MCO should retrospectively review the claims previously paid, determine if any fall within the effective date of eligibility, and attempt to collect the money from the provider or the third party insurer. In order for the provider to resubmit a retroactive TPL resource claim for payment, they would need to attach the appropriate EOB with the dollar amount paid by the other insurance (Provider Reported). The amount collected when a provider resubmits a claim that was previously denied due to a TPL resource without an EOB attached should be recorded as Provider Reported and captured as part of the claims payment process.

Complete Report 11B as follows:

Step 1: The MCO must first identify whether it is a **COMMERCIAL** or a **MEDICARE** resource and the type of claim (Inpatient, Outpatient/Professional) as indicated in column A.

Step 2: Identify the number of claims reported by a provider as paid by the third party insurer and enter that number in the appropriate **NUMBER OF CLAIMS** field in column B.

Step 3: Identify the amount the provider billed the MCO and enter the amount in the appropriate row in column C, **AMOUNT BILLED** field.

Step 4: Identify the amount the provider received from the third party insurer noted/document on the EOB and enter the amount in the appropriate row in column D, the **AMOUNT REPORTED** field.

Report 11B

Column A	Column B	Column C	Column D
Type of Resource by Type of Claim	Number of Claims	Amount Billed	Amount Reported

Note: If BOTH Medicare and Commercial Medicare Supplemental insurance is available to pay for an encounter/service, the **claim is counted as Medicare**, because **Medicare is always the primary payer over a Commercial Medicare Supplemental insurance**. However, each of the two payments should be reported separately under the two types of resource.

Example:

The Provider bills the MCO **\$15,000** for **1** inpatient claim and **received a payment of \$1,500** from Medicare. The claim also shows that the provider **received \$500** from the Commercial Medicare Supplemental insurance.

Report 11B

Column A	Column B	Column C	Column D
Type of Resource by Type of Claim	Number of Claims	Amount Billed	Amount Reported
Commercial			
Inpatient			500
Medicare			
Inpatient	1	15,000	1,500

REPORT 11C- RECOVERED: These are the RECOVERED amounts regarding a TPL resource that has not been captured in the claims processing system as Other Insurance, and not reported as Provider Reported on Report B. An example of a RECOVERED amount would be direct recoveries from the third party insurer or if the MCO uses a third-party recovery vendor and the vendor reports recoveries based on discovering a TPL resource or other TPL-related missed opportunity. The vendor recovery dollars, if not recorded in the claims system on individual claims as other insurance paid (Provider Reported), would be reported as recovered.

Complete Report 11C as follows:

Step 1: The MCO must first identify whether it is a **COMMERCIAL** or a **MEDICARE** resource and the type of claim (Inpatient, Outpatient/Professional)

Step 2: Identify the number of claims associated with the recovered amount (as defined above) and enter that number in the appropriate **NUMBER OF CLAIMS** field in column B.

Step 3: Enter the Total Amount Recovered in the **GROSS AMOUNT RECOVERED** field.

Step 4: If some of the recovered dollars is paid to a contractor (e.g. recovery vendor), enter the Portion Received by the MCO in the **NET AMOUNT RECOVERED** field and DO NOT report any third party payment with the Provider Reported data if the MCO bills the third party insurer directly

Example:

The MCO has a contract with a recovery vendor. The vendor recovers **\$1,000** for the MCO for **1** commercial inpatient claim. The vendor charges a fee of 25% or \$250. **The Gross amount of \$1,000** is reported in Column C. The **Net Dollar Amount recovered is \$750** (\$1,000 less \$250) and is reported in Column D

Report 11C

Column A	Column B	Column C	Column D
Type of Resource by Type of Claim	Number of Claims	Gross Amount Recovered	Net Dollar Amount Recovered by the MCO
Commercial			
Inpatient	1	1,000	750

NOTE: If an amount is recovered due to a TPL resource and not captured as “Provider Reported” in the claims system as other insurance paid, the amount should be reported on Part C as Recovered and mapped to the type of resource and type of claim. A description of the recovered amounts should be provided if the detail by type of claim is not available and recorded on the bottom section of Part C on report 11.

This report is to be submitted electronically via DPW’s secure server. The record layout for this report is included as Attachment I of this document. This report is due 45 days after the end of the program quarter and must comply with the specifications shown in **Attachment K** of this document.

3.12 Report #12 - Reinvestment Report

The purpose of this report is to monitor reinvestment activity. All approved allocations to and distributions from the reinvestment account are to be shown on this report. This report must be prepared on a cash-basis (report deposits and payments in the month in which they occur). No accruals for services should be reflected on this report.

Reinvestment funds can be deposited when identified, but **must** be placed in a restricted account within 30 days of the OMHSAS written approval of the County’s reinvestment plan(s).

IMPORTANT NOTE: The services reported on this report should **NOT** be reported on Report #9. Report #9 should only reflect those medical services being provided under the current year’s capitation revenue.

A separate report must be provided for each of the following rating groups:

1. TANF
2. Healthy Beginnings
3. SSI & Healthy Horizons w/ Medicare
4. SSI & Healthy Horizons w/o Medicare
5. Federal GA
6. GA CNO
7. GA MNO (all age groups combined)
8. Other (non-HealthChoices recipients or non-identifiable recipients)
9. Total (total of the eight categories above)

A methodology for allocating costs that are not attributable to a specific rating group must be submitted and approved by DPW prior to implementation.

In addition, if reinvestment funds from more than one contract year are being utilized, a separate set of reports must be filed for each contract year's reinvestment funds.

The Prior Period Balance is the reinvestment account balance as of the last day of the prior calendar month for the "Current Period" column; the reinvestment account balance as of the last day of the prior year for the "Year to Date" column; and \$0 for the "Contract to Date" column.

Allocations/contributions are funds transferred into the reinvestment account.

Investment Revenue is income generated by the undistributed funds retained in the reinvestment account. Reinvestment revenue represents earnings on prior year funds and should appear on Report #12 only.

Approved Distributions are funds withdrawn from the reinvestment account in accordance with the DPW-approved Reinvestment Plan. A written plan for reinvestment must be submitted to and approved by DPW prior to making any distribution. Administrative costs, such as bank fees, should be reported on a separate line. Any administrative costs reported **must** be disclosed in detail in the footnotes to these reports.

Ending Balance is the reinvestment account balance as of the end of the last day of the calendar month.

The Budgeted Amount column should reflect the amounts and services contained in the DPW-approved reinvestment plan. Budgeted Investment/Interest Income should reflect either estimated interest to be earned on HealthChoices funds deposited in the reinvestment bank account and included in the Budget Forms submitted with your reinvestment plans to DPW for approval or interest earned on funds deposited in the reinvestment bank account and allocated to approved reinvestment plans. Budgeted Amounts are not required to be allocated by rating group and can be reported only on the Total page. For electronic reporting, Budgeted Amounts may be reported in total as "Other".

The HealthChoices Behavioral Health Program Requirements for County Reinvestment Plans requires that revisions to an individual reinvestment plan priority, which are the greater of twenty-five percent (25%) or \$50,000 for the priority being revised, be approved by OMHSAS in advance. Revisions less than the preceding requirements can be made without OMHSAS approval. All revisions to budget amounts made without OMHSAS approval must be included in

the footnotes to the reports.

The bank statements for the reinvestment account, as well as the bank reconciliation that reconciles the general ledger to the reinvestment account bank statements, must be submitted with each month's report. The Department reserves the right to request additional documentation.

Columns are provided for reporting the number of unduplicated recipients served, current month units of service provided and dollar amount paid for those services, as well as cumulative year to date and contract to date units of service provided and dollar amount paid. **This information is no longer required to be submitted on this report, but should still be collected internally to monitor cost effectiveness/cost neutrality for Supplemental In-Lieu of services being funded through reinvestment.**

3.13 Report #13 - Balance Sheet/Statement of Net Assets

This report should include all HealthChoices Behavioral Health contract assets and liabilities. IBNRs and RBUCs should be reported separately. The Balance Sheet should be broken out, at a minimum, into current and noncurrent assets and liabilities. Claims liability on the balance sheet must agree with Report #6 and Report #7. If any single balance sheet item classified under "Other" Current Asset/Liability or Noncurrent Asset/Liability is ≥ 5 percent (5%) of the total for that section, please provide an itemized list and dollar amount for that item.

Any Risk and Contingency Fund must be reported as a separate line item on the Balance Sheet.

County operated BH-MCOs as primary contractors must submit the balance sheet for the Special Revenue/Enterprise Fund containing the HealthChoices Behavioral Health contract transactions monthly. An actuarial certification of the claims liabilities shown on the balance sheet must be submitted QUARTERLY. All others should file the balance sheet as indicated in Attachment D and submit an actuarial certification of the claims liabilities shown on the balance sheet ANNUALLY.

NO FORM IS PROVIDED FOR THIS REPORT.

3.14 Report #14 - Statement of Revenues, Expenses and Changes in Retained Earnings (Deficit)/Fund Balance

County operated BH-MCOs as primary contractors must provide the Statement of Revenues, Expenses and Changes in Retained Earnings (Deficit)/Fund Balance for the Special Revenue/Enterprise Fund containing the HealthChoices Behavioral Health contract transactions when Reports #2, 3 and #9 are due. All others should file this report as indicated in Attachment D. This report must include a current period and a year to date column. The revenue and expense line items should include, at a minimum, the line items listed in Report #9. If any revenue or expense item classified as "Other" is ≥ 5 percent (5%) of the total for that account classification, please provide an itemized list and dollar amount for that item.

NO FORM IS PROVIDED FOR THIS REPORT.

3.15 Report #15 - Statement of Cash Flows

County operated BH-MCOs as primary contractors must provide the Statement of Cash Flows for the Special Revenue/Enterprise Fund containing the HealthChoices Behavioral Health contract transactions when Reports #2, #3 and #9 are due. All others should file this report as indicated in Attachment D.

NO FORM IS PROVIDED FOR THIS REPORT.

3.16 Report #16 - Federalized GA Report

This report is to be provided via an electronic file transfer on a monthly basis. This report will include information on all payments for State-Only General Assistance recipients for Inpatient admissions for the following provider types:

PROMISe Provider Type: 01 Inpatient Facility

PROMISe Provider Specialty: 010 Acute Care Hospital
 019 D&A Rehab Hosp
 441 D&A Rehab Unit
 011 Private Psych Hosp
 022 Private Psych Unit
 018 Extended Acute Psych Inpatient Unit

The report is required for all GA-CNO and GA-MNO State-Only recipients who meet all of the criteria reflected on the Managed Care Payment System Table for HealthChoices in effect during the period being reported.

This report is to be submitted electronically via DPW's secure server. Record layouts for this report are included as Attachment A of this document. Data elements for this report are included as Attachment B of this document. This report is due 45 days after the end of the program month and must comply with the specifications shown in Attachments A & B of this document.

NO FORM IS PROVIDED FOR THIS REPORT (ELECTRONIC FILING ONLY). THE DATA FILE LAYOUT IS ATTACHMENT A; THE DATA ELEMENT DICTIONARY IS ATTACHMENT B.

3.17 Report #17 - Contract Reserves Compliance Report

The HealthChoices Behavioral Health PSR effective 1/01/08 specifies equity requirement: This report states whether or not the overall reserve requirement has been met. The report should include the detailed calculation used to determine compliance. If there is a lack of compliance, the report must include an analysis of the fiscal status of the contract and a corrective action plan for fiscal improvement that management plans to take to ensure compliance. All HealthChoices capitation revenues, for all contracts, must be included in the calculation of the reserve requirement for entities responsible for meeting this requirement.

The Report for the quarter ending December 31 is due March 1 to coincide with the due date for Report #24, Insurance Department Annual Filing.

A FORM IS PROVIDED FOR THIS REPORT.

3.18 Report #18 - Insurance Department Quarterly Filings

These reports must be filed with DOI by any licensed, risk-bearing MCO. These reports should be provided on the forms created for DOI. Provide a copy of the reports as submitted to DOI, including any and all amendments to these reports.

NO FORM IS PROVIDED FOR THIS REPORT.

3.19 Report #19 – Adult Outpatient Services in Alternative Settings

This report is to be completed quarterly by all Contractors with an approved supplemental service description and alternative payment arrangement for Adult Outpatient Services in an Alternative Setting. Information should be completed for each client served at the facility during the quarter on a separate tab. Instructions, Data Certification Form and Procedure Code Reference Chart for the completing the report are included as Attachments H, I and J.

A FORM IS PROVIDED FOR THIS REPORT.

3.20 Report #20 - Annual Counterpart Reports

Annual counterparts to Monthly Reports #2, #3, #4, and #9A must be filed. The annual counterparts should reflect the sum of the reports submitted for the year to DPW. The amounts reported will be verified against the monthly reports by DPW. The annual counterparts should be submitted in the same formats as the monthly reports, and should include the annual certification statement, included in this package. No revisions will be accepted for either the annual counterpart reports or the last quarter of the fiscal year's financial reports unless requested by DPW.

THE ANNUAL CERTIFICATION STATEMENT IS PROVIDED FOR THIS REPORT.

3.21 Report #21 - Annual HealthChoices Behavioral Health Contract Audit

The annual contract audit shall be performed in accordance with the HealthChoices Behavioral Health Contract Audit Guide for the applicable contract year, and the HealthChoices Behavioral Health Contract Audit Clause.

NO FORM IS PROVIDED FOR THIS REPORT.

3.22 Report #22 – Audited General Purpose Financial Statements

NO FORM IS PROVIDED FOR THIS REPORT.

3.23 Report #23 - Annual Subcontractor Entity-Wide Audit

This report should be the annual entity-wide audit complete with independent auditor's opinion, notes to the financial statements, and management letters. Please refer to Attachment D for additional information on which entities are required to submit this audit.

NO FORM IS PROVIDED FOR THIS REPORT.

3.24 Report #24 - Insurance Department Annual Filing

These reports must be filed with DOI by any licensed, risk-bearing BH MCO. These reports should be provided on the forms created for DOI. Provide a copy of the reports as submitted to DOI, including any and all amendments.

NO FORM IS PROVIDED FOR THIS REPORT.

3.25 Report #26 - Insurance Department Annual Audited Financial Statements

These reports must be filed with DOI by any licensed, risk-bearing MCO. Provide a copy of the reports as submitted to DOI, including a copy of the management letter. Any revisions to these financial statements must also be submitted to DPW.

NO FORM IS PROVIDED FOR THIS REPORT.

3.26 Other Financial Requirements

1. Physician Incentive Arrangement

To ensure that each managed care contractor is in compliance with the Physician Incentive Arrangement requirements issued by HCFA (61 Fed. Reg. 13430), the County must notify DPW in writing whether any reporting by the County or BH-MCO is required.

2. Equity Requirement

Submit documentation to support the ability to meet the equity requirement for the subsequent year if anything other than the DOI filings reflecting SAP based equity is being used to meet the requirement.

3. Insolvency Protection Arrangement

Submit documentation to support the ability to meet the insolvency protection arrangement for the subsequent contract year.

4. Risk Protection Arrangements (Stop-Loss Reinsurance)

Submit a copy of the Individual Stop-Loss Reinsurance policy for the subsequent contract year.

5. Reinsurance Experience - Estimated

The estimate of reinsurance experience should include information on high utilizers whose costs exceeded the reinsurance threshold throughout the year. The estimate should be provided by rating group and category of service. This report should also include the current estimate of reinsurance collections.

6. Reinsurance Experience - Actual

The actual reinsurance experience should include information on high utilizers whose costs exceeded the reinsurance threshold throughout the preceding year. Actual experience should be provided by rating group and category of service. This report should also include actual reinsurance collections for the preceding year.

3.27 Financial Data Certification Form

Reports submitted to the Division of Medicaid and Financial Review (DMFR) by HealthChoices Behavioral Health Contractors require certification by authorized signatories on file with DMFR. All reports submitted electronically that are used in rate-setting require concurrent certification per Federal BBA Regulations. The following chart identifies which reports require submission of the Financial Data Certification Form, as well as those that require concurrent faxed submission if submitted electronically:

Faxed Concurrently	Certification Required	#	Report Description
	X	1	Enrollment Table
X	X	2	Primary Contractor Summary of Transactions
X	X	3	Subcontractor Summary of Transactions
	X	4	Related Party Transactions and Obligations
	X	5	Risk Pool Analysis
	X	6	Claims Payable (RBUCs and IBNRs)
X	X	7	Lag Reports
	X	8	Claims Processing Report
X	X	9	Analysis of Revenues and Expenses
	X	11	Coordination of Benefits Report
X	X	12	Reinvestment Report
		13	Balance Sheet
		14	Stmt of Rev, Exp, and Changes in RE (Deficit)/Fund Balance
		15	Statement of Cash Flows
		16	Federalized GA Report
		17	Contract Reserves Compliance Report
		18	Insurance Department Qtrly Filing
X	X	19	Adult Outpatient Services in an Alternative Setting
X	X	20	Annual Counterpart Reports
	X	21	Annual HealthChoices Behavioral Health Contract Audit
		22	General Purpose Financial Statements (CAFR)
		23	Annual Subcontract-or Entity-Wide Audit
		24	Insurance Department Annual Filing
		26	Insurance Dept Annual Audited Fin'l Stmts (Audited SAP-based Financials)
			Physician Incentive Arrangement
			Equity Requirement
			Insolvency Protection Arrangement
			Risk Protection (Stop-Loss Reinsurance)
X	X		Estimated Reinsurance Experience
X	X		Actual Reinsurance Experience
			Actuarial Certification of Claims Liabilities

All reports listed in the report grid on the Certification Statement must have a Certification Statement sent concurrently at the time of submission (both original and revised submissions). Certification Statements must be faxed concurrent with electronic and/or e-mail report submissions. Original hard copy Certification Statements must accompany hard copy reports sent in the mail. Reports not listed in the report grid on the Certification Statement but listed above as requiring certification do not need to be faxed concurrently. The certification can be mailed following the submission of electronic or e-mail submissions.

The Date of Submission must be completed on all Certification Statements. The Time of Submission is required on all reports being submitted electronically or via e-mail. It is not required if only submitting hard copy reports,

4.0 REPORTING FORMS

This section includes most of the forms to be completed by the County and the subcontractor. Instructions on the completion of these reporting forms are included in Section 3.

FINANCIAL DATA CERTIFICATION FORM

MONTHLY/QUARTERLY/ANNUAL CERTIFICATION STATEMENT OF

Name of Primary Contractor and Subcontractor

TO THE

PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE

FOR THE PERIOD ENDED

_____, 20_____
(Month & Day) (Yr.)

Name of Preparer _____

Title _____

Phone Number _____

I hereby attest that the information submitted in the reports herein is complete and accurate to the best of my knowledge. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of a Primary Contractor's contract with the Department of Public Welfare.

Additionally, I attest in accordance with 42 C.F.R. § 438.604 that the reports listed in the following table have been reviewed and found to be complete, true and accurate to the best of my knowledge, information and belief and have been submitted in accordance with the agreement with the Department of Public Welfare. I understand that any knowing and willful false statement or representation on the attached data submission may be subject to prosecution under applicable state laws. In addition, any knowing and willful failure to fully and accurately disclose the requested information may result in termination of the agreement with the Department of Public Welfare.

Date of Submission _____ Time of Submission _____

Original Submission? Y N

Revised Submission? Y N

Report #	Name	Type of Submission (Check One for each report transmitted)	
		Web Based *	Hard Copy **
2	Analysis of Revenues & Expenses – Primary Contractor		
3	Analysis of Revenues & Expenses - Subcontractor		
7	Lag Report		
9	Analysis of Revenues & Expenses		
12	Reinvestment Report		
20	Annual Counterpart Reports		
21	HealthChoices Contract Audit		
31	Estimated Reinsurance Experience		
32	Actual Reinsurance Experience		

*Data Certification forms for Web Based submissions MUST be converted to PDF and uploaded to the OMHSAS Financial Report Website concurrent with the upload of selected financial reports.

** Data Certification forms for Hard Copy reports sent via e-mail, USPS, or fax MUST accompany the reports being certified.

Date

Primary Contractor
Authorized Signatory
(Name & Title Typewritten)

Signature

Date

Chief Financial Officer/
Subcontractor
(Name & Title Typewritten)

Signature

REPORT #1 - Enrollment Table

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

Rating Group	Count of Members Enrolled on Last Day of Period	-----Member Month Equivalents-----												YR TO DATE
		Month #1	Month #2	Month #3	Month #4	Month #5	Month #6	Month #7	Month #8	Month #9	Month #10	Month #11	Month #12	
TANF														
Healthy Beginnings														
SSI and Healthy Horizons With Medicare														
SSI and Healthy Horizons Without Medicare														
Federal GA														
Categorically Needy State Only - GA														
Medically Needy State Only - GA														
TOTALS														

SE/SW - Month #1 = January
 All Other's - Month #1 = July

REPORT #2 - Primary Contractor Summary of Transactions

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

Revenues/Expenses	TANF	Healthy Beginnings	SSI and Healthy Horizons w/ Medicare	SSI and Healthy Horizons w/o Medicare	Federal GA	Categorically Needy State Only GA	Medically Needy State Only GA	TOTAL
1) Beginning Balance								
Revenue:								
a) Capitation Revenue								
b) Investment Revenue								
c) Other (Identify)								
2) Revenue Total								
Distributions:								
Distributions to Subcontractor:								
a) Medical Services								
b) Administration								
c) Profit								
d) Reinvestment								
e) Other (Identify)								
3) Total Distributions to Subcontractor								
Distributions for:								
4) Reserves								
5) Reinvestment								
6) Incentive/Risk Pools								
7) Medical Expenses								
8) Other (Identify)								
Administrative Expenses:								
a) Compensation								
b) Interest Expense								
c) Occupancy, Depreciation, & Amortization								
d) Gross Receipt Tax								
e) Distributions to Management Corporation/ASO								
f) Clinical Care/Medical Management								
g) Other (Identify)								
9) Administrative Expense Total								
10) Total Distributions (Lines 3 through 9)								
Balance (Line 1 + Line 2 - Line 10)								

Please refer to instructions for this report for guidelines on allocating expenses among the seven behavioral health rating groups.

REPORT #3 - Subcontractor Summary of Transactions

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

Revenues/Expenses	TANF	Healthy Beginnings	SSI and Healthy Horizons w/ Medicare	SSI and Healthy Horizons w/o Medicare	Federal GA	Categorically Needy State Only GA	Medically Needy State Only GA	TOTAL
1) Beginning Balance								
Revenue:								
a) Capitation Revenue								
b) Investment Revenue								
c) Other (Identify)								
2) Revenue Total								
Distributions:								
Distributions for:								
a) Medical Services								
b) Profit								
c) Reinvestment								
d) Other (Identify)								
3) Total Distributions								
Administration Expenses:								
a) Compensation								
b) Interest Expense								
c) Occupancy, Depreciation, & Amortization								
d) Gross Receipt Tax								
e) Clinical Care/Medical Management								
f) Other (Identify)								
4) Total Administration Expenses:								
5) Other (Identify)								
6) Incentive/Risk Pool(s)								
7) Reinvestment								
8) Total Distributions (Lines 3 through 7)								
Balance (Line 1 + Line 2 - Line 8)								

Please refer to instructions for this report for guidelines on allocating expenses among the seven behavioral health rating groups.

REPORT #4 - Related Party Transactions and Obligations

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

Name & Address of Related Party/Affiliate	Description of Relationship or Affiliation	Tran. Code	Income or Receipts	Expense or Distribution	Amount Due From (To) Current	Amount Due From (To) Non-Current
TOTALS	N/A	N/A				

Report #5, Part A - Risk Pool Analysis

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

	Current Period			Year-To-Date		
	\$	Member Months	PMPM	\$	Member Months	PMPM
1. Revenues Allocated To Risk Pool(s)						
Less Expenses Allocated To Pool(s):						
2. Inpatient Psychiatric						
3. Inpatient D&A						
4. Non-Hospital D&A						
5. Outpatient Psychiatric						
6. Outpatient D&A						
7. Beh. Health Rehab. Services for Children & Adolescents						
8. RTF - Accredited						
9. RTF - Non-Accredited						
10. Ancillary Support						
11. Community Support						
12. Other						
13. Administrative Expense						
14. Total Expenses Allocated to Pool(s) (Lines 2 through 13)						
15. Total Risk Pool Expense Adjustment(s) for the Period (Line 1 minus Line 14)						
16. Risk Pool Balance(s) at the Beginning of the Period						
17. Subtotal (Line 15 + Line 16)						
18. Less Risk Pool Distributions During the Period						
19. Risk Pool Payable (Receivable) (Line 17 minus Line 18)						

Please refer to instructions for this report for guidelines on allocating amounts to behavioral health major service groupings.

Report #6 - Claims Payable (RBUCs and IBNRs)

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

Category of Service	-----Received But Unpaid Claims (RBUCs)-----					IBNR	TOTAL RBUCs & IBNRs
	1 - 30 Days	31 - 45 Days	46 - 90 Days	91 + Days	TOTAL RBUCs		
Inpatient Psychiatric							
Inpatient D & A							
Non-Hospital D & A							
Outpatient Psych.							
Outpatient D & A							
B.H. Rehab. Services for Children & Adolescents							
RTF - Accredited							
RTF - Non-Accredited							
Ancillary Support							
Community Support							
Other							
TOTAL CLAIMS PAYABLE							

Statement as of: _____ (Reporting Date)

County: _____ (County Name)

Reported By: _____ (Reporting Entity)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	
		-----Month In Which Service Was Provided-----													
	Month of Payment	Current	1st Prior	2nd Prior	3rd Prior	4th Prior	5th Prior	6th Prior	7th Prior	8th Prior	9th Prior	10th Prior	11th Prior	12th Prior	
1	Current														
2	1st Prior														
3	2nd Prior														
4	3rd Prior														
5	4th Prior														
6	5th Prior														
7	6th Prior														
8	7th Prior														
9	8th Prior														
10	9th Prior														
11	10th Prior														
12	11th Prior														
13	12th Prior														
14	13th Prior														
15	14th Prior														
16	15th Prior														
17	16th Prior														
18	17th Prior														
19	18th Prior														
20	19th Prior														
21	20th Prior														
22	21st Prior														
23	22nd Prior														
24	23rd Prior														
25	24th Prior														
26	Totals														
27	Expense Reported														
28	Remaining Liability*														

See instructions before completing schedule.
 Complete a separate form for EACH of the eleven behavioral health major service groupings and one for the total of all services.

Statement as of: _____ (Reporting Date)

County: _____ (County Name)

Reported By: _____ (Reporting Entity)

(1)	(2)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)	(24)	(25)	(26)	(27)	(28)	
		-----Month In Which Service Was Provided-----													
	Month of Payment	13th Prior	14th Prior	15th Prior	16th Prior	17th Prior	18th Prior	19th Prior	20th Prior	21st Prior	22nd Prior	23rd Prior	24th and Prior	*TOTAL	
1	Current														
2	1st Prior														
3	2nd Prior														
4	3rd Prior														
5	4th Prior														
6	5th Prior														
7	6th Prior														
8	7th Prior														
9	8th Prior														
10	9th Prior														
11	10th Prior														
12	11th Prior														
13	12th Prior														
14	13th Prior														
15	14th Prior														
16	15th Prior														
17	16th Prior														
18	17th Prior														
19	18th Prior														
20	19th Prior														
21	20th Prior														
22	21st Prior														
23	22nd Prior														
24	23rd Prior														
25	24th Prior														
26	Totals														
27	Expense Reported														
28	Remaining Liability*														

Report #8, Part A - Claims Processing Report By # of Claims

Statement as of: _____ (Reporting Date)

County: _____ (County Name)

Reported By: _____ (Reporting Entity)

Month	# of Claims Received	# of Clean Claims	# of Claims Not Adjudicated	# w/in 30 Days			# w/in 45 Days			# w/in 90 Days			# Not w/in 90 Days		
				Paid	Clean Rejected	Unclean Rejected	Paid	Clean Rejected	Unclean Rejected	Paid	Clean Rejected	Unclean Rejected	Paid	Clean Rejected	Unclean Rejected
Month #1															
Month #2															
Month #3															
Month #4															
Month #5															
Month #6															
Month #7															
Month #8															
Month #9															
Month #10															
Month #11															
Month #12															
YTD Totals:															

See instructions before completing schedule.

Report #8, Part B - Claims Processing Report by \$ Amount of Claims

Statement as of: _____ (Reporting Date)

County: _____ (County Name)

Reported By: _____ (Reporting Entity)

Month	\$ Amount of Claims Received	\$ Amount of Clean Claims	\$ Amount of Claims Not Adjudicated	\$ Amount w/in 30 Days			\$ Amount w/in 45 Days			\$ Amount w/in 90 Days			\$ Amount Not w/in 90 Days		
				Paid	Clean Rejected	Unclean Rejected	Paid	Clean Rejected	Unclean Rejected	Paid	Clean Rejected	Unclean Rejected	Paid	Clean Rejected	Unclean Rejected
Month #1															
Month #2															
Month #3															
Month #4															
Month #5															
Month #6															
Month #7															
Month #8															
Month #9															
Month #10															
Month #11															
Month #12															
YTD Totals:															

See instructions before completing schedule.

Report #8, Part C - Claims Processing, Listing of Claims Not Adjudicated within 45 Days

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

Date Claim Received	Claim Reference #	Service Type (1, 2, or 3)	Provider #	Provider Name	Amount
SUBTOTAL - Service Type "1" (Inpatient)					
SUBTOTAL - Service Type "2" (Practitioner and Outpatient)					
SUBTOTAL - Service Type "3" (Other)					

Total # of Claims _____
 Total \$ Amount of Claims _____

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

Revenues/Expenses	TANF	Healthy Beginnings	SSI & Healthy Horizons w/ Medicare	SSI & Healthy Horizons w/o Medicare	Federal GA	Categorically Needy State-Only GA	Medically Needy State-Only GA	TOTAL
<i>MEMBER MONTH EQUIVALENTS</i>								
REVENUES:								
1. Capitation								
2. Investment Income								
3. Other (Specify)								
4. TOTAL REVENUES (Lines 1 through 3)								
EXPENSES:								
5. Inpatient Psychiatric:								
a) Freestanding Psych Facilities(22-64)								
b) Other								
SUBTOTAL								
6. Inpatient D & A:								
7. Non-Hospital D & A:								
a) All Treatment								
b) Non-Accredited Room and Board (CISC)								
SUBTOTAL								
8. Outpatient Psychiatric								
9. Outpatient D & A:								
10. BHRS								
a) All Treatment								
b) CRR Host Home Room and Board								
SUBTOTAL								
11. RTF - Accredited								
12. RTF - Non-Accredited								
a) Treatment								
b) Room and Board								
SUBTOTAL								

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

Revenues/Expenses	TANF	Healthy Beginnings	SSI & Healthy Horizons w/ Medicare	SSI & Healthy Horizons w/o Medicare	Federal GA	Categorically Needy State-Only GA	Medically Needy State-Only GA	TOTAL
13. Ancillary Support								
14. Community Support Services								
a) Crisis Intervention								
b) Family Based Services for Children & Adolescents								
c) Targeted MH Case Management								
SUBTOTAL								
15. Other								
a) Stop-Loss Reinsurance Premiums								
b) Other Medical Services								
SUBTOTAL								
TOTAL MEDICAL EXPENSES (Lines 5 through 15)								
16. Administration:								
a) Compensation								
b) Interest Expense								
c) Occupancy, Depreciation, & Amortization								
d) Gross Receipt Tax								
e) Distributions to Management Corporation/ASO/Subcontractor								
f) Clinical Care/Medical Management								
g) Other (Specify)								
TOTAL ADMINISTRATION								
17. TOTAL EXPENSES (Lines 5 through 16)								
18. INCOME (LOSS) FROM OPERATIONS								

See instructions before completing this line item.

19. Non - Accredited Room & Board C & Y Secondary Funding Sources								
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THIS REPORT FORMAT SHOULD BE USED FOR REPORTING MONTHS BEGINNING WITH 01/10.

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

Revenues/Expenses	Current Month		Year-To-Date	
	Current Month Amount	PMPM	Year-To-Date Amount	PMPM
<i>MEMBER MONTH EQUIVALENTS</i>				
REVENUES:				
1. Capitation				
2. Investment Income				
3. Other (Specify)				
4. TOTAL REVENUES (Lines 1 through 3)				
EXPENSES:				
5. Inpatient Psychiatric:				
a) Freestanding Psych Facilities(22-64)				
b) Other				
SUBTOTAL				
6. Inpatient D & A:				
7. Non-Hospital D & A:				
a) All Treatment				
b) Non-Accredited Room and Board				
SUBTOTAL				
8. Outpatient Psychiatric				
9. Outpatient D & A:				
10. BHRS				
a) All Treatment				
b) CRR Host Home Room and Board				
SUBTOTAL				
11. RTF - Accredited				
12. RTF - Non-Accredited				
a) Treatment				
b) Room and Board				
SUBTOTAL				
13. Ancillary Support				

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

Revenues/Expenses	Current Month		Year-To-Date	
	Current Month Amount	PMPM	Year-To-Date Amount	PMPM
14. Community Support Services				
a) Crisis Intervention				
b) Family Based Services for Children & Adolescents				
c) Targeted MH Case Management				
SUBTOTAL				
15. Other				
a) Stop-Loss Reinsurance Premiums				
b) Other Medical Services				
SUBTOTAL				
TOTAL MEDICAL EXPENSES (Lines 5 through 15)				
16. Administration:				
a) Compensation				
b) Interest Expense				
c) Occupancy, Depreciation, & Amortization				
d) Gross Receipts Tax				
e) Distributions to Management Corporation/ASO/Subcontractor				
f) Clinical Care/Medical Management				
g) Other (Specify)				
TOTAL ADMINISTRATION				
17. TOTAL EXPENSES (Lines 5 through 16)				
18. INCOME (LOSS) FROM OPERATIONS				

See instructions before completing this line item.

19. Non - Accredited Room & Board C & Y Secondary Funding Sources				
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THIS REPORT FORMAT SHOULD BE USED FOR REPORTING MONTHS BEGINNING WITH 10/04 for LC and 01/05 for SE/SW.

Report #11, Part A - Coordination of Benefits

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

CLAIMS COST AVOIDED

COLUMN A TYPE OF RESOURCE BY TYPE OF CLAIM	COLUMN B TOTAL NUMBER OF CLAIMS WITH COORDINATION OF BENEFITS PROCESSED WITH A KNOWN TPL RESOURCE	COLUMN C TOTAL NUMBER OF CLAIMS DENIED DUE TO A KNOWN TPL RESOURCE WITHOUT AN EOB ATTACHMENT	COLUMN D TOTAL NUMBER OF CLAIMS WITH A TPL RESOURCE COORDINATED OR DENIED (COLUMN B + COLUMN C)	COLUMN E PERCENT OF CLAIMS DENIED WITH A KNOWN TPL RESOURCE WITHOUT AN EOB ATTACHMENT (COLUMN C DIVIDED BY COLUMN D)	COLUMN F TOTAL NUMBER OF MEMBERS ACTIVE WITH A TPL RESOURCE AT THE END OF THE REPORTING PERIOD (COMMERCIAL, MEDICARE, TOTAL COMMERCIAL AND MEDICARE)
COMMERCIAL					
INPATIENT					
OUTPATIENT/PROFESSIONAL					
COMMERCIAL SUBTOTAL					
MEDICARE					
INPATIENT					
OUTPATIENT/PROFESSIONAL					
MEDICARE SUBTOTAL					
TOTAL COMMERCIAL AND MEDICARE					

Report #11, Part B - Coordination of Benefits

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

PROVIDER REPORTED

COLUMN A TYPE OF RESOURCE BY TYPE OF CLAIM	COLUMN B NUMBER OF CLAIMS	COLUMN C AMOUNT BILLED	COLUMN D AMOUNT REPORTED
COMMERCIAL			
INPATIENT			
OUTPATIENT/PROFESSIONAL			
COMMERCIAL SUBTOTAL			
MEDICARE			
INPATIENT			
OUTPATIENT/PROFESSIONAL			
MEDICARE SUBTOTAL			
TOTAL COMMERCIAL AND MEDICARE			

Report #11, Part C - Coordination of Benefits

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

RECOVERED

COLUMN A TYPE OF RESOURCE BY TYPE OF CLAIM	COLUMN B NUMBER OF CLAIMS	COLUMN C GROSS AMOUNT RECOVERED	COLUMN D NET DOLLAR AMOUNT RECOVERED BY THE MCO
COMMERCIAL			
INPATIENT			
OUTPATIENT/PROFESSIONAL			
COMMERCIAL SUBTOTAL			
MEDICARE			
INPATIENT			
OUTPATIENT/PROFESSIONAL			
MEDICARE SUBTOTAL			
TOTAL COMMERCIAL AND MEDICARE			

Description of recovered amounts if detail by type of claim is not available:

Report #17 - Contract Reserves Compliance Report

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

SOURCE OF EQUITY REPORTED _____						
DPW Capitation Payments						
	Contract A *	Contract B *	Contract C *	Contract D *	Contract E *	TOTAL
Capitation Payments for Applicable Period						
Required % of Capitation Payments						
Equity/Reserve Requirement						
Total Equity						
Amount Over/(Under) Equity Requirement						

* Equity requirement to be calculated on all HealthChoices contracts for which the entity is responsible for meeting this requirement.

FEDERALIZING GENERAL ASSISTANCE (GA) FILE LAYOUT

Effective December 1, 2007

NAME: Unique to each plan – xxMMYY.fga format, where:
 xx = two-digit MCO code
 MM = month of file submission
 YY = year of file submission
 .fga = constant file extension

DESCRIPTION: A monthly file provided by the MCOs to DPW containing select information about inpatient hospital claims for state GA recipients. DPW is authorized to claim the federal share for services provided to state GA recipients through capitation programs.
 Each monthly file is due approximately 45 days after the end of the program month. Files are to be placed on DPW's server in the fedga directory by the 15th of each month.

FORMAT: ASCII

RECORD LENGTH: 113

<i>Field Name</i>	<i>Record Position</i>	<i>Field Length</i>	<i>Alpha/ Numeric</i>	<i>Special Instructions</i>
MCO Code	01-02	02	A	
Provider Type	03-04	02	A	
Provider Number	05-17	13	A	
Recipient Number	18-26	09	A	
Recipient's Current ID (on Date of Service)	27-42	16	A	
Recipient Birth Date	43-50	08	A	YYYYMMDD
Begin Service Date	51-58	08	A	YYYYMMDD
End Service Date	59-66	08	A	YYYYMMDD

Amount Reimbursed	67-75	09	N	RJ, zero fill
Amount Indicator	76	01	A	
Claim Number	77-96	20	A	LJ
Claim Adjustment Indicator	97	01	A	
Number of Days Paid	98-100	03	N	RJ, zero fill
Payment Date	101-108	08	A	YYYYMMDD
Program Status Code	109-110	02	A	
Provider Specialty	111-113	03	A	
Inpatient/Outpatient Indicator	114	01	A	I = Inpatient O = Outpatient

Effective December 2007

GENERAL ASSISTANCE FEDERAL FUNDING FILE
DATA ELEMENT DICTIONARY

<p>ELEMENT: MCO CODE</p> <p>DESCRIPTION: Two character alpha numeric, identifying the particular MCO—See attachment.</p>
<p>ELEMENT: PROVIDER TYPE</p> <p>DESCRIPTION: Two digit number identifying the type of provider: PROMISE Provider Type: April 1, 2004 01 – Inpatient Facility</p>
<p>ELEMENT: PROVIDER NUMBER</p> <p>DESCRIPTION: Thirteen digit PROMISE provider number (service provider)</p>
<p>ELEMENT: RECIPIENT NUMBER</p> <p>DESCRIPTION: Nine digit recipient CIS number.</p>
<p>ELEMENT: RECIPIENT'S CURRENT ID (on Date of Service)</p> <p>DESCRIPTION: Sixteen character alpha-numeric recipient number. The format is CCRRRRRRRAAGDLL, where: CC = County Number RRRRRRR = Record Number AAA = Rating Group (left justified with trailing blanks) G = Grant Group D = Control Digit, (not required as of 10/2003, space fill) LL = Line Number</p>
<p>ELEMENT: RECIPIENT'S BIRTH DATE</p> <p>DESCRIPTION: The recipient's date of birth. Date in YYYYMMDD format.</p>
<p>ELEMENT: BEGIN SERVICE DATE</p> <p>DESCRIPTION: The date the service began. Date in YYYYMMDD format.</p>
<p>ELEMENT: END SERVICE DATE</p> <p>DESCRIPTION: The date the service ended. Date in YYYYMMDD format.</p>

<p>ELEMENT: AMOUNT REIMBURSED</p> <p>DESCRIPTION: Amount approved for payment. If the record is an adjustment, the amount should be the adjustment amount, not the final value. Do not enter the decimal point.</p>
<p>ELEMENT: AMOUNT INDICATOR</p> <p>DESCRIPTION: A code to indicate whether the amount is a positive or a negative value: 0 = positive amount, 1 = negative amount.</p>
<p>ELEMENT: CLAIM NUMBER</p> <p>DESCRIPTION: A unique control number assigned to the claim by the contractor. The number must include a Julian date to indicate the date of claim receipt by the contractor. This number must appear on a record of paid claims maintained by the contractor that is available to an auditor, as provided by the contractor's contract with DPW. (20) CHARACTER FIELD, left justified with trailing blanks.</p>
<p>ELEMENT: CLAIM ADJUSTMENT INDICATOR</p> <p>DESCRIPTION: A code to indicate that the claim record is an adjustment: 1 = not an adjustment, 2 = an adjustment</p>
<p>ELEMENT: NUMBER OF DAYS PAID</p> <p>DESCRIPTION: Three digit field indicating the number of days that were paid.</p>
<p>ELEMENT: PAYMENT DATE</p> <p>DESCRIPTION: The date the provider of service was paid. YYYYMMDD format.</p>
<p>ELEMENT: RECIPIENT PROGRAM STATUS CODE</p> <p>DESCRIPTION: A two-digit code that identifies budgets which meet certain characteristics. It is used for federal reimbursement, reporting, and general control purposes. See Supplementary MA Codes (PA 601).</p>
<p>ELEMENT: PROVIDER SPECIALTY</p> <p>DESCRIPTION: A three-digit code that identifies provider scope of practice.</p>
<p>ELEMENT: INPATIENT/OUTPATIENT INDICATOR</p> <p>DESCRIPTION: A one character code used to differentiate between Inpatient and Outpatient claims. I = Inpatient O = Outpatient</p>

Last Update: JANUARY 2008

**PA Medical Assistance Managed Care Organization List
(Attachment to Attachment B)**

HMO CODE	HMO NAME
03	THREE RIVERS HEALTH PLANS, INC. / MEDPLUS+
10	UPMC / BEST HEALTH CARE OF WESTERN PA
11	GATEWAY HEALTH PLAN, INC.
12	HRM HEALTH PLANS, INC. / HEALTHMATE
28	AMERIHEALTH HMO INC.
55	PARTNERSHIP HEALTH PLAN
30	UPMC / BEST HEALTH CARE OF WESTERN PA
31	GATEWAY HEALTH PLAN, INC.
33	THREE RIVERS HEALTH PLANS, INC. / MEDPLUS+
43	HEALTH RISK MANAGEMENT
45	HEALTH PARTNERS OF PHILADELPHIA
46	AMERICHoice OF PA (FORMERLY HMA)
48	KEYSTONE MERCY HEALTH PLAN
88	FAMILY CARE NETWORK (FCN)
89	LANCASTER COMMUNITY HEALTH PLAN (LHCP)
90	HIPP (HEALTH INSURANCE PREMIUM PAYMENT PLAN)
91	HIPP (HMO)
95	LONG TERM CARE CAPITATION (LTCCAP)
AL	ALLEGHENY COUNTY BEHAVIORAL HEALTH (COMMUNITY CARE BHO)
AI	ARMSTRONG/INDIANA MH/MR PROGRAM(VBH OF PA)
BE	BEAVER COUNTY BEHAVIORAL HEALTH (VBH OF PA)
BT	BUTLER COUNTY BEHAVIORAL HEALTH (VBH OF PA)
FA	FAYETTE COUNTY BEHAVIORAL HEALTH (VBH OF PA)
GR	GREENE COUNTY BEHAVIORAL HEALTH (VBH OF PA)
LW	LAWRENCE COUNTY BEHAVIORAL HEALTH (VBH OF PA)
WS	WASHINGTON COUNTY BEHAVIORAL HEALTH (VBH OF PA)
WE	WESTMORELAND COUNTY BEHAVIORAL HEALTH (VBH OF PA)
BU	BUCKS CO. BH (MAGELLAN BH)
CH	CHESTER CO. BH (COMMUNITY CARE BHO)
DE	DELAWARE COUNTY BH (MAGELLAN BH)
MO	MONTGOMERY COUNTY BH (MAGELLAN BH)
PH	PHILADELPHIA COUNTY BH (COMMUNITY BH)

HMO CODE	HMO NAME
AD	ADAMS COUNTY BEHAVIORAL HEALTH
BK	BERKS COUNTY BEHAVIORAL HEALTH
CU	CUMBERLAND COUNTY BEHAVIORAL HEALTH
DA	DAUPHIN COUNTY BEHAVIORAL HEALTH
LA	LANCASTER COUNTY BEHAVIORAL HEALTH
LB	LEBANON COUNTY BEHAVIORAL HEALTH
LE	LEHIGH COUNTY BEHAVIORAL HEALTH
NH	NORTHAMPTON COUNTY BEHAVIORAL HEALTH
PE	PERRY COUNTY BEHAVIORAL HEALTH
YO	YORK COUNTY BEHAVIORAL HEALTH
NB	NORTHEAST BEHAVIORAL HEALTH CARE CONSORTIUM
BI	BLAIR COUNTY
BS	BEHAVIORAL HEALTH SERVICES OF SOMERSET AND BEDFORD COUNTIES
CK	CARBON, MONROE, PIKE
CM	BEHAVIORAL HEALTH OF CAMBRIA COUNTY
ER	ERIE COUNTY
FF	TUSCARORA MANAGED CARE ALLIANCE (FRANKLIN & FULTON COUNTIES)
LC	LYCOMING CLINTON JOINDER BOARD
CV	NWBHP (CRAWFORD, MERCER, VENANGO)
NC	COMMUNITY CARE BEHAVIORAL HEALTH ORGANIZATION, INC. (NC SO)

PRIVATE PSYCH HOSPITAL IN-STATE (FREESTANDING)

Provider Type 01, Inpatient Facility – Provider Specialty 011, Private Psychiatric Hospital

<u>Provider Number</u>	<u>Provider Name</u>
001965180 0002	Brooke Glen Behavioral Hospital
100001913 0411	Devereux Children's Behavioral Health Center
100002080 0041	First Hospital Wyoming Valley
100728370 0001	Kidspeace Hospital
100728595 0022	Clarion Psychiatric Center
100728595 0051	The Meadows Psychiatric Center
100728595 0065	Horsham Clinic, Inc.
100741775 0009	Bellmont Center for Comprehensive Treatment
100756375 0008	Divine Providence Hospital
100756802 0011	Montgomery MH/MR Emergency Services
100772000 0016	Philhaven Hospital
100772010 0003	Fairmount BH System
100773760 0004	Kirkbride Center
100778710 0020	Southwood Psychiatric Hospital
100814352 0063	ABC
101277695 0001	Friends BH System LP
101666835 0001	Roxbury Psychiatric Hospital
101921938 0001	Foundations Behavioral Health
102096380 0001	PA Psychiatric Institute
102511157 0001	Haven Behavioral Hospital of Eastern Pennsylvania

PRIVATE PSYCH HOSPITAL OUT OF STATE (FREESTANDING)

Provider Type 01, Inpatient Facility – Provider Specialty 011, Private Psychiatric Hospital

<u>Provider Number</u>	<u>Provider Name</u>	<u>State</u>
000984977 0002	Brook Lane Psychiatric Center, Inc.	MD
001394465 0001	Sheppard and Enoch Pratt Hospital	MD
001842662 0002	William S. Hall Psychiatric Institute	SC
001828823 0001	Virginia Beach Psychiatric Center	VA
001877873 0001	BHC Windsor Hospital	OH
001962750 0001	Rockford Center	DE
100001913 0413	Devereux Hospital	TX
100763182 0006	Kennedy Krieger Institute	MD
100769266 0003	Belmont Pines	OH
100769284 0003	Fox Run Hospital	OH
100776108 0003	The Browns School at Laurel Ridge	TX
102118610 0001	Meadow Wood Behavioral Health System	DE
102642613 0001	Meadow Wood Behavioral Health System	DE

Refer to Line Item 2 on the Behavioral Health Services Reporting and Classification Chart

Attachment D – Reporting Entities

The Department’s primary contractor is responsible for the timely filing and accuracy of all financial reports. The following tables are provided as a guideline to assist in determining which entity(s) must file the necessary financial reports. Report #s and titles are found in Section 2.00.

Zone 1 Contractors

Bucks, Montgomery and Delaware Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26	
County		Q		Q**	Q**				Q*		M	A	A	A		Q		N/A	A*	A*	A				
MBH-PA	Q		Q	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q						A	A	A

Chester County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26	
County		Q		Q**	Q**				Q*		M	A	A	A		Q		Q	A*	A*	A				
CCBHO	Q		Q	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q						A	A	A

Philadelphia County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26	
County		Q		Q**	Q**				Q*		M	M	Q	Q		Q	N/A	Q	A*	A*	A		N/A	N/A	
CBH	Q		Q	Q**	Q**	M	M	M		Q					M								A		

*These reports will be a combination of data from several reporting entities.

** Each entity must file a separate report.

Zone 2 Contractors

Allegheny County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
County	Q	Q*		Q**	Q**				Q*		M	A	A	A		Q		Q	A*	A*	A			
CCBHO			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q					A	A	A
AHCI		Q*		Q**																		A		
UPMC												Q	Q	Q								A		

Beaver County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
County	Q	Q	N/A	Q**	Q**	M	M	M	Q*	Q	M	M	Q	Q	M	Q	N/A	Q	A	A*	A	N/A	N/A	N/A
VBH-PA				Q**	Q**							Q	Q	Q										

Fayette County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
County	Q	Q	N/A	Q**	Q**	M	M	M	Q*	Q	M	M	Q	Q	M	Q	N/A	N/A	A	A*	A	N/A	N/A	N/A
VBH of PA				Q**	Q**							Q	Q	Q										

VBH of PA/Greene County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
VBH-PA	Q	Q	N/A	Q**	Q	M	M	M	Q	Q	M	Q	Q	Q	M	Q	Q	Q	A	A	N/A	A	A	A
ValueOptions												Q	Q	Q								A		

*These reports will be a combination of data from several reporting entities.

** Each entity must file a separate report

Zone 2 Contractors – (continued)

Butler, Lawrence, Washington, and Westmoreland Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
County	Q	Q		Q**	Q**				Q*		M	A	A	A		Q		Q ⁽¹⁾	A*	A*	A			
VBH-PA			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q					A	A	A
SBHM				Q**																		A		

⁽¹⁾Butler, Lawrence and Washington Only

Armstrong-Indiana

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
Armstrong/Indiana MH/MR	Q	Q		Q**	Q**				Q*		M	A	A	A		Q		Q	A*	A*	A			
VBH-PA			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q					A	A	A
SBHM				Q**																		A		
County Specific Reports	A**	A***	A***				A***		A***		A***													

*These reports will be a combination of data from several reporting entities.

** Each entity must file a separate report.

*** **County specific Annual reports must be submitted upon request.**

If requested, the Individual County Annual Reports for Multi-County contracts must be submitted as follows:

- Reports #1, #2, #3, #9 & #12: Submit YTD reports in an Excel file submitted via e-mail to behackenbe@pa.gov
- Report #7: Submit extended lag report beginning January 1, 2012 through March 31, 2012 as an Excel file to be submitted via e-mail to behackenbe@pa.gov

Revised 7/1/2012

Zone 3 Contractors

Cumberland, Dauphin, Lancaster, Lebanon and Perry Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
County	Q	Q*		Q**	Q**	M	M	M	Q*	Q	A***	M	Q	Q	M	Q	N/A	N/A	A*	A*	A		N/A	N/A
CBHNP			N/A	Q**	Q**							Q	Q	Q								A		
CABHC		Q*		Q**							M	M	Q	Q								A		
Cumberland/ Perry Joinder																						A		

*** Report #12: Submit YTD report in an Excel file submitted via e-mail to behackenbe@pa.gov . Due September 1, 2013.

Adams, Berks and York Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
County	Q	Q		Q**	Q**				Q*		M	A	A	A				N/A	A*	A*	A			
CCBHO			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q					A	A	A
UPMC												Q	Q	Q								A		

Lehigh and Northampton Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
County	Q	Q		Q**	Q**				Q*		M	A	A	A				Q ⁽¹⁾	A*	A*	A			
MBH-PA			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q					A	A	A

(1) Northampton Only

*These reports will be a combination of data from several reporting entities.

** Each entity must file a separate report.

Revised 7/1/2012

Zone 4 Contractors

NBHCC on behalf of Lackawanna, Luzerne, Susquehanna and Wyoming Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
NBHCC	Q	Q*	N/A	Q**	Q	M	M	M	Q*	Q	M	M	Q	Q	M	Q	N/A	N/A	A	A	N/A	A	N/A	N/A
Lackawanna	A***	A***					A***		A***		A***													
Luzerne	A***	A***					A***		A***		A***													
Susquehanna	A***	A***					A***		A***		A***													
Wyoming	A***	A***					A***		A***		A***													
CCBHO				Q**	Q							Q	Q	Q										

*These reports will be a combination of data from several reporting entities.

** Each entity must file a separate report.

*** **County specific Annual reports must be submitted upon request.**

If requested, the Individual County Annual Reports for Multi-County contracts must be submitted as follows:

- Reports #1, #2, #3, #9 & #12: Submit YTD reports in an Excel file submitted via e-mail to behackenbe@pa.gov .
- Report #7: Submit extended lag report beginning July 1, 2012 through September 30, 2013 as an Excel file to be submitted via e-mail to behackenbe@pa.gov .

Zone 5 Contractors

CCBH on behalf of the 23 State Option Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
CCBH	Q	Q	N/A	Q	Q	M	M	M	Q	Q	M	Q	Q	Q	M	Q	Q	N/A	A	A	N/A	A	A	A
UPMC												Q	Q	Q								A		

Zone 6 Contractors

Carbon, Monroe, Pike Joinder Board

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
CMP Joinder	Q	Q		Q**	Q**				Q*		M	A	A	A				N/A	A*	A*		A		
CCBH			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q					A	A	A
UPMC												Q	Q	Q								A		
County Specific Reports	A***	A***	A***				A***		A***		A***													

Cambria County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
Cambria County	Q	Q*		Q**	Q**				Q*		M	A	A	A				N/A	A*	A*	A			
BHoCC		Q*																				A		
VBH-PA			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q					A	A	A
VOI												Q	Q	Q								A		

Erie County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
Erie County	Q	Q		Q**	Q**				Q*		M	A	A	A				N/A	A*	A*	A			
CCBH			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q					A	A	A
UPMC												Q	Q	Q								A		

Zone 6 Contractors (continued)

Northwest Behavioral Health Partnership - Crawford, Mercer, Venango

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
NWBHP	Q	Q		Q**	Q**				Q*		M	A	A	A				Q	A*	A*		A		
VBH-PA			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q					A	A	A
VOI												Q	Q	Q								A		
County Specific Reports	A***	A***	A***				A***		A***		A***													

Blair County

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
Blair HealthChoices	Q	Q*		Q**	Q**				Q*		M	A	A	A				N/A	A*	A*		A		
Blair County		Q*																			A			
CSI			Q*	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q					A	A	A

Behavioral Health Services of Somerset and Bedford Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
BHSSBC	Q	Q		Q**	Q**				Q*		M	A	A	A				N/A	A*	A*		A		
CSI			Q*	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q					A	A	A
County Specific Reports	A***	A***	A***				A***		A***		A***													

Zone 6 Contractors (continued)

Tuscarora Managed Care Alliance - Franklin and Fulton

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
TMCA	Q	Q		Q**	Q**				Q*	Q	M	M	Q	Q	M	Q	N/A	N/A	A*	A*		A	N/A	N/A
CBHNP			N/A	Q**	Q**	M	M	M				Q	Q	Q								A		
County Specific Reports	A***	A***					A***		A***		A***													

Lycoming and Clinton Counties

Entity/Report #	1	2	3	4	5	6	7	8	9	11	12	13	14	15	16	17	18	19	20	21	22	23	24	26
Lycoming/Clinton Joinder	Q	Q		Q**	Q**				Q*		M	A	A	A				N/A	A*	A*		A		
CSI			Q*	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q					A	A	A
County Specific Reports	A***	A***	A***				A***		A***		A***													

*These reports will be a combination of data from several reporting entities.

** Each entity must file a separate report.

*** **County specific Annual reports must be submitted upon request.**

If requested, the Individual County Annual Reports for Multi-County contracts must be submitted as follows:

- Reports #1, #2, #3, #9 & #12: Submit YTD reports in an Excel file submitted via e-mail to behackenbe@pa.gov .
- Report #7: Submit extended lag report beginning July 1, 2012 through September 30, 2013 as an Excel file to be submitted via e-mail to behackenbe@pa.gov .

HealthChoices Behavioral Health Program

CLAIMS PROCESSING REQUIREMENTS

This appendix describes the claims processing requirements for Primary Contractors and BH-MCO Subcontractors. This appendix also contains the timeliness standards which must be met, and instructions for determining compliance with these standards. A monthly report of summary claims processing information is also required. The HealthChoices (HC) Behavioral Health (BH) Financial Reporting Requirements contain additional detail and instructions for the monthly (Report #8) report.

A. Claims Processing Standards

The Contractor must make timely payments to its providers. In addition to any Federal and state requirements, or standards included in the Contractor's provider agreements or subcontracts, the Contractor will adjudicate fee for service (FFS) claims consistent with the adjudication timeliness standards below.

Adjudication Timeliness Standards:

- A. 90% of **clean** claims must be adjudicated within **30** days.
- B. 100% of **clean** claims must be adjudicated within **45** days.
- C. 100% of **all** claims must be adjudicated within **90** days.

"Adjudicate" means to pay or reject a claim. A "clean claim" is a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in the Contractor's claims processing computer system, and those originating from human errors. It does not include a claim under review for medical necessity, or a claim that is from a provider who is under investigation by a governmental agency or the Contractor for fraud or abuse. However, if under investigation by the Contractor, the Department must have prior notification of the investigation.

Capitation claims must also be paid timely and in accordance with any Federal requirements and/or standards included in the Contractor's provider agreements or subcontracts, and must be included in Report #8, Claims Processing, found in the HC Behavioral Health Financial Reporting Requirements.

The Contractor must identify, on every claim processed, the date the claim was received. This date must be carried on claims records in the claims processing computer system. Each hard-copy claim received by the Contractor must be date-stamped with the date of receipt not later than the first workday after the date of receipt.

Every claim entered into the Contractor's claims processing computer system must be adjudicated. The Contractor must maintain an electronic file of rejected claims, inclusive of the dollar amount of the rejected claim and a reason or reason code for rejection.

The amount of time required to adjudicate a paid claim is computed by comparing the date the claim was received, either in the mail or via an electronic filing, with the date the check was

created, or electronic funds transfer date. The amount of time required to adjudicate a rejected claim is computed by comparing the date the claim was received with the date the denial notice was created, or the transmission date of an electronic denial notice. If claims processing is the responsibility of a subcontractor, the date of initial receipt, either at the Contractor or at the claims processing subcontractor, is the date of receipt applicable to these requirements.

B. Claims Processing Reports

Monthly Claims Processing Report - The Contractor will provide the Department with summary information on the number and amount of claims received, pending, rejected and paid, by aging category, each month, including payments to capitated providers. Detailed instructions, report formats and due dates can be found in the HC BH Financial Reporting Requirements, Report #8, Claims Processing Report.

ADMINISTRATIVE OVERHEAD AND CLINICAL CARE / MEDICAL MANAGEMENT COST DEFINITIONS

Administrative Overhead costs are expenditures associated with the overall management and operation of a BH-MCO, agreeing to contract with OMHSAS for the provision of behavioral health services. For DPW reporting purposes, Clinical Care/Medical Management services are part of medical services and are distinguished from provider payments as services necessary to ensure the continuity of a member's behavioral health care treatment; these services do not constitute treatment, but are considered indirect costs associated with direct care. The following describes proposed definitions for various administrative categories. Note that County and subcontracted or parent company allocations should also be categorized as follows.

ADMINISTRATIVE OVERHEAD *	CLINICAL CARE / MEDICAL MANAGEMENT *
1. General and Administrative <ul style="list-style-type: none"> ➤ Senior operational management ➤ General administrative support staff (i.e., Administrative Assistants, Data Entry, Medical Records, Public Relations, Receptionist, etc.) ➤ Accounting and Finance ➤ Consultants/Actuaries (See #8 under Clinical Care/Medical Management for exceptions) ➤ Depreciation and Amortization ➤ Malpractice, General, and Liability Insurance ➤ Marketing ➤ Office Supplies ➤ Postage ➤ Printing and Copier expenses ➤ Recruiting ➤ Relocation ➤ Rent ➤ Training and Education (See #18 under Clinical Care/Medical Management for exceptions) ➤ Travel (See #17 under Clinical Care/Medical Management for exceptions) ➤ Utilities ➤ Other miscellaneous administrative 	1. Clinical staff salaries 2. Community Relations staff salaries 3. Medical Affairs staff salaries 4. Intake staff salaries 5. Quality Management staff salaries 6. Service Management staff salaries 7. Case Management 8. Consultants (i.e. Language and Deaf Interpreter services, Psychological testing, etc.) 9. Consulting Physician services (Peer to peer physician review of cases) 10. Intake/Member Services Coordinator 11. Medical Director services 12. Other Appropriate Clinical Staff services 13. Outreach/Consumer and Public Education 14. Quality Improvement and Management programs 15. Training for certification and licensing purposes (Clinical staff only) 16. Travel (Interagency team meetings and medical director/provider meetings) 17. 24-hour telephone accessibility for crisis response, screening, referral, and authorization 18. 24-hour accessibility to physician

ADMINISTRATIVE OVERHEAD *	CLINICAL CARE / MEDICAL MANAGEMENT *
<p>expenses</p> <ol style="list-style-type: none"> 2. Claims Processing – Direct or vendor related expenditures related to the processing of provider claims 3. Information Systems – Information systems and communications 4. Provider Services/Network <ul style="list-style-type: none"> ➤ Contracting ➤ Provider credentialing ➤ Provider education 5. Member Services <ul style="list-style-type: none"> ➤ Customer service/support ➤ Grievance and Appeals 6. Patient Transportation 7. Sanctions 8. Member Handbooks 	<p>and/or board certified addictionologist physician for consultation and review</p> <ol style="list-style-type: none"> 19. Utilization Management 20. Utilization Review

* Costs which can be directly or indirectly attributed to the HealthChoices Behavioral Health Program only.

Prepared 2/20/01 by OMHSAS/DMFR

Web-based Financial Report Submission Process

PRIOR YEAR ADJUSTMENTS – 2011 & 2011/2012 and Prior

NOTE: Adjustments to Report #7 for 2011 & 2011/2012 and 2010 & 2010/2011; as well as Adjustments to Report #12 for FYE December 2011 and FYE June 30, 2012 must also include resubmission of the INITIAL Report #7 or Report #12 to the new Finance System.

Prior year adjustments will be submitted in accordance with the HealthChoices Behavioral Health Electronic Financial Data Submission Manual. Character coding must be in the ASCII format. Use submission Indicator “A” for Adjustments in the Header Record (F00), Catalog #0006.

Refer to Attachment L for instructions for submitting adjustments to 2012 & 2012/2013 and beyond.

For Prior Year Adjustments – 2011 & 2011/2012 and Prior, submit adjustments to previously submitted data only. Adjustment submissions will automatically be appended to the existing data in the database. (NOTE: Although the adjustment submission will only include adjustments to previously submitted data, the report will be submitted in its entirety. Data that is not being adjusted will be zero filled.)

If the exact month or quarter of the adjustment is unknown, please submit the adjustment for the last month or quarter of the contract year (i.e., June for LC, NE & NC and December for SE and SW). Please note that adjustments should **not** be made to the Annual report for period 2011 & 2011/2012 and prior.

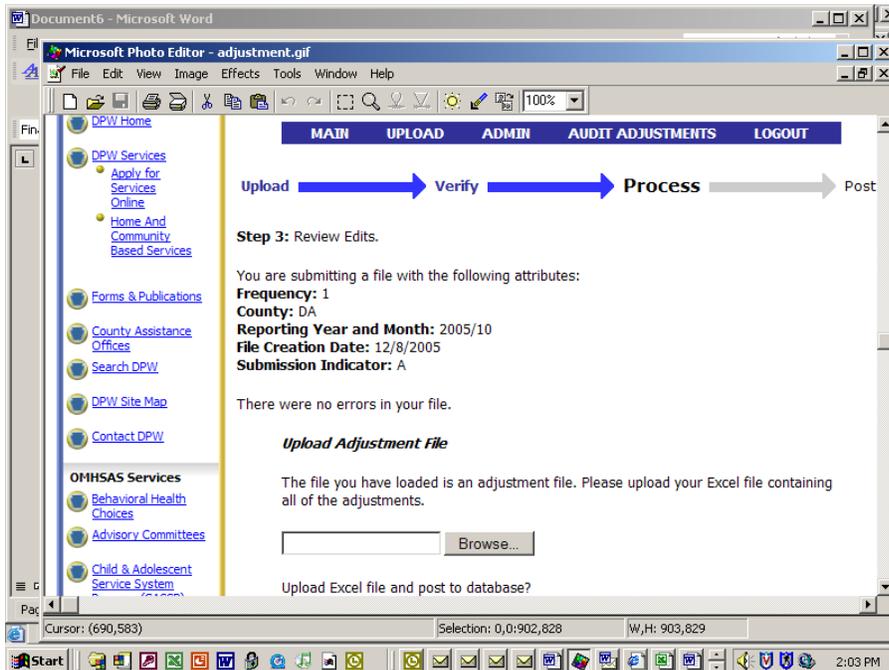
Adjustments to Report #12 must be made in the Current Period columns. Adjustments reported only in the Year to Date and Contract to Date Columns will not be reflected in the ASCII file.

Adjustments will only be submitted via the electronic web-based submission process for two years after submission of the annual contract audit. Prior year adjustments made two years after submission of the contract audit will be submitted to OMHSAS in Excel spreadsheets only.

Audit adjustments are due November 15th for the LC Zone and May 15th for the SE and SW Zones, in conjunction with submission of the annual contract audit.

Subsequent adjustments made after the audit can be made at anytime during the two year period.

During the on-line submission process, the original Excel file used to create the ASCII file must be submitted along with the ASCII text file. The system will prompt to upload the Excel file. The naming convention for the Excel file is the same as the ASCII file, but using an .xls extension. (NOTE: The system will only accept one (1) Excel file. If the ASCII file is created from several Excel files, please create one (1) ZIP file changing the file extension from “.zip” to “.xls”.)



After receipt of prior year adjustments to Reports #2, #3 or #9, OMHSAS will send contractor an Excel file reflecting year to date totals housed in the finance database for comparison to contractor's internal records. After receipt of prior year adjustments to Reports #7 and #12, OMHSAS will send contractor a PDF file reflecting year to date totals housed in the finance database.

Adjustments are not required for Report #4.

REMINDER: When making adjustments to reports, the adjustments may affect various other reports. (i.e., An adjustment to medical expenses may impact Reports #2, #3, #6, #7 and #9.) The contractor must submit adjustments for **ALL** reports affected by the adjustment.

Adult Outpatient Services in Alternative Settings

Instructions – Quarterly Reporting

Descriptions of Tabs:

Tab	Description	Instructions for completing the tabs
Cert Form	Certification for data submitted	This form should be signed by the authorized signatories on file with OMHSAS. All reports submitted electronically that are used in rate-setting require concurrent certification per Federal BBA regulations. This form can be faxed to (717) 705-8128.
Report #19 Service Package	Type and frequency of services provided to clients	<p>1. Please fill in the Reporting Period Begin and End Dates, Client CIS #, Client SSN, Client Name, Client's County of Residence (not county where currently located, if different), Admission Date, Discharge Date, the Provider's 13 digit PROMISe ID# (which includes the Service Location) and Provider Name. The Admission date should reflect the date the client was admitted to the facility. If the client is still in the facility, the discharge date field should be left blank.</p> <p>2. Service: The chart has been pre-populated with outpatient services provided to clients in the alternative settings. For the rows labeled "Additional Service," please indicate any Medicaid reimbursable services being provided to the clients but not identified in the list, one line per service. See PC Reference Chart for potential service list.</p> <p>3. Procedure Code/Modifier (if applicable): The chart has been pre-populated with the applicable codes and unit definition. Please see the attached Procedure Code Reference Sheet for additional services and procedure codes/modifiers.</p> <p>4. Unit Definition: OMHSAS has identified MA unit definitions to aid in completing this chart. If you track these services differently, please specify the unit definition accordingly. Please note that variations on the Unit Definition are permitted; please reflect the correct total of the pre-populated units in the Units in Reporting Period column. For example, if the Individual Psychotherapy session (30 minutes) only lasted for 15 minutes, please reflect 0.5 Units in the Reporting Period column.</p> <p>5. Unit Cost: Please provide the cost per unit of service. Costs should be provided in accordance with the unit definitions.</p> <p>6. Units in Reporting Period: For each service listed, please provide the number of units of service utilized by each client during the reporting period. If this information is tracked differently, please provide comments at the bottom of the chart.</p>
Procedure Code (PC) Reference Chart	Additional types and units of service	

General Instructions:

Please complete a separate worksheet for each client in your facility. These charts should be completed quarterly and should reconcile to the monthly Alternative Payment Arrangement/837 submissions.

Excel Files are to be placed on DPW's eGov secure server according to previously defined transfer method. Any questions regarding connectivity can be directed to Barb Wadlinger at 717-346-4332 or c-bwadling@state.pa.us.

Naming Convention – xx_AOP#QTRYY format, where:

xx = two-letter county alpha code

= Calendar Quarter – 1, 2, 3 or 4

YY = two-digit year

The data certification form should be faxed to Dawn at (717) 705-8128 concurrent with report submission. The report is due no later than 45 days after the end of each reporting quarter.

If there are any questions on the quarterly report or the instructions, please contact Dawn Hamme (717) 705-8175 or dhamme@state.pa.us.

DATA CERTIFICATION FORM Adult Outpatient Services

CERTIFICATION STATEMENT OF

Name of County

TO THE

PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE

FOR THE QUARTER BEGINNING

(Month & Day) (Year)

(Month & Day) (Year)

Name of
Preparer: _____
Title: _____
Signature of Preparer: _____
Date: _____
Phone
Number: _____

I hereby attest that the information submitted in the reports herein is complete and accurate to the best of my knowledge. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates a termination of a Primary Contractor's contract with the Department of Public Welfare.

Additionally, I attest in accordance with 42 C.F.R. § 438.604 that the information listed in the attached charts has been reviewed and found to be complete, true and accurate to the best of my knowledge, information and belief and have been submitted in accordance with the agreement with the Department of Public Welfare. I understand that any knowing and willful false statement or representation on the attached data submission may be subject to prosecution under applicable state laws. In addition, any knowing and willful failure to fully and accurately disclose the requested information may result in termination of the agreement with the Department of Public Welfare.

Procedure Code Reference Chart

Proc. Code	Price Mod.	Info Modifier	Service Description	Units
90801	UB		Psychiatric diagnostic interview examination (Psychiatric Eval; Exam & Eval of Patient)	Occurrence
90804	UB		Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	30 min
90846	UB		Family Psychotherapy (without the patient present)	15 min
90847	UB		Family Psychotherapy (conjoint psychotherapy) w/ patient present	15 min
90853	UB		Group Psychotherapy (other than of a multiple-family group)	15 min
90862	UB		Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy (Psychiatric Clinic Med Visit for Drug Admin & Eval)	15 min
H0034			Medication training & support (Medication Mgmt Visit)	15 min
H0036	HB		Psychiatric Rehabilitation Services	1 hour
H0038			Certified Peer Specialist	15 min
S9484			Crisis Intervention Svc, MH Svcs (Crisis In-Home Support)	per hour

REPORT #11 COORDINATION OF BENEFITS FILE LAYOUT

Effective January 1, 2007

NAME: Unique to each plan – xxTPLCAMMYYYY.txt format, where:
 xx = two-letter county alpha code
 MM = two-digit month – 03, 06, 09 or 12
 YYYY = four-digit year

DESCRIPTION: A quarterly file provided by the MCOs to DPW containing select information to capture the MCO's activities involving third party resources. Each file contains three reports. Each report is separated into the types of claims that the service represents. Each report is also divided by resource type, Commercial and Medicare. Refer to the HCBH Financial Reporting Requirements document for further instructions.

Each Quarterly file is due 45 days after the end of the reporting period. Files are to be placed on DPW's server according to previously defined transfer method for each plan. Any questions regarding connectivity can be directed to Barb Wadlinger at 717-346-4332 or c-bwadling@state.pa.us.

FORMAT: ASCII
 Fixed Length
 Right justified, Zero-filled

REPORT #11, PART A RECORD - CLAIMS COST AVOIDED:**RECORD LENGTH:** 191

<i>Field Name</i>	<i>Record Position</i>	<i>Field Length</i>	<i>Alpha/Numeric</i>	<i>Special Instructions</i>
MCO Code	01-02	02	A	
Reporting Period	03-10	08	A	YYYYMMDD
Report Part	11	01	A	Constant "A"
Commercial I/P # claims w/COB	12-20	09	N	
Commercial I/P # claims denied	21-29	09	N	

Field Name	Record Position	Field Length	Alpha/ Numeric	Special Instructions
Commercial I/P # claims w/TPL Resource	30-38	09	N	
Commercial I/P % claims denied	39-47	09	N	
Filler – zero filled	48-56	09	N	
Commercial O/P – Professional # claims w/COB	57-65	09	N	
Commercial O/P – Professional # claims denied	66-74	09	N	
Commercial O/P – Professional # claims w/TPL resource	75-83	09	N	
Commercial O/P – Professional % claims denied	84-92	09	N	
Commercial Total active members w/TPL resource	93-101	09	N	
Medicare I/P # claims w/COB	102-110	09	N	
Medicare I/P # claims denied	111-119	09	N	
Medicare I/P # claims w/TPL resource	120-128	09	N	
Medicare I/P % claims denied	129-137	09	N	
Filler – zero filled	138-146	09	N	
Medicare O/P- Professional # claims w/COB	147-155	09	N	
Medicare O/P- Professional # claims denied	156-164	09	N	
Medicare O/P- Professional # claims w/TPL resource	165-173	09	N	

<i>Field Name</i>	<i>Record Position</i>	<i>Field Length</i>	<i>Alpha/ Numeric</i>	<i>Special Instructions</i>
Medicare O/P- Professional % claims denied	174-182	09	N	
Medicare Total active members w/TPL resource	183-191	09	N	

REPORT #11, PART B RECORD - PROVIDER REPORTED:

RECORD LENGTH: 191

<i>Field Name</i>	<i>Record Position</i>	<i>Field Length</i>	<i>Alpha/ Numeric</i>	<i>Special Instructions</i>
MCO Code	01-02	02	A	
Reporting Period	03-10	08	A	YYYYMMDD
Report Part	11	01	A	Constant "B"
Commercial I/P # claims	12-20	09	N	
Commercial I/P amount billed	21-29	09	N	
Commercial I/P amount reported	30-38	09	N	
Commercial O/P – Professional # claims	39-47	09	N	
Commercial O/P – Professional amount billed	48-56	09	N	
Commercial O/P – Professional amount reported	57-65	09	N	
Medicare I/P # claims	66-74	09	N	
Medicare I/P amount billed	75-83	09	N	

<i>Field Name</i>	<i>Record Position</i>	<i>Field Length</i>	<i>Alpha/ Numeric</i>	<i>Special Instructions</i>
Medicare I/P amount reported	84-92	09	N	
Medicare O/P- Professional # claims	93-101	09	N	
Medicare O/P- Professional amount billed	102-110	09	N	
Medicare O/P- Professional amount reported	111-119	09	N	
Filler	120-191	09	N	

REPORT #11, PART C RECORD - RECOVERED:

RECORD LENGTH: 191

<i>Field Name</i>	<i>Record Position</i>	<i>Field Length</i>	<i>Alpha/ Numeric</i>	<i>Special Instructions</i>
MCO Code	01-02	02	A	
Reporting Period	03-10	08	A	YYYYMMDD
Report Part	11	01	A	Constant "C"
Commercial I/P # claims	12-20	09	N	
Commercial I/P gross amount recovered	21-29	09	N	
Commercial I/P net \$ amount recovered by MCO	30-38	09	N	
Commercial O/P – Professional # claims	39-47	09	N	
Commercial O/P – Professional gross amount recovered	48-56	09	N	

<i>Field Name</i>	<i>Record Position</i>	<i>Field Length</i>	<i>Alpha/ Numeric</i>	<i>Special Instructions</i>
Commercial O/P – Professional net \$ amount recovered by MCO	57-65	09	N	
Medicare I/P # claims	66-74	09	N	
Medicare I/P gross amount recovered	75-83	09	N	
Medicare I/P net \$ amount recovered by MCO	84-92	09	N	
Medicare O/P- Professional # claims	93-101	09	N	
Medicare O/P- Professional gross amount recovered	102-110	09	N	
Medicare O/P- Professional net \$ amount recovered by MCO	111-119	09	N	
Filler	120-191	09	N	

Report #11, Part C Record - Common Text Area:

Record Length: 191

<i>Field Name</i>	<i>Record Position</i>	<i>Field Length</i>	<i>Alpha/ Numeric</i>	<i>Special Instructions</i>
MCO Code	01-02	02	A	
Reporting Period	03-10	08	A	YYYYMMDD
Report Part	11	01	A	Constant "T"
Common Text Line Number	12-13	02	A	Number each line of text beginning with 01
Description of Recovered amounts	14-191	178	A	

Revised 07/20/07

**HEALTHCHOICES BEHAVIORAL HEALTH
FINANCIAL REPORTING INSTRUCTIONS
FOR PRIMARY CONTRACTORS
COMMONWEALTH OF PENNSYLVANIA
OFFICE OF MENTAL HEALTH &
SUBSTANCE ABUSE SERVICES**

AUGUST 20, 2012

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Introduction

The Commonwealth of Pennsylvania, Department of Public Welfare (DPW), Office of Mental Health and Substance Abuse Services (OMHSAS) has implemented a new web-based financial reporting system (Financial System). The Financial System is a secure, web-based application which Behavioral Health HealthChoices Contractors and Behavioral Health Managed Care Organizations (BH-MCOs) will use to submit required financial and utilization data periodically. The automated system will include the following key features:

- Provides the ability for Contractors to upload Financial Reporting templates via an online submission process on a monthly, quarterly and annual basis.
- Allows Contractors to view and save actual reports previously submitted to the system.
- Allows Contractors to generate output reports based on the previous financial report submissions.
- Maintains a history of all file submissions and tracks all file uploads and upload attempts. Contractors will be able to view the status of each uploaded file.
- Validates various financial reporting data in real time and immediately notifies Contractors of receipt or rejection of Financial Reporting submissions. These will also be referred to as “edits” throughout this document.
- Provides a detailed error report for failed and successfully submitted reports for Contractors to keep for their records. The error reports also allow Contractors to understand the items that need to be corrected to achieve a successful submission, in the case of erroneous submissions.

This document outlines the general instructions for submitting Portable Document Format (PDF) and Excel-based monthly, quarterly and annual reports to the new Financial System. Unless specific instructions are provided, please follow the instructions set forth in the HealthChoices Behavioral Health Program Financial Reporting Requirements (FRR) for completing the required monthly, quarterly and annual reports, where applicable.

The Financial System website address is: <https://ereporting.mercer.com/OMHSAS/Login.aspx>

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General Overview and Requirements

The following section outlines the instructions for completing the required Excel-based Financial Reports 1 – 4, 6 – 9 and 12 and the timelines for submitting these reports.

Guidelines for Reporting

Excel-based Financial Reporting templates containing the raw data that DPW requires will be used to produce the financial reports. When uploading completed financial reports to the Financial System, each completed report template must be transmitted within the requested submission time period. Please refer to the Financial Reporting Requirements table in Section 2.0 of the FRR for the established time periods for submitting financial reports.

The heading of each report should contain the following fields:

Statement as of: This should be the month-, quarter- or year-end date for the report and should be entered using the MM/DD/YYYY format.

Primary Contractor: This should be the name of the Contractor for which the report is applicable and can be selected from the drop down box in each Financial Reporting template.

Reported By: This should be the entity that collected the data and compiled the report. In instances where a report contains data from more than one entity, this field should name the primary contractor. Refer to Appendix A for a list of Financial Reporting Entity ID numbers required for each report. Contractors are to enter the Financial Reporting ID, including the leading zeros, followed by the organization name.

Line titles and columnar headings of the reports are, in general, self explanatory and therefore do not constitute instructions. Specific instructions are provided for items about which there may be some question as to the content. Any entry for which no specific instructions are included should be made in accordance with sound accounting principles and in a manner consistent with related items covered by specific instructions.

To ensure values tie across reports, OMHSAS has designed the Financial Reporting templates to automatically populate certain cells. Contractors will see several cells with blue shading throughout the templates. This shading is applied to cells that contain formulas and will be automatically populated based on data reported in non-highlighted cells of each report. Column headers and standard fields in each template have also been locked and protected to ensure consistent reporting by all Contractors. Other than the white cells within the body of the report for each template, the following sections are unprotected for Contractors to use at their discretion, shown in Excel coordinates:

Monthly

- Report #6 – Columns I:GG
- Report #7 – Columns AC:GG and all gray cells between columns C:Z
- Reports #6, 7 Notes – Columns D:GG
- Reports #8A and 8B – Columns Q:GG
- Report #8C – Columns G:GG
- Reports #8, 12 Notes – Columns E:GG
- Report #12 Year Tabs – Columns CC:IT

Quarterly

- Report #1 – Columns P:GG
- Report #1 Notes – Columns D:GG
- Reports #2, 3, 9 Notes – Columns H:GG

Quarterly and Annual

- Report #2 – Columns J:GG and all gray cells between columns B:H
- Report #3 – Columns J:GG and all gray cells between columns B:H
- Report #4 (Entity #1 – 3) – Columns H:GG
- Report #4 (Entity #1 – 3) Notes – Columns D:GG
- Report #9A – Columns J:GG, and all gray cells between columns B:H
- Report #9B – Columns F:GG and all gray cells between columns B:D

Annual

- Reports #2, 3, 9 Notes – Columns D:GG

NOTE: If data are present in the unprotected cells of a submitted report, they will transfer to the user generated output report. Ideally, it is preferred that users delete this information prior to report submission, but it is understood that cells in the actual report range may depend on it. However, since this information is outside the print range, it will not be visible on printed output reports.

Rounding

The report templates are formatted to round non-per member per month (PMPM) values. Therefore, amounts can be entered with decimals or rounded to the nearest dollar, except for PMPM amounts which should include two decimal places. **IMPORTANT:** When rounding or truncating numbers, do not perform rounding or truncation until arriving at the final amount. (Example: If calculation is $1.5892 \times 2.059 = 3.272163$, report final amount as 3.27; not $1.59 \times 2.06 = 3.28$.)

Other Supporting Information

Below are additional features and requirements of the Excel-based financial reports. This information will assist in Contractors achieving successful submission to the Financial System.

Features

- Report magnification can be adjusted by selecting View > Zoom from the Excel menu.
- Cells are formatted to autofit and wrap text within each cell, but users have the ability to manually adjust row and column sizes as necessary.
- The font and text size are pre-defined, so there is no need for user adjustments.
- The “Freeze panes” feature is enabled in every report.
- Report templates can be saved and uploaded in .xls and .xlsx versions of Excel. Refer to Section 4 for more information.
- Users can link and formulate unprotected cells within the templates at their discretion for ease of reporting. For example, Report #1 can be referenced within the Quarterly report template to populate Member Months in Report #9.

NOTE: Linked data in completed reports **do not** have to be value pasted prior to submitting to the system. Enhancements have been made to allow data to be linked between tabs in the templates, outside the body of the report or from external files. In addition, calculations within the body of the report can remain as formulated and do not need to be value pasted prior to submission.

Requirements

- All cells within the report templates need to be populated with the appropriate values outlined in Section 3 below and no cells can be left blank (except Report #12).
- If a Contractor chooses to paste data directly into the report templates, this data needs to be value pasted to maintain consistent formatting between the reports. For example, after copying a value, select the destination in the template and go to Edit > Paste Special > Values from the Excel menu.
- Additional rows, columns and tabs should not be added to the report templates.

Initial Reporting Requirements

Below are the financial reports and corresponding reporting periods the Contractors must submit as part of the initial submission of January 2012 and July 2012 monthly reports for the Calendar Year (CY) and State Fiscal Year (SFY) Contractors, respectively. Please refer to the Financial Reporting Requirements table in Section 2.0 of the FRR for the established time periods for submitting the subsequent Quarterly and Annual reports. The Financial System will be open for initial submissions from 3/1/2012 to 3/20/2012 for the CY zones and 9/1/2012 to 9/20/2012 for the SFY zones. All reports must be submitted on or before the indicated deadlines. Note that some Contractors may be required to submit additional monthly reports outside those listed in the chart below. Please refer to Section 3 and the FRR for more details.

Zone	Data Time Period	Type of Submission	Report #s	Deadline for Submission to OMHSAS Website
CY	January 2012	Monthly	6	March 20, 2012
			7	
			8A, 8B, 8C	
			12	
SFY	July 2012	Monthly	6	September 20, 2012
			7	
			8A, 8B, 8C	
			12	

3

Overview of the Financial Reports

Below is a summary of the monthly, quarterly and annual Excel-based and PDF files Contractors are required to complete and submit to the Financial System. Each report in the Excel-based template below has its own tab followed by its respective Notes Tab.

Quarterly

- Report #1

Quarterly and Annual

- Report #2
- Report #3
- Report #4 (Entity #1)
- Report #4 (Entity #2)
- Report #4 (Entity #3)
- Report #9A
- Report #9B

Monthly

- Report #6
- Report #7 (one for each Category of Service and Total)
- Report #8A
- Report #8B
- Report #8C
- Report #12

Additional Financial Reports

Some Contractors are required to submit Additional Financial Reports (Additional reports) electronically. These reports are not required to be completed using a standard template; however, they must be submitted to the Financial System in PDF format using the correct file naming convention (see Section 5 for more information on file naming conventions).

Please refer to the Financial Reporting Requirements table in Section 2.0 and Attachment D in the FRR for further details. The Additional reports include, but are not limited to those listed below. A complete listing of the Additional reports to date and their corresponding Report Group Designations for the file name can be found in Table 3 of Appendix B:

- Actual Reinsurance Experience
- Actuarial Certification of Claims Liability (CY Counties)
- Actuarial Certification of Claims Liability (SFY Counties)
- Balance Sheet
- Contract Reserves Compliance Report
- Equity Reserve Bank Statement
- Estimated Reinsurance Experience
- General Account Bank Statement
- Parental Guaranty Quarterly Monitoring Report
- Physician Incentive Arrangement
- Reinsurance Waiver Report > \$75,000
- Reinvestment Bank Statement
- Risk & Contingency Bank Statement
- Reports #13, #14, #15 (Primary Contractor)
- Reports #13, #14, #15 (Subcontractor)
- Annual Audited Financial Statements (DOI) - Statutory Basis

- Audited County General Purpose Financial Statements (CAFR)
- Entity Wide Audit (Primary Contractor)
- Entity Wide Audit (Subcontractor)
- Insurance Department Annual Filing
- Insurance Department Quarterly Filing

Instructions for Completing the Financial Reports

The remainder of this section contains detailed instructions for completing the above reports, where applicable.

Report #1 – Enrollment Table

This tab is pre-populated with zero values in the financial reporting template. Contractors are to update this report for all months through the current reporting period with numeric values, leaving all other cells populated with zeros.

For additional descriptions and instruction, please consult the FRR.

Report #2 – Primary Contractor Summary of Transactions

All fields in this report are required and should be completed using numeric values. For additional descriptions and instruction, please consult the FRR.

Report #3 – Subcontractor Summary of Transactions

All fields in this report are required and should be completed using numeric values. For additional descriptions and instruction, please consult the FRR.

Report #4 (Entity 1 – 3) – Related Party Transactions and Obligations

These tabs are pre-populated with “N/A” and zero values, where applicable. Contractors are to overwrite these values as necessary, leaving all other cells with their pre-populated values. This report is to be completed assuming Entity #1 is the Primary Contractor, Entity #2 is the Subcontractor and Entity #3 is the Management Corporation.

The “Name & Address of Related Party/Affiliate”, “Description of Relationship or Affiliation” and “Tran. Code” fields should be completed in text format. When completing the “Name & Address of Related Party/Affiliate” field, please enter the name, street address, city, state and zip code in one cell separated by commas.

The remaining fields should be completed using numeric values. For additional descriptions and instruction, please consult the FRR.

Report #6 – Claims Payable (RBUCs and IBNRs)

All fields in this report are required and should be completed using numeric values. For additional descriptions and instruction, please consult the FRR.

Report #7 – Lag Reports

All COS tabs are pre-populated with zero values. Contractors are only required to update the values for the month(s) that are being reported with numeric values, leaving all other cells populated with zeros. Although not required, the Contractors may complete the report in its entirety. A user generated Report #7 output report will be available for print or download (See “Output Reports” below for more information). For additional descriptions and instruction, please consult the FRR.

Reports #8A, #8B and #8C – Claims Processing Report

Part A and B

All fields in this report are required and should be completed using numeric values. Note that "Month #1" in column A should tie to the month for the reporting period in the "Statement as of:" date. Months #2 - #12 should reflect the previous 11 months from the "Statement as of:" date. For additional descriptions and instruction, please consult the FRR.

Part C

These tabs are pre-populated with “N/A” and zero values, where applicable. Contractors are to overwrite these values as necessary, leaving all other cells with their pre-populated values.

Complete the “Date Claim Received” field using the MM/DD/YYYY date format. The “Claim Reference #”, “Provider

#” and “Provider Name” fields should be completed in text format. The “Service Type” and “Amount” fields should be completed using numeric values.

Rows 207 – 806, 1009 – 1608 and 1811 – 2410 are hidden in the 8C Tab. If there are not enough rows to fully complete the report, users can unhide these rows at their discretion.

Reports #9A and #9B – Analysis of Revenues and Expenses

Part A

All fields in this report are required and should be completed using numeric values. For additional descriptions and instruction, please consult the FRR.

Part B

This tab is for Contractors’ internal documentation. Users should feel free to submit their Quarterly and Annual reports with or without completing this report. A user generated Report #9B output report will be available for print or download (See “Output Reports” below for more information).

Report #12 – Reinvestment Report

This template includes a tab for each Reinvestment Fund Year (1999 – YTD). Within each tab are separate reports for each of the following rating groups:

1. TANF
2. Healthy Beginnings
3. SSI & Healthy Horizons w/ Medicare
4. SSI & Healthy Horizons w/o Medicare
5. Federal GA
6. GA CNO (all age groups combined)
7. GA MNO
8. Other (non-HealthChoices recipients or non-identifiable recipients)
9. Total (total of the eight categories above)

Note that the “Statement as of:”, “Primary Contractor:” and “Reported By:” Lines at the top of each tab will be populated based on what is entered in the “2011” Tab.

Rows 40 – 74 in each Reinvestment Fund Year tab are hidden and can be expanded if more lines are needed to complete the report. In addition, the Report #12 template includes an “Input” Tab for the Contractors to use at their discretion for completing the report. For example, Contractors can use the “Input” Tab as a data entry sheet to link to the other tabs.

Where applicable, please complete the “Unduplicated Recipients”, “Current Period” units and dollars and “Budget Amount” dollars for the “Allocations/contributions” (Line 2), “Investment/interest income” (Line 3) and “Approved distributions for Reinvestment Services” being reported for each applicable year and rating group. For additional descriptions and instruction, please consult the FRR.

The Approved Reinvestment Services being reported should be in text format. All other fields should be numeric values. A user generated Report #12 output report will be available for print or download (See “Output Reports” below for more information). For additional descriptions and instruction, please consult the FRR.

Notes Tabs

Each report above has a corresponding “Notes” Tab. Rows are hidden in the following reports and Contractors can expand these rows at their discretion:

Monthly

- Reports #6, 7 – Rows 28 – 60
- Report #8 – Rows 44 – 60

Quarterly and Annual

- Reports #1, 4 (Entity #1 – 3) – Rows 28 – 60
- Reports #2, 3 – Rows 28 – 49, 71 – 80

NOTE: Please complete the Notes Tabs as you normally would. Keep in mind the following guidelines:

- "Other Admin" only needs to be reported for Reports #2 and 3.
- Additional notes for Reports #2 and 3 can be entered in rows 51 – 80 below the "Other Admin Total".
- Excel rows 3 – 39 in the Report #9 Notes Tab are pre-populated with common Other Medical procedure codes. Contractors should input the corresponding values, where applicable. Rows 40 – 49 are placeholders for Contractors to enter additional Other Medical procedure codes as necessary. Additional notes should be entered beneath the total line in Excel row 50.
- Quarterly Reports #2, 3 and 9 Notes Tabs should include values for all quarters leading up to the reporting period. For example, if submitting the Q3 2012 reports, the Reports #2, 3 and 9 Notes Tabs should include values in the "1st Qtr", "2nd Qtr" and "3rd Qtr" columns.

4

Web-based Access

This section includes information on how to access the financial report templates and website along with considerations for users with different versions of Excel. This section also includes technical advice to make it easier for users to navigate the Financial System website.

The website address where completed submissions are uploaded were provided during the web-based training on February 16th, 2012. OMHSAS will send User Name and Password information to Contractors via email.

Accessing the Financial Report Templates and Website

OMHSAS will send the Microsoft Excel-based Financial Report templates to the Contractors via email. Users with Excel 2003, 2007 or 2010 will be able to access and use the Financial Report templates.

Contractors can verify their version of Excel by clicking on the “Help” button and then the “About Microsoft Office Excel” selection. This shows the version that is currently installed on the computer. If you need the Financial Report templates in a version of Excel prior to 2003, please submit a request to Kimberly Butsch at kbutsch@pa.gov.

Considerations for Excel 2007 or 2010 Users

There have been interaction issues between Excel 2003 and Excel 2007/2010. If the Contractor repeatedly switches back and forth between using Excel 2003 and Excel 2007/2010, the Contractor may experience file corruption issues. If possible, OMHSAS recommends the Contractor only use Excel 2003 when completing the Financial Reports. In cases where the Contractor only has access to Excel 2007 or Excel 2010, OMHSAS recommends the Contractor work in one of those versions the entire time. Contractors who do switch back and forth between Excel 2003 and Excel 2007/2010 may see that Excel adds an extra tab to the Financial Report template files listing potential errors that occurred in the conversion. In this case, the Contractor will need to delete the extra tab prior to uploading the file to the automated website or the Financial Report file will be rejected.

Lastly, Excel 2007 and Excel 2010 may cause the Financial Report file size to grow. This increased file size will contribute to longer upload times.

Additional IT Tips for Using the Financial Report Website

Internet Connectivity

A high-speed internet connection is required to download or upload the Financial Report templates. Using a dial-up modem will likely result in the action timing out before the entire file has been downloaded to your computer or before the entire file is uploaded to the website. Contractors that have a dial-up modem should submit an email to Kimberly Butsch (kbutsch@pa.gov) indicating that they have dial-up internet connectivity and need assistance in obtaining the Financial Report templates and in submitting their completed Financial Reports.

Internet Browser

It is recommended that you use a current version of an internet browser to upload your completed Financial Reports. The most commonly used browsers include Internet Explorer and Firefox. It is recommended that you use Internet Explorer Version 6.0 or higher and Firefox Version 2.3 or higher.

Pop-up Windows

Pop-up windows must be enabled to see error messages or submission confirmation reports. If you are not seeing these types of items upon upload, then pop-ups may be blocked on your computer. Please follow these steps to enable them:

- **Internet Explorer**
 - Open Internet Explorer
 - Click on Tools
 - Click on the Internet Options
 - Click on Pop-up Blocker
 - Click on Turn Off Pop-up Blocker

- Click on Yes when prompted to turn off Internet Explorer's pop-up blocker
- **Firefox**
 - Open Firefox
 - Click on Tools
 - Select Options
 - Select Content
 - Uncheck Block Pop-up Windows

Internet Cookies

Internet Cookies must be accepted in order for the Financial Report upload processes to work correctly. To enable Internet Cookies please follow these steps:

- **Internet Explorer**
 - Open Internet Explorer
 - Click on Tools
 - Click on Privacy
 - Click Settings bar level to Low
 - Click on Apply
- **Firefox**
 - Open Firefox
 - Click on Tools
 - Select Options
 - Select Privacy
 - Check Accept Cookies from Sites
 - Click on OK

Macintosh Computers

There may be issues with the Excel Financial Report templates not being fully functional on a Macintosh computer. OMHSAS recommends Macintosh computers not be used for work related to the Financial Report templates.

5

Submission Process

This section provides detailed information regarding the process Contractors should follow to successfully complete and upload the Financial Reports. Topics covered include: file naming conventions that must be used to ensure that submissions are not rejected upon upload, submission process, erroneous submissions, prior year adjustments, generic submission, generating output reports, generating trend charts and downloading previously submitted files.

File Naming Conventions

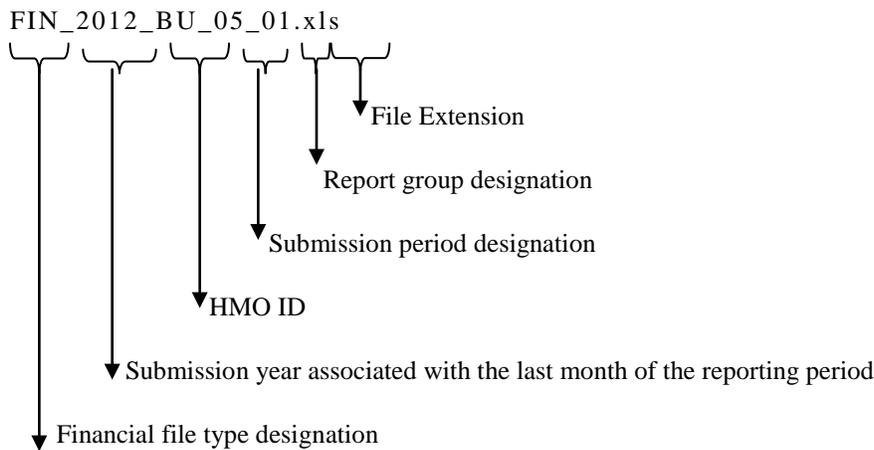
Each file that a Contractor uploads to the Financial System must conform to specific naming conventions. Any files that do not exactly follow the naming conventions will be rejected in the real-time edit process and will require resubmission. See below for information on a File Naming Convention tool available on the website that is designed to automatically generate file names based on criteria entered by the Contractor. The components of the Financial System file naming conventions are as follows:

Character #	Description
1 – 3	File type designation (e.g., FIN = Financial and Additional Reports or CER = Data Certification)
4	_ (underscore)
5 – 8	Four-digit submission year (year associated with the final month of the submission period)
9	_ (underscore)
10 – 11	Two-character HMO ID (see Appendix B Table 1)
12	_ (underscore)
13 – 14	Two-character submission period designation (see Appendix B Table 2a and 2b)
15	_ (underscore)
16 – 17	Two- or three-character upload report group designation (see Appendix B Table 3)
Suffix	Standard Excel file suffix for financial and PDF suffix for data certification and Additional Reports

Example: Bucks County May 2012 submission of financial Reports # 6 – 8C

File name example: FIN_2012_BU_05_01.xls

NOTE : This example is also located in Appendix B.



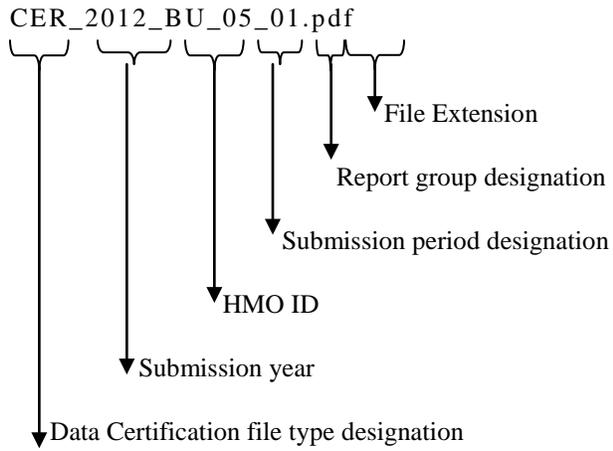
All Financial Report submissions must be based on the **OMHSAS Excel-based financial report templates** and must contain “FIN” at the beginning of the file name to be recognized as a valid and successful submission. The **Additional reports**, submitted in PDF format, must also contain “FIN” at the beginning of the file, but do not need to be based on a standard template. The Additional reports are not subject to critical or non-critical edits (see “Instructions for Uploading Files” below), but do need to follow the proper file naming conventions.

In addition, Financial and Additional report files cannot be zipped prior to upload. If these reports are uploaded as a zip file (file extension is .zip), the file will be rejected. If the Contractor’s completed Financial and Additional report files are very large in size, and the Contractor is experiencing significantly slow upload durations, the Contractor should submit a question to Kimberly Butsch at kbutsch@pa.gov.

File names for submitting resubmissions due to failed edits must match the file name of the original submission. For example: a Contractor originally submits its May 2012 Monthly Reports # 6 – 8C and the file is rejected because it did not pass the real-time edits process. Upon fixing the errors, the Contractor would upload its resubmission with the same naming convention that was originally used. The electronic date stamp will be used to identify the most current version when multiple versions are submitted by the same Contractor.

Signed non-actuarial **Data Certifications of Reports 1 – 4, 6 – 9 and 12** should be uploaded through the financial submission process as PDF documents after the financial reports have been successfully submitted. As with Additional reports, these documents are not subject to critical or non-critical edits, but do need to follow the proper naming conventions. The data certification file name should mirror the Financial Report submission for which it is being submitted with “CER” instead of “FIN” as the file type designation.

Example: Data Certification for the Bucks County May 2012 submission of financial report # 6 – 8C
File name example: CER_2012_BU_05_01.pdf



File Naming Conventions Tool

To ensure that all financial files submitted to the Financial System adhere to the correct naming convention, a file naming convention tool is available for download on the Financial System website. This tool is located the *Financial File Submission* screen of the Financial System, and will allow Contractors to select HMO ID, Submission Type, Final Month of the Year, Report Type and Financial Report from **drop-down boxes** and **manually enter the Reporting Year** to aid in generating the appropriate file name for a successful financial report submission.

Financial File Submission

Welcome

Welcome to the PA OMHSAS Financial File Submission page. This screen is used to submit financial reports and notes. The dashboard below displays the status of each file needed to make a complete financial report submission.

To submit a file, please follow the steps below:

Step 1) Click the "Browse" button and select the file to upload from your computer or network. Make sure the file follows the required naming convention. Once you have selected the file to submit and clicked "Open" in the dialog box, press the "Submit File" button.

File naming convention details can be found by clicking [here](#). For assistance with naming the files you are submitting, you can access a [Financial File Naming Tool](#) by clicking [here](#).

Step 2) Once the upload process is completed, you will have the opportunity to review the "Submission Edit Results" report. This report will identify whether your submitted file contains Critical Errors, Structural Errors, Non-Critical Errors or No Errors and can be viewed by clicking on the following links:

Financial File Naming Tool:

A	B	C	D
Step #	Reporting Components	Details	Entity
1	HMO ID		
2	Submission Type		
3	Final Month of the Year		Reporting Year Note:
4	Reporting Year (YYYY)		
5	Report Type		
6	Financial Report		
7	Press Button To Generate File Name	Generate File Name	Clear Contents
8	File Name to Export		
Instructions:			
-Select criteria for the file being submitted from drop-downs in column C for steps 1 - 3 and 5 - 6.			
-Manually enter the Reporting Year in step 4 in YYYY format. Please read the "Reporting Year Note:" in column D prior to completing this step.			
-Once steps 1 - 6 are complete, press "Generate File Name" button in step 7, column C.			
-The file name generated in step 8 can be copied and pasted as needed, when naming files for submission to the OMHSAS Financial System Website.			

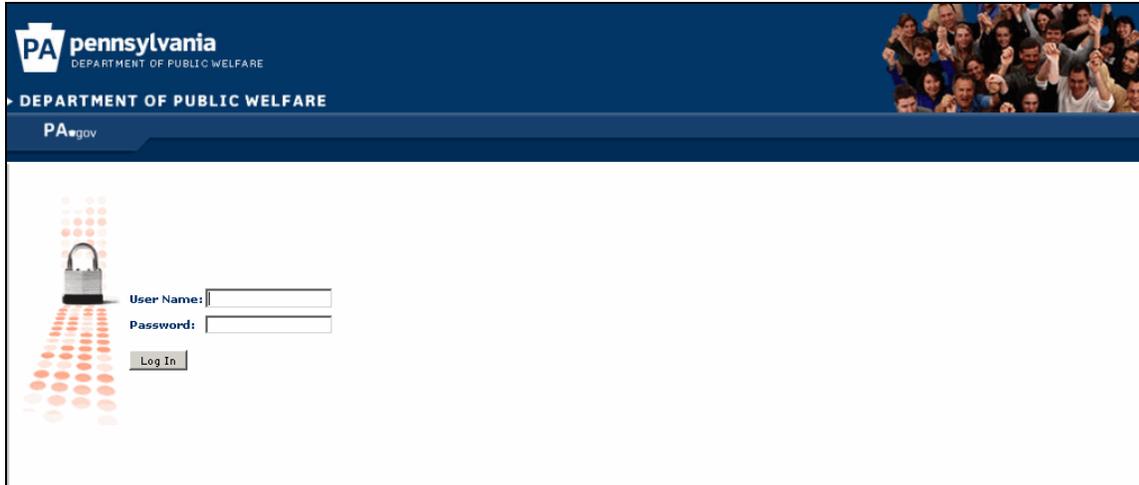
Once all six lines are completed, the Contractor will push the button on Line 7 (“Press Button to Generate File Name”) to run the macro that will output the final file naming convention on Line 8 (“File Name to Export”). The file name generated on Line 8 can be used to name the Contractor’s file prior to submission. **Please note that the file extension .xls and .pdf are included in the file name to indicate if the file needs to be submitted as a valid Excel file or as a PDF file.**

NOTE: If you do not use this as a resource, it is still important to check your file name against this tool since the Financial System naming convention is programmed on a CY basis. That is, if a SFY Contractor, Perry County for example, submits Quarterly Report #1 – 4 and 9A for October – December 2012 (Q2 of SFY 2012-2013), the file name is FIN_2012_PE_Q4_03.xls, not FIN_2012_PE_Q2_03.xls.

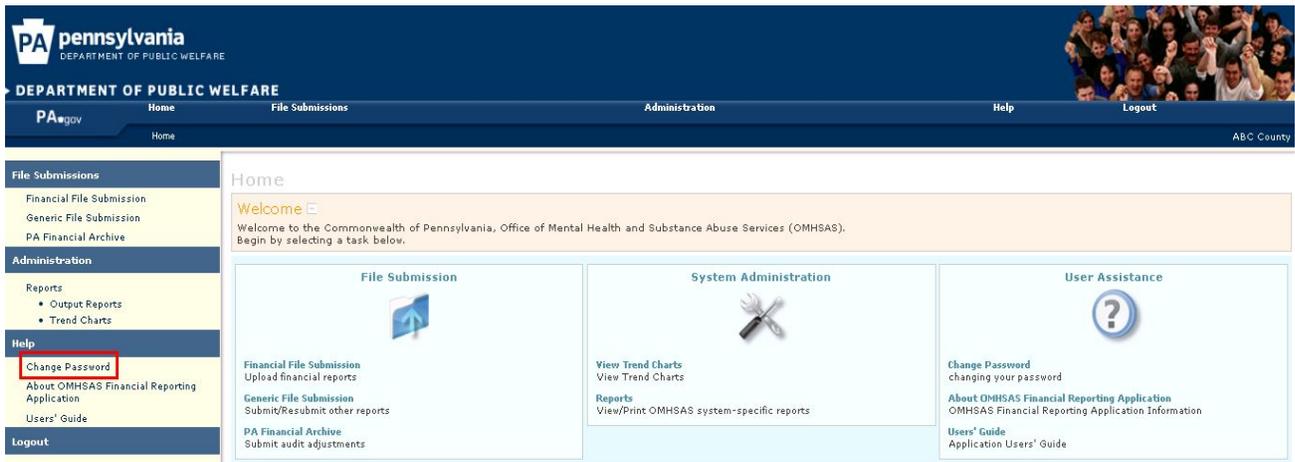
Instructions for Uploading Files

Upon naming all files in accordance with the file-naming conventions, Contractors should complete the following steps to successfully upload the Financial Reports templates to the website:

Step 1: OMHSAS will send User Name and Password information to Contractors via email. Upon arriving at the website's home page (see screen shot below), the Contractor should use their user account information to log into the website (<https://ereporting.mercer.com/OMHSAS/Login.aspx>).



Step 2: Once logged in, the user will arrive at the Contractor's Home page. It is optional for the user to change their password. To do so click on the "Change Password" link under "Help" on the left side of the screen.



Step 3: Click the “*Financial File Submission*” link on the left side of the screen to proceed to the file submissions page. This is the screen where Contractors submit their Financial Reports. Included in the Welcome section are step by step instructions for submitting Financial Reports. These instructions can be viewed or hidden using the +/- button next to Welcome.

Financial File Submission

Welcome

Welcome to the PA OMHSAS Financial File Submission page. This screen is used to submit financial reports and notes. The dashboard below displays the status of each file needed to make a complete financial report submission.

To submit a file, please follow the steps below:

Step 1) Click the "Browse" button and select the file to upload from your computer or network. Make sure the file follows the required naming convention. Once you have selected the file to submit and clicked "Open" in the dialog box, press the "Submit File" button.

File naming convention details can be found by clicking [here](#). For assistance with naming the files you are submitting, you can access a **Financial File Naming Tool** by clicking [here](#).

Step 2) Once the upload process is completed, you will have the opportunity to review the "Submission Edit Results" report. This report will identify whether your submitted file contains Critical Errors, Structural Errors, Non-Critical Errors or No Errors and can be viewed by clicking on the following links:

- **CRITICAL ERRORS:**
You will receive the message "Critical errors encountered, Click here to see a detailed list of errors." Click this link to view a description of the errors. All of these errors must be corrected and the file resubmitted to the website, beginning with Step 1.
- **STRUCTURAL ERRORS:**
You will receive the message "Structural errors encountered, Click here to see a detailed list of errors." Click this link to view a description the errors. All of these errors must be corrected and the file resubmitted to the website, beginning with Step 1.
- **NON-CRITICAL ERRORS or NO ERRORS:**
You will receive the message "All edits have passed. You may have encountered some non-critical errors. Please review the submission report before submitting the file" followed by the link "Click here to view/print a submission upload report." Click on this link to view a description of the errors. If you would like to correct these errors before submitting your file, please click the 'No' button next to the question "Are you sure you want to submit?" and then proceed back to Step 1. If your file does not have errors or you want to submit the file as is, proceed to Step 3.

Step 3) Once you are ready to submit your file, click the "Yes" button next to "Are you sure you want to submit?" you will receive the message "File uploaded successfully" followed by the link "Click here to view/print a submission confirmation report." Click this link and print the submission report for your records.

Please note that this screen should only be used to upload financial report related documents.

Step 4: Upon arriving at the *Financial File Submission* screen, click “Browse” to locate the financial report to upload. Once located, select the file from your computer’s directory and click “Open”. Note that the step by step instructions are hidden in the screenshot below.

Financial File Submission

Welcome

Only OMHSAS financial documents may be s

Show/Hide Naming Convention Details

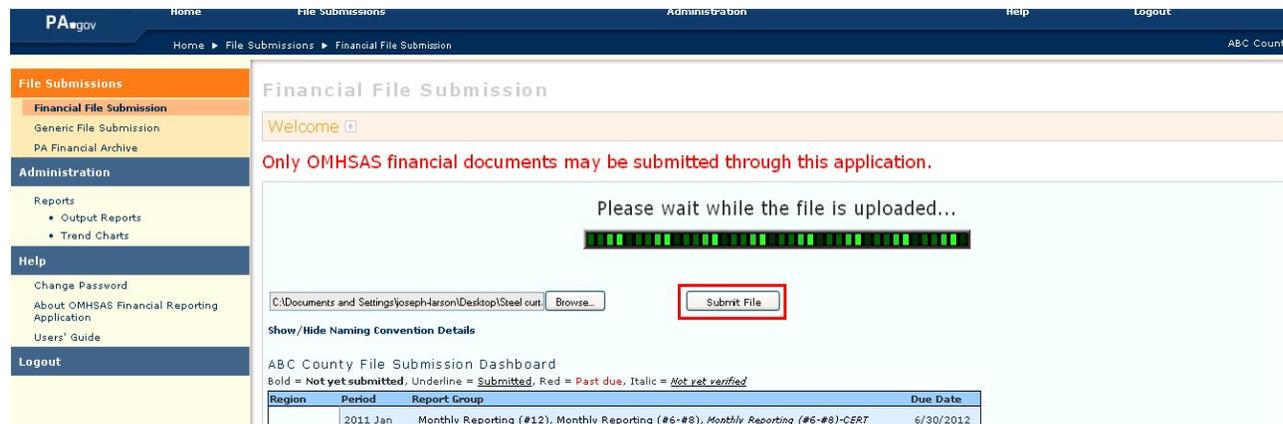
ABC County File Submission Dashboard

Bold = Not yet submitted, Underline = Submitted, Red = Past due, It

Region	Period	Report Group	Monthly Report
2011 Jan	Monthly Reporting (#12)	Monthly Report	
2011 Feb	Monthly Reporting (#12)	Monthly Report	
2011 Mar	Monthly Reporting (#12)	Monthly Report	

File Upload dialog: Look in: 1 Clean. File name: FIN_2011_AB_AN_04.xls. Files of type: All Files.

Step 5: Upon opening the file, click “Submit File” to initiate the upload process. You will see the following wait message while the file is processing.

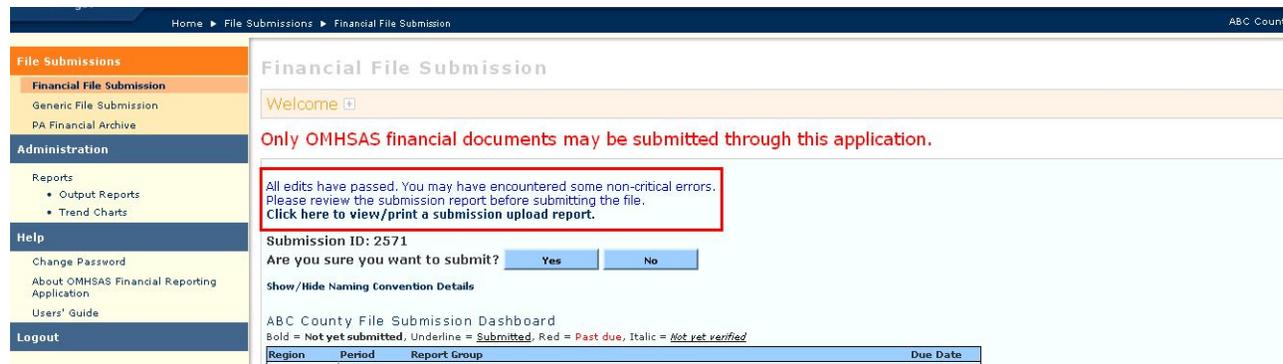


NOTE: After the file is uploaded, the user will receive one of four results:

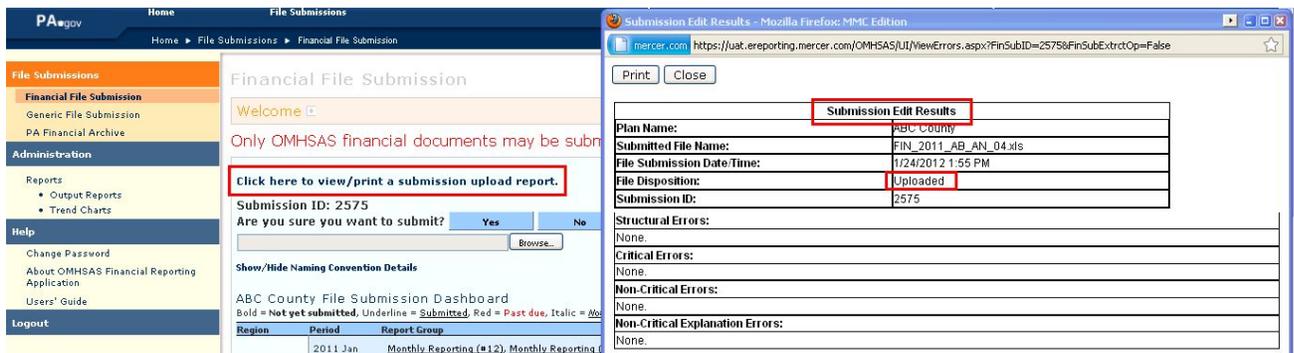
1. The report has passed the real-time edit process and the file has uploaded successfully (see Steps 6 and 7).
2. The report has encountered **Non-Critical Errors**, but can still be uploaded successfully.
3. The report contains **Structural Errors** and needs to be fixed for a successful upload.
4. The report contains **Critical Errors** and needs to be fixed for a successful upload.

For more details regarding the errors in 2 – 4 above, please see the “Erroneous Submissions” section starting on page 22.

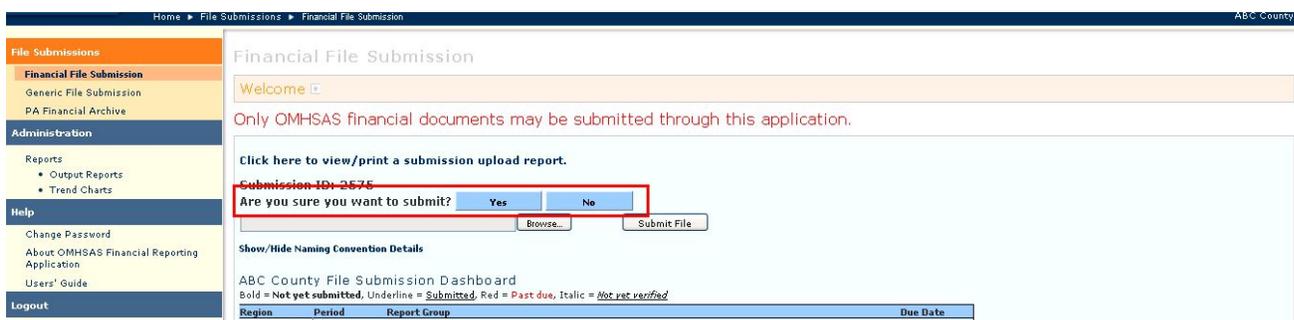
Step 6: Below is the message the user will receive for result #s 1 and 2 noted above. This means the submitted file is either free from errors or contains Non-Critical errors.



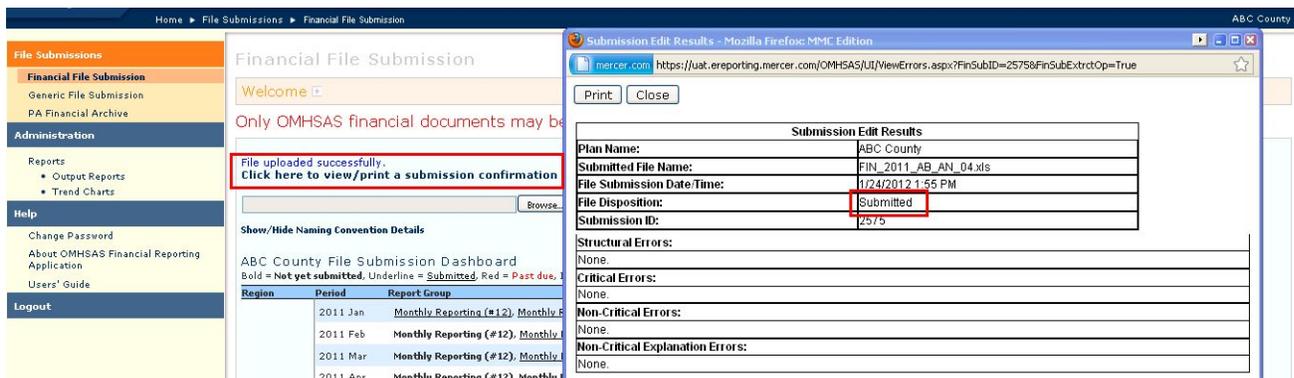
Step 7: Below is the output from selecting the “Click here to view/print a submission upload report” link. Contractors have the option to print the Submission Edit Results and are urged to review this report for accuracy of the submission. **Note that the file has been uploaded, but not yet submitted to the system.**



To complete the submission process, Contractors must confirm they would like to submit the successfully uploaded file.



Below is the result of selecting “Yes” after the prompt “Are you sure you want to submit?” As you can see, the Submission Edits Results indicate that the file has been submitted to the system.



Erroneous Submissions – Non-Critical Errors

Non-Critical Errors occur when a user submits a financial report containing values that disagree with formulas or relationships based on the DPW’s Math Edits. Reports containing Non-Critical Errors will not cause a report submission to be rejected. However, Contractors are urged to review Non-Critical error reports before submitting a file containing these errors. Below are the two types of Edits that would trigger Non-Critical Errors.

Non-Critical Edits:

- **Math Warnings** — Some cells are expected to be greater than, less than or equal zero (e.g., Report #2, Reinvestment (Line 5), must be zero).
- **Comparison Errors** — The relationship between certain cells must be appropriate (e.g., Report #9 Capitation Revenue (Line 1) must be within \$20 of Report #2: Capitation Revenue (Line 2a)).

Below are the Submission Edit Results for a submitted financial report containing Non-Critical errors. The edit results identify the report number, cell coordinates, cell values and a description of the edits that are failing. This allows the user to quickly locate and correct the errors.

The screenshot shows a web browser window displaying the 'Submission Edit Results' page. The page is titled 'Submission Edit Results - Mozilla Firefox: MMC Edition' and has a URL of 'https://uat.ereporting.mercer.com/OMHSAS/UI/ViewErrors.aspx?FinSubID=2577&FinSubExtrctOp=False'. The page contains a table with the following information:

Plan Name:	ABC County
Submitted File Name:	FIN_2011_AB_AN_04.xls
File Submission Date/Time:	1/24/2012 2:32 PM
File Disposition:	Uploaded
Submission ID:	2577

Below the table, there is a section titled 'Non-Critical Errors' with the following text:

Sheet(Annual Report #2), Cell(E7) has wrong value(6007500) or Sheet(Annual Report #9A), Cell(E10) has wrong value(7955816) (-1948316) <==== Error - Rpt 2: SSI & Healthy Horizons w/o Medicare Cap Rev (Line 2a) must be within \$20 of Rpt 9A: SSI & Healthy Horizons w/o Medicare Cap Rev (Line 1)

Sheet(Annual Report #2), Cell(B7) has wrong value(400000) or Sheet(Annual Report #9A), Cell(B10) has wrong value(3935226) (-3535226) <==== Error - Rpt 2: TANF Cap Rev (Line 2a) must be within \$20 of Rpt 9A: TANF Cap Rev (Line 1)

Sheet(Annual Report #9A), Cell(B12) has wrong value(300000) (L: 300000 = R: 0) <==== Warning - Rpt 9A: TANF Other Revenue (Line 3) must equal \$0

Sheet(Annual Report #2), Cell(G7) has wrong value(456694) or Sheet(Annual Report #2), Cell(I7) has wrong value(8414097) or Sheet(Annual Report #2), Cell(G20) has wrong value(23413651412301) (1525.8885284150206) <==== Error - Rpt 2:

If the Contractor determines the data is correct, the user can proceed to upload the report by clicking “Yes” after the “Are you sure you want to submit?” or click “No” to reject the submission and go to Step 4 to resubmit a revised report.

Erroneous Submissions – Structural and Critical Errors

Structural and Critical Errors will cause a submitted report to be rejected. The user will need to fix reports with these types of errors in order to successfully upload a file. Below are the types of Edits that would trigger Structural or Critical Errors (see below for examples).

Structural Edits:

- If a file does not follow the file naming conventions, it will be rejected immediately. The error message will indicate the improper name used.
- Tab names cannot be changed, and tabs cannot be added or deleted, as these items will cause the submission to be rejected.
- Each cell in the financial template has been programmed to only accept specific data types: text, decimal, whole number or date.
 - Note: if the data type is decimal, a decimal point is not required but is allowed.

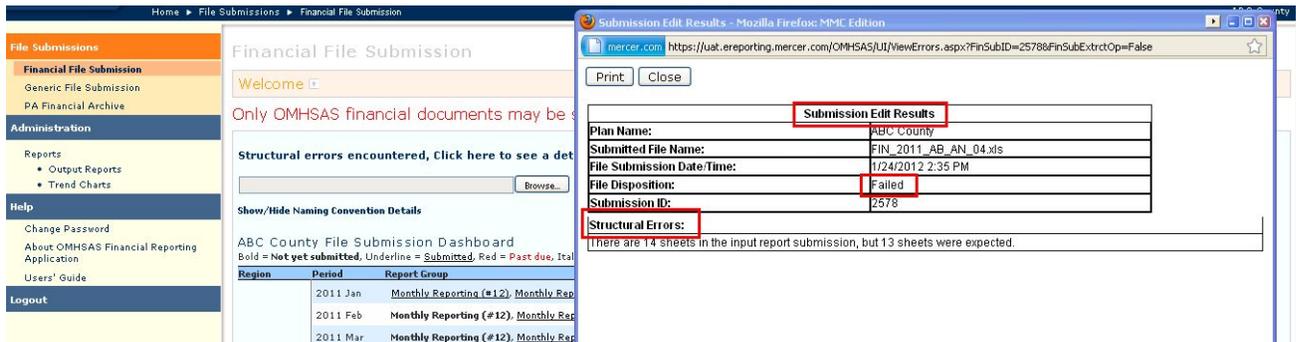
Structural error messages provide the tab, row and column of the Excel spreadsheet where the data type error is present; detailed descriptions are provided for the remaining Structural errors.

Users will receive the following message if Structural errors are identified in the submitted report.



Below is the detailed error report generated by selecting, “Structural errors encountered, Click here to see a detailed list of errors”. These errors need to be corrected for the file to pass all edits and be successfully uploaded to the site.

In this example, the user added an extra tab to the report template in the uploaded file.



Once the user corrects the errors identified in the detailed error report, they will need to resubmit the report until all Structural edits have passed (starting from Step 4).

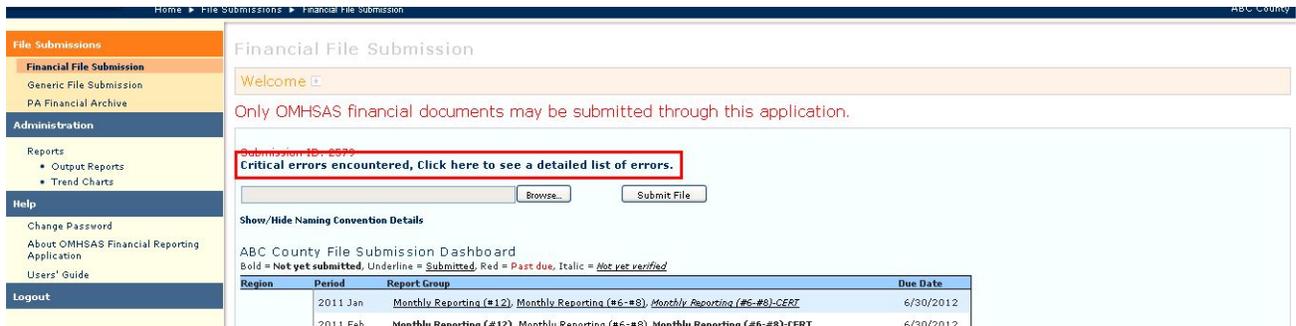
Critical Edits:

- Incomplete Cells — All cells must be populated.

NOTE: Non-Critical and Critical Edit messages have two parts:

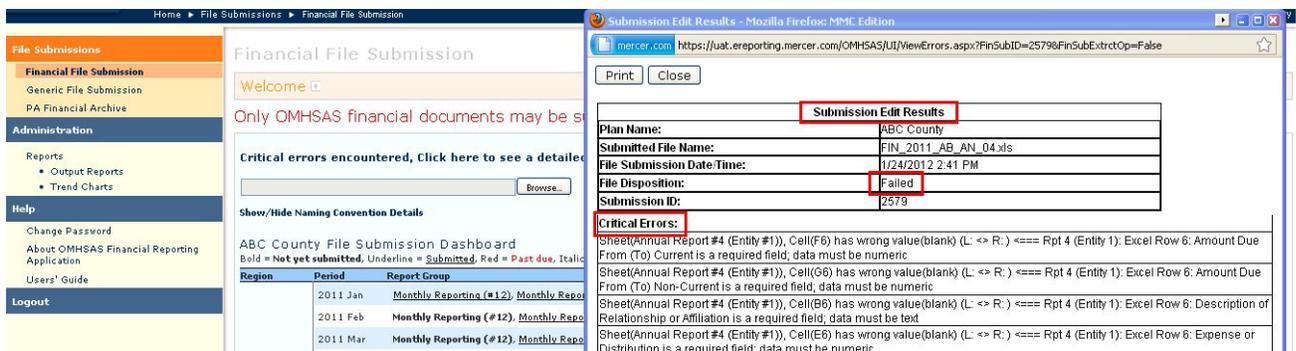
- The first part provides the Excel coordinates of the cell and the value in the spreadsheet that is in error.
- The second part gives a description of the column and line number on the financial report, as described in the Hard Edits Excel file received from OMHSAS.

Users will receive the following message if Critical errors are identified in the submitted report.



Below is the detailed error report generated by selecting, “Critical errors encountered, Click here to see a detailed list of errors”. These errors need to be corrected for the file to pass all edits and be successfully uploaded to the site.

In this example, the uploaded file contains null or blank cells.



Once the user corrects the errors identified in the detailed error report, they will need to continue to resubmit the report until all Critical edits have passed (starting from Step 4).

Instructions for Downloading Submitted Reports

Contractors can download their submitted financial reports at any time. To do this, go to the “*Financial File Submission*” screen and click the underlined file in the **File Submission Dashboard** at the bottom of the page (see screen shot below). From here user will have the option to open or save the document.

The screenshot shows the 'Financial File Submission' dashboard. A red box highlights the 'ABC County File Submission Dashboard' link in the table. A dialog box titled 'Opening FIN_2011_AB_01_01.xls' is open, showing options to 'Open with Microsoft Office Excel (default)' or 'Save File'. A tooltip points to the underlined link in the table, stating 'Click the underlined file link to download submitted reports'.

Region	Period	Report Group	Due Date
2011 Jan	Monthly Reporting (#12)	<u>Monthly Reporting (#6-#8)</u>	6/30/2012
		Monthly Reporting (#6-#8)-CERT	

Prior Year Adjustments

The information below describes the process for submitting prior year adjusted financial reports. Adjusted reports are to be submitted to the appropriate Financial System depending on the year of the original financial report submission.

CY 2011 and SFY 2011-2012 and Prior

Contractors should continue to follow the process for submitting prior year adjustments for **CY 2011 and SFY 2011/2012 and prior financial reports** as outlined in Appendix G of the FRR. The original Financial System can be accessed from the link in the new Financial System below or <https://ereporting.mercer.com/omhsasfinancial/>.

The screenshot shows the 'PA Financial Archive' page. A red box highlights the text: 'This screen allows you to login to the previous PA Financial submission portal to submit audit adjustments. Please click [here](#) to submit audit adjustments for prior submissions.'

CY 2012 and SFY 2012-2013 and Beyond

For prior year adjustments in the original system, Contractors only submit the value of adjustments to previously submitted data according to the applicable report line titles and columnar headings. To reflect prior year adjustments in the new Financial System for **CY 2012 and SFY 2012-2013 and beyond**, Contractors are required to incorporate the value of the adjustment into the originally submitted Excel-based financial report file and then submit the restated report to the new system. Following is an example of how to complete the Excel-based financial report template to reflect prior year adjustments in the new Financial System.

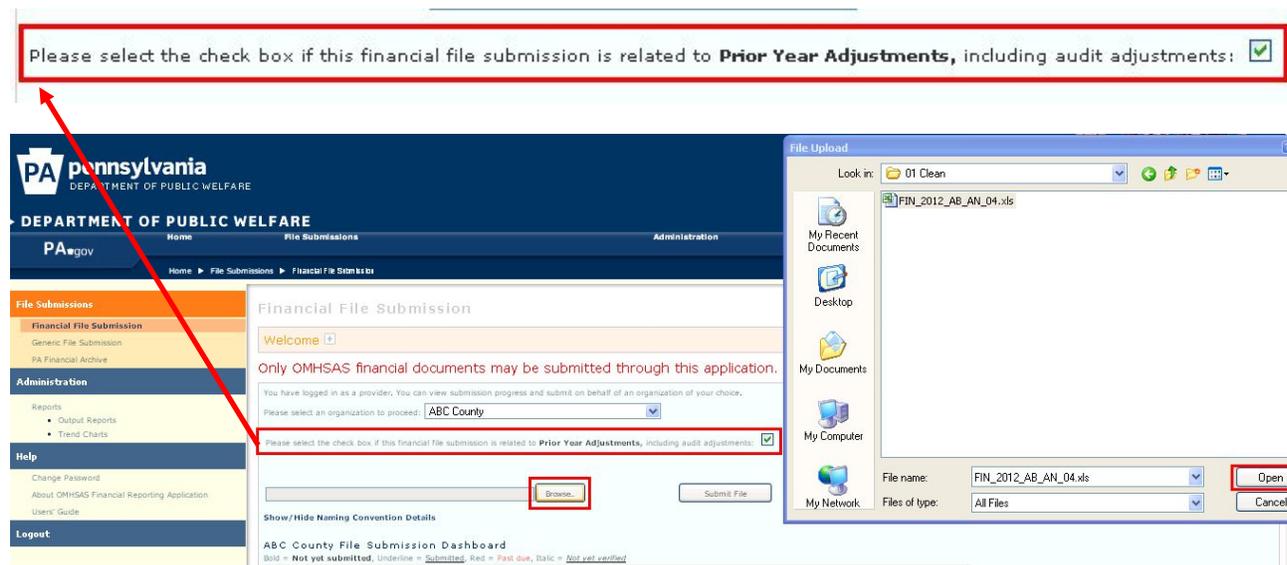
Example: A Contractor is submitting a \$200,000 downward adjustment to the Report #9A OP Psych line for the TANF rating group in their December 2013 quarterly report following an audit adjustment. The original value in that cell is \$1.8M.

- I. The Contractor accesses the **most recent** Excel-based Quarterly Report #1 – 4 and 9A financial report that was **successfully submitted** for the year ending December 2013. *Note that this report can be downloaded from the Contractor's Dashboard in the Financial System.*
- II. The Contractor opens the file and adjusts the OP Psych line for TANF to \$1.6M and leaves all other values in the file as is, unless further adjustments are necessary.

III. The file is then saved with the **same file naming convention that was originally used** and then the process outlined in the steps 1 – 7 below is followed.

Steps 1 - 3: Follow Steps 1 through 3 under the “Instructions for Uploading Files” section starting on page 18.

Step 4: Upon arriving at the *Financial File Submission* screen, click the box next to “Please select the check box if this financial file submission is related to **Prior Year Adjustments**, including audit adjustments”. Next click “Browse” to locate the financial report to upload. Once located, select the file from your computer’s directory and click “Open”. Upon opening the file, click “Submit File” to initiate the upload process.



Steps 5 – 7: Follow steps 5 through 7 on pages 20-21 under the section “Instructions for Uploading Files” to complete the adjusted financial report uploading process.

NOTE: When submitting prior year adjustments to the new Financial System (CY 2012 and SFY 2012-2013 and beyond), please keep in mind the following guidelines:

- Adjustments to prior year reports must be submitted using the Excel-based financial templates.
- The value of the adjustment must be reported in addition to the originally submitted values prior to submission. Meaning, when submitting reports that include prior year adjustments following steps 1 – 7 above, the financial report must contain the original amount plus or minus the adjustment amount.
- It is recommended that Contractors download originally submitted reports from the County/MCE Dashboard (see Instructions for Downloading Submitted Reports above) as the starting point for populating the prior year adjusted financial reports.
- The file name of the adjusted financial report that is being submitted must exactly match the name of the originally submitted financial file.
- **In addition to monthly and quarterly reports, prior year adjustments to the Annual Counterpart reports are required to be submitted to the Financial System.**

Generic File Submissions

The generic file submission interface will allow the user to browse and find any file (supporting documentation, voluntary submissions, etc.) and then upload it to the Financial System.

The user will click on the Browse button to select the file to upload, include a text description of the file in the “File description” box, choose the submission period that the file pertains to and click on the Submit File button. The file will be uploaded but no edits will be performed. Files can be uploaded in multiple formats, including: Excel, Word, PDF, zipped, etc. Note that only OMHSAS can access generic files once they are submitted.

The screenshot shows a web application interface for "Generic File Submission". The top navigation bar includes "Home", "File Submissions", "Generic File Submission", and "ABC County". A left sidebar menu contains sections for "File Submissions" (with "Generic File Submission" highlighted), "Administration", "Reports" (with sub-items "Output Reports" and "Trend Charts"), "Help" (with sub-items "Change Password", "About OMHSAS Financial Reporting Application", and "Users' Guide"), and "Logout".

The main content area is titled "Generic File Submission" and features a "Welcome" message with instructions: "Welcome to the PA e-FRM Generic File Submission page. This screen can be used to upload files that are not required for the FRR, but may be necessary to support your FRR submission. If you wish to upload an FRR required document, please use the Financial File Submission screen. To submit a file, click on the 'Browse' button, navigate to the file you wish to upload and select it. A description must be entered for each file uploaded. Please try to make the description as specific as possible. Include such information as what the file is, what it contains, why it is relevant to the FRRs and any relative time periods or zones, etc. You may optionally choose a submission period, if appropriate, for the file. When you are finished, click 'Submit File' to complete the transfer."

Below the welcome message is a red warning: "Only documents that apply to the Financial Reporting Requirements may be submitted through this web application." The form includes a "File description:" text box, a "Submission period (optional):" dropdown menu, a "Browse..." button, and a "Submit File" button. Red boxes highlight the "File description:" label, the "Submission period (optional):" dropdown, the "Browse..." button, and the "Submit File" button.

Instructions Generating Output Reports

Users can generate output reports for any successfully submitted report, except Additional reports. Additional reports submitted to the Financial System can be accessed from the File Submission Dashboard (see Instructions for Downloading Submitted Reports above). To create an output report for all other successfully submitted reports, go to the “Output Reports” screen from the link on the left side of the screen.

Step A: Below is the *Output Reports* screen. Note that files will only display in the “Active Reports” box for Report Cycles and Periods in which a report was submitted.

Home ► Administration ► Reports ► Output Reports

File Submissions

- Financial File Submission
- Generic File Submission
- PA Financial Archive

Administration

Reports

- **Output Reports**
- Trend Charts

Help

- Change Password
- About OMHSAS Financial Reporting Application
- Users' Guide

Logout

Output Reports

This screen allows you to produce a report on the below selection criteria.
You can filter the report based on organization and reporting period.
After you make your filter selections click on the “Submit” button to run the report.

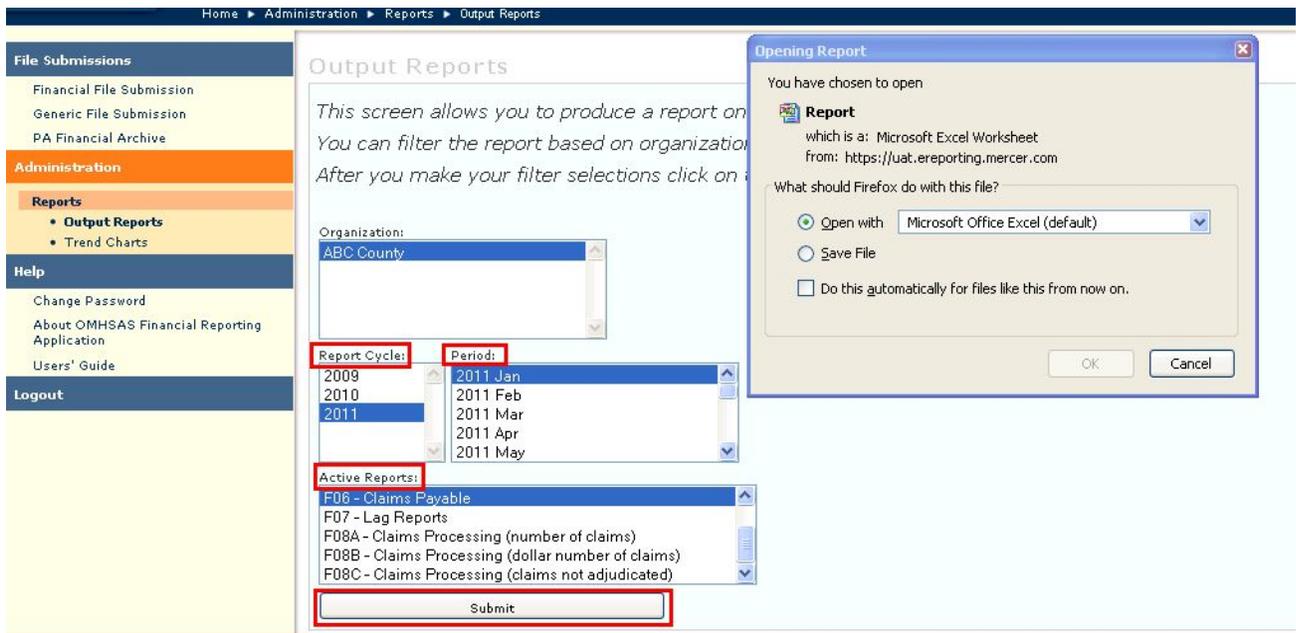
Organization:
ABC County

Report Cycle: 2009 2010 2011
Period: 2011 Jan 2011 Feb 2011 Mar 2011 Apr 2011 May

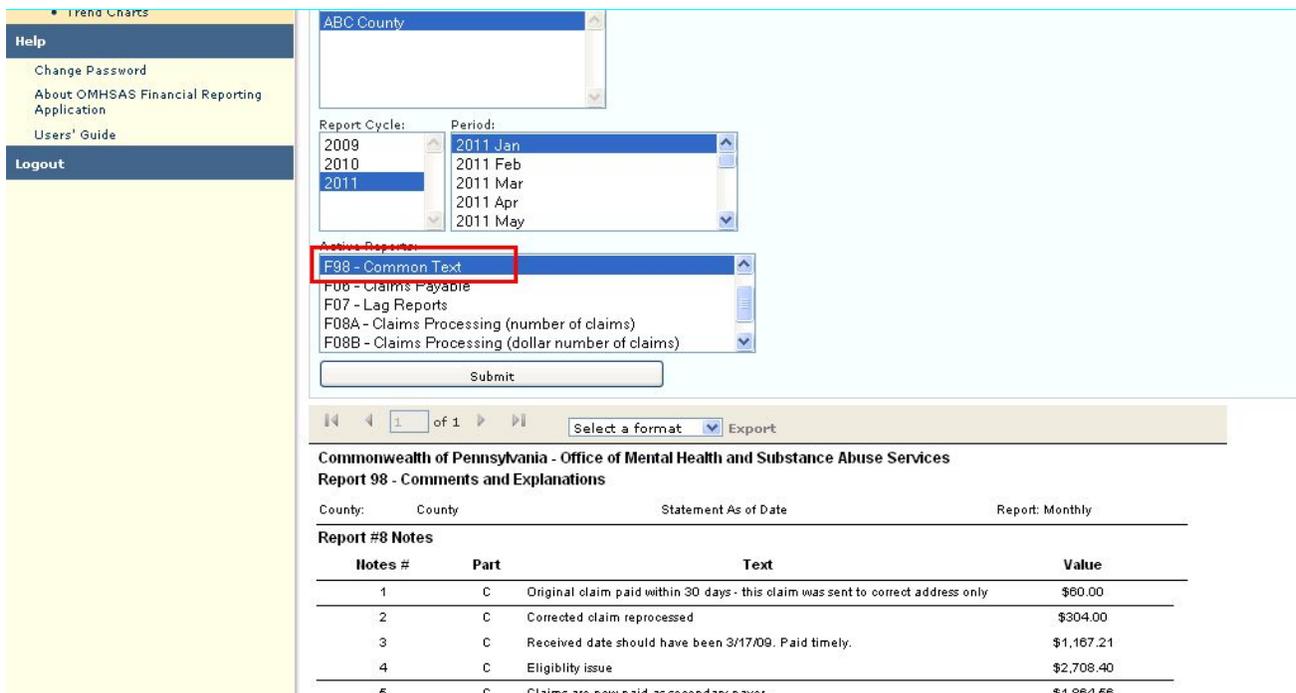
Active Reports:
F12 - Reinvestment
F98 - Common Text
F06 - Claims Payable
F07 - Lag Reports
F08A - Claims Processing (number of claims)

Submit

Step B: Reports #1 – 4, 6 – 8 and 9A – 9B can be viewed and saved as Excel spreadsheets. To generate one of these reports, select the Year (Report Cycle), Time Period/Report Cycle (Period) and Report Type (Active Reports) you would like to review, and then click Submit. Below is the dialogue box that appears prompting the user to open or save the file.



Step C: Report #98 can be viewed in three different formats. The first option is the on-screen view from the bottom of the *Output Reports* screen. For this view, follow the instructions in Step B and choose “F98 – Common Text” in the Active Reports box and press the “Submit” button.



Step D: The second and third formats are in Excel or PDF file types. The user has the option to export these formats from the “Select a format” drop-down box on the bottom half of the screen. Below is the dialogue box that appears after selecting PDF format and clicking “Export”.

Organization: ABC County

Report Cycle: 2011 Period: 2011 Jan

Active Reports:
 F98 - Common Text
 F06 - Claims Payable
 F07 - Lag Reports
 F08A - Claims Processing (number of claims)
 F08B - Claims Processing (dollar number of claim)

Submit

Opening Notes%2DMonthly2.pdf

You have chosen to open
 Notes%2DMonthly2.pdf
 which is a: Adobe Acrobat Document
 from: https://uat.ereporting.mercer.com

What should Firefox do with this file?

Open with Adobe Reader (default)

Save File

Do this automatically for files like this from now on.

OK Cancel

1 of 1

Select a format Export

Commonwealth of Pennsylvania - Office of Mental Health and Substance Abuse Services

Report 98 - Comments and Explanations

County: [] Statement As of Date: [] Report: Monthly

Notes #	Part	Text	Value
1	C	Original claim paid within 30 days - this claim was sent to correct address only	\$60.00
2	C	Corrected claim reprocessed	\$304.00
3	C	Received date should have been 3/17/09. Paid timely.	\$1,167.21
4	C		\$0.00

Instructions for Generating Trend Charts

To create a trend chart, go to the “*Trend Charts*” screen from the link on the left side of the screen, choose the trend time period from the “Start Period” and “End Period” boxes, check the applicable service category boxes under “Service Group” and click the “Submit” button.

File Submissions

- Financial File Submission
- Generic File Submission
- PA Financial Archive

Administration

Reports

- Output Reports
- Trend Charts**

Help

- Change Password
- About OMHSAS Financial Reporting Application
- Users' Guide

Logout

Trend Charts

This screen allows you to produce trend charts.

Organization: ABC County

Start Period: 2011 Jan

End Period: 2011 May

Service Group:

- Inpatient Psychiatric
- Inpatient D&A
- NonHosp D&A
- Outpatient Psych
- Outpatient D&A
- BHRS
- RTF - Accredited
- RTF - Non-Accredited
- Ancillary Support
- Community Support
- Total Other
- TOTAL

Submit

APPENDIX A

Financial Reporting Entity ID Numbers

The following section provides information regarding the entity that should be entered in the “Reported By” field at the heading of each Financial Report template. In instances where a report contains data from more than one entity, this field should name the primary contractor.

Entity IDs by Report and Organization

Report 1

Financial Reporting ID	Organization	Financial Reporting ID	Organization	Financial Reporting ID	Organization
01840917	Adams	01847346	Dauphin	00000003	Montgomery
01703981	Allegheny	00000003	Delaware	00000047	Montour
00000076	Armstrong/Indiana MH/MR	00000024	Elk	01848441	Northampton
01704002	Armstrong	00000025	Erie	00000005	North Central State Option / CCBH
01704011	Beaver	01704030	Fayette	00000015	Northeast Behavioral Health Care Consortium
00000105	Bedford	00000027	Forest	00000049	Northumberland
00000070	Bedford/Somerset (BHSSBC)	00000028	Franklin	01846385	Perry
01841576	Berks	00000073	Franklin/Fulton (TMCA)	00000004	Philadelphia
00000107	Blair	00000029	Fulton	00000052	Pike
00000108	Bradford	00000006	Greene / VBH-PA	00000053	Potter
00000003	Bucks	00000031	Huntington	00000054	Schuylkill
01704020	Butler	01704058	Indiana	00000055	Snyder
00000012	CABHC	00000033	Jefferson	00000056	Somerset
00000111	Cambria	00000034	Juniata	00000057	Sullivan
00000112	Cameron	00000013	Lackawanna	00000016	Susquehanna
00000113	Carbon	01847050	Lancaster	00000059	Tioga
00000071	Carbon/Monroe/Pike	01704067	Lawrence	00000060	Union
00000114	Centre	01841567	Lebanon	00000061	Venango
01608946	Chester	01847364	Lehigh	00000062	Warren
00000116	Clarion	00000014	Luzerne	01704076	Washington
00000117	Clearfield	00000041	Lycoming	00000017	Wayne
00000018	Clinton	00000072	Lycoming/Clinton	01704085	Westmoreland
00000019	Columbia	00000042	McKean	00000017	Wyoming
00000020	Crawford	00000043	Mercer	01840935	York
00000074	Crawford/Mercer/Venango (NWBHP)	00000044	Mifflin		
01846376	Cumberland	00000045	Monroe		

Report 2 and Report 9

Financial Reporting ID	Organization	Financial Reporting ID	Organization	Financial Reporting ID	Organization
01840917	Adams	01847346	Dauphin	01608973	Montgomery
01703981	Allegheny	01608955	Delaware	00000047	Montour
00000076	Armstrong/Indiana MH/MR	00000024	Elk	01848441	Northampton
01704002	Armstrong	00000025	Erie	00000005	North Central State Option / CCBH
01704011	Beaver	01704030	Fayette	00000015	Northeast Behavioral Health Care Consortium
00000105	Bedford	00000027	Forest	00000049	Northumberland
00000070	Bedford/Somerset (BHSSBC)	00000028	Franklin	01846385	Perry
01841576	Berks	00000073	Franklin/Fulton (TMCA)	01608964	Philadelphia
00000107	Blair	00000029	Fulton	00000052	Pike
00000108	Bradford	00000006	Greene / VBH-PA	00000053	Potter
01608937	Bucks	00000031	Huntington	00000054	Schuylkill
01704020	Butler	01704058	Indiana	00000055	Snyder
00000012	CABHC	00000033	Jefferson	00000056	Somerset
00000111	Cambria	00000034	Juniata	00000057	Sullivan
00000112	Cameron	00000013	Lackawanna	00000016	Susquehanna
00000113	Carbon	01847050	Lancaster	00000059	Tioga
00000071	Carbon/Monroe/Pike	01704067	Lawrence	00000060	Union
00000114	Centre	01841567	Lebanon	00000061	Venango
01608946	Chester	01847364	Lehigh	00000062	Warren
00000116	Clarion	00000014	Luzerne	01704076	Washington
00000117	Clearfield	00000041	Lycoming	00000017	Wayne
00000018	Clinton	00000072	Lycoming/Clinton	01704085	Westmoreland
00000019	Columbia	00000042	McKean	00000017	Wyoming
00000020	Crawford	00000043	Mercer	01840935	York
00000074	Crawford/Mercer/Venango (NWBHP)	00000044	Mifflin		
01846376	Cumberland	00000045	Monroe		

Report 3

Financial Reporting ID	Organization
00000003	MBH of PA - Magellan Behavioral Health of PA
00000004	CBH - Community Behavioral Health
00000005	CCBH - Community Care Behavioral Health
00000006	VBH of PA - Value Behavioral Health of PA
00000077	CSI - CBHNP Services Inc.

Report 6, Report 7 and Report 8

Financial Reporting ID	Organization
00000003	MBH of PA - Magellan Behavioral Health of PA
00000004	CBH - Community Behavioral Health
00000005	CCBH - Community Care Behavioral Health
00000006	VBH of PA - Value Behavioral Health of PA
00000077	CSI - CBHNP Services Inc.
01704011	Beaver
01704030	Fayette

Report 4

Financial Reporting ID	Organization	Financial Reporting ID	Organization	Financial Reporting ID	Organization
01840917	Adams	01846376	Cumberland	00000015	Northeast Behavioral Health Care Consortium
01703981	Allegheny	01847346	Dauphin	01846385	Perry
00000076	Armstrong/Indiana MH/MR	01608955	Delaware	01608964	Philadelphia
01704011	Beaver	00000025	Erie	01704076	Washington
00000070	Bedford/Somerset (BHSSBC)	01704030	Fayette	01704085	Westmoreland
01841576	Berks	00000073	Franklin/Fulton (TMCA)	01840935	York
00000107	Blair	00000006	Greene / VBH-PA	00000003	MBH of PA - Magellan Behavioral Health of PA
01608937	Bucks	01847050	Lancaster	00000004	CBH - Community Behavioral Health
01704020	Butler	01704067	Lawrence	00000005	CCBH - Community Care Behavioral Health
00000012	CABHC	01841567	Lebanon	00000006	VBH of PA - Value Behavioral Health of PA
00000111	Cambria	01847364	Lehigh	00000008	SBHM
00000071	Carbon/Monroe/Pike	00000072	Lycoming/Clinton	00000009	AHCI
01608946	Chester	01608973	Montgomery	00000010	CBHNP
00000074	Crawford/Mercer/Venango (NWBHP)	01848441	Northampton	00000077	CSI - CBHNP Services Inc.

Report 12

Financial Reporting ID	Organization	Financial Reporting ID	Organization	Financial Reporting ID	Organization
01840917	Adams	01846376	Cumberland	00000015	Northeast Behavioral Health Care Consortium
01703981	Allegheny	01847346	Dauphin	01846385	Perry
00000076	Armstrong/Indiana MH/MR	01608955	Delaware	01608964	Philadelphia
01704011	Beaver	00000025	Erie	01704076	Washington
00000070	Bedford/Somerset (BHSSBC)	01704030	Fayette	01704085	Westmoreland
01841576	Berks	00000073	Franklin/Fulton (TMCA)	01840935	York
00000107	Blair	00000006	Greene / VBH-PA		
01608937	Bucks	01847050	Lancaster		
01704020	Butler	01704067	Lawrence		
00000012	CABHC	01841567	Lebanon		
00000111	Cambria	01847364	Lehigh		
00000071	Carbon/Monroe/Pike	00000072	Lycoming/Clinton		
01608946	Chester	01608973	Montgomery		
00000074	Crawford/Mercer/Venango (NWBHP)	01848441	Northampton		

APPENDIX B

File Naming Conventions

This section provides information regarding the naming convention the Contractors should use on files they upload to the Financial System website. Any files that do not exactly follow the naming conventions will be rejected in real-time and will require resubmission.

File Naming Key

The tables following the descriptions below define the two-character codes identified under the “File Naming Conventions” in Section 5.

Table 1 – DPW Assigned HMO ID

Includes the two-character HMO ID that maps to each County/Multi-County Entity/Zone.

Table 2a – Monthly Submission Period Designation

Includes the two-character code associated with the month that a report is submitted. This only applies to the Reports # 6 – 8C and 12 monthly submissions.

Table 2b – Quarterly and Annual Submission Period Designation

Includes the two-character code associated with the last month that a report is submitted (quarterly submission only). Note that the quarterly codes vary by the “Zone Year” defined in Table 1. The quarterly codes apply to the Reports # 1 – 4 and 9A quarterly submissions. The annual code, “AN”, applies to the Reports # 2 – 4 and 9A annual submissions.

Table 3 – Quarterly, Annual and Additional Report Group Designation

Includes the two-character code assigned to each report template.

Example: Bucks County May 2012 submission of financial Reports # 6 – 8C

File name example: FIN_2012_BU_05_01.xls

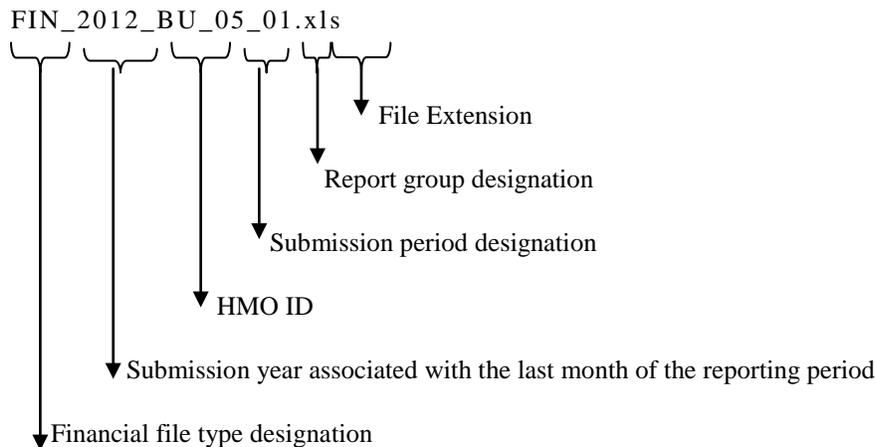


TABLE 1 - DPW Assigned HMO ID, Subcontractors and Management Corporations

Zone	Year	ID	
CY	AI	Armstrong/Indiana MCE Behavioral Health	
CY	AL	Allegheny County Behavioral Health	
CY	BE	Beaver County Behavioral Health	
CY	BT	Butler County Behavioral Health	
CY	FA	Fayette County Behavioral Health	
CY	GR	Greene County Behavioral Health	
CY	LW	Lawrence County Behavioral Health	
CY	WS	Washington County Behavioral Health	
CY	WE	Westmoreland County Behavioral Health	
CY	BU	Bucks County BH	
CY	CH	Chester County BH	
CY	DE	Delaware County BH	
CY	MO	Montgomery County BH	
CY	PH	Philadelphia County BH	
SFY	AD	Adams County Behavioral Health	
SFY	BK	Berks County Behavioral Health	
SFY	CU	Cumberland County Behavioral Health	
SFY	DA	Dauphin County Behavioral Health	
SFY	LA	Lancaster County Behavioral Health	
SFY	LB	Lebanon County Behavioral Health	
SFY	LE	Lehigh County Behavioral Health	
SFY	NH	Northampton County Behavioral Health	
SFY	PE	Perry County Behavioral Health	
SFY	YO	York County Behavioral Health	
SFY	NB	Northeast Behavioral Health Care Consortium	
SFY	BI	Blair HealthChoices	
SFY	BS	Behavioral Health Services of Somerset And Bedford Counties	
SFY	CK	Carbon, Monroe, Pike Counties	
SFY	CM	Behavioral Health of Cambria County	
SFY	CV	Northwest Behavioral Health (Crawford, Mercer, Venango)	
SFY	ER	Erie County	
SFY	FF	Tuscarora Managed Care Alliance (Franklin & Fulton Counties)	
SFY	LC	Lycoming Clinton Joinder Board	
SFY	NC	State Option - Community Care Behavioral Health Organization, Inc. (NC SO)	
	C5	Capital Area Behavioral Health Collaborative, Inc. (CABHC)	
	CC	Community Care Behavioral Health Organization (Community Care)	
	CS	Community Behavioral HealthCare Network of Pennsylvania Services, Inc. (CSI)	
	MB	Magellan Behavioral Health of Pennsylvania (MBH-PA)	
	SB	Southwest Behavioral Health Management, Inc. (SBHM)	
	VB	Value Behavioral Health of Pennsylvania, Inc. (VBH-PA)	

TABLE 2a - Monthly Submission Period Designation

Monthly Submission Period	2-character Submission Period Designation
January	01
February	02
March	03
April	04
May	05
June	06
July	07
August	08
September	09
October	10
November	11
December	12

TABLE 2b - Quarterly and Annual Submission Period Designation

Zone Year¹	Submission Period (Last month in submission period)	2-Character Submission Period Designation
SFY	September	Q3
SFY	December	Q4
SFY	March	Q1
SFY	June	Q2
CY	March	Q1
CY	June	Q2
CY	September	Q3
CY	December	Q4
SFY or CY	Annual	AN

¹ Refer to Table 1 for Zone Year assignments.

TABLE 3 - Report Group Designation (as of September 1, 2012)

Submission Period	Financial Report #	Report Group Designation
Monthly	6 – 8C	01
Monthly	12	02
Quarterly	1 – 4 and 9A	03
Annual	2 – 4 and 9A	04
Additional Reports		
Actual Reinsurance Experience		05
Actuarial Certification of Claims Liability (CY)		06
Balance Sheet		07
Contract Reserves Compliance Report		08
ELTSR Reinvestment Bank Statement		09
ELTSR Reinvestment Report #12		10
Equity Reserve Bank Statement		11
Estimated Reinsurance Experience		12
General Account Bank Statement		13
Parental Guaranty Quarterly Monitoring Report		14
Physician Incentive Arrangement		15
Reinsurance Waiver Report > \$75,000		16
Reinvestment Bank Statement		17
Risk & Contingency Bank Statement		18
Reports #13, #14, #15 (Primary Contractor)		19
Reports #13, #14, #15 (Subcontractor)		20
Actuarial Certification of Claims Liability (SFY)		21
Annual Audited Financial Statements (DOI) - Statutory Basis		22
Audited County General Purpose Financial Statements (CAFR)		23
Entity Wide Audit (Primary Contractor)		24
Entity Wide Audit (Subcontractor)		25
Insurance Department Annual Filing		26
Insurance Department Quarterly Filing		27

APPENDIX C

Financial Reporting Templates

The Excel-based financial reporting templates are included as separate attachments with these instructions.

Excel-based Templates

Below are the names of the Excel-based financial reporting templates and Financial Data Certification form. When submitting these completed files to the website, please follow the file naming conventions discussed in Section 5 and Appendix B.

- Annual Reporting Template (#2-#4 & #9).xls
- Monthly Reporting Template Part 1 (#6-#8).xls
- Monthly Reporting Template Part 2 (#12).xls
- Quarterly Reporting Template (#1-#4 & #9).xls
- Monthly Reporting Template Part 1 (#6-#8)_INITIAL SUBMISSION.xls
- Monthly Reporting Template Part 2 (#12)_INITIAL SUBMISSION.xls
- Financial Data Certification.doc

**BEHAVIORAL HEALTH
APPENDIX IV**

Managed Care Payment System Table

PROMISE Managed Care Payment System Table

Rate Cell	Promise Program Code	PH FRR Report #	PH Rate	Vol Rate	BH Rate	Description	Gen	Age Min/Max	Medicare Part A	Category of Assistance group type		Program Status Code group type			
01	EXC		N/A	N/A	N/A	Excluded from managed care payment process	B	All	N/A	Combinations 02/00 & 00/12 are applicable for rate cell 01.					
										02	ACX, B, BW, E, EIX, H10-H91, MHX, MRX, PG, PSF, PVN, SC, TB, TVN	00	All program status codes		
										00	All categories of assistance	12	17, 21, 38, 39, 47, 48, 49, 55, 65, 67, 86, 87		
13	HB	Report 5B Healthy Beginnings	TANF/HB < 2 mos	TANF/HB < 1	HB	Healthy Beginnings - < 2 mos	B	0 - 1 mo	N/A	Combination 11/16 is applicable for rate cells 13, 14, 11, 12.					
TANF/HB 2 mos - < 1				Healthy Beginnings - 2 mos - < 1		2 - 11 mos									
HB 1+			HB 1+	Healthy Beginnings - 1-17		1 - 17		11		PS	16	16, 18			
				Healthy Beginnings - 18+		18+									
60	TNF	Report 5A TNF	TANF/HB < 2 mos	TANF/HB < 1	TANF 0-21	TANF - Cat/Med - < 2 mos	B	0 - 1 mo	N/A	Combinations 03/17 & 04/18 are applicable for rate cells 60, 61, 21, 25, 26, 27, 28. Combination 05/19 is applicable for rate cells 60, 61, 65, 66.					
TANF/HB 2 mos - < 1				TANF - Cat/Med - 2 mos - < 1		2 - 11 mos									
			TANF/CN 1-13	TANF - Cat - 1-13		1 - 13									
61												03	C, U	17	00, 04, 06, 07, 08, 09, 53, 56, 57, 58, 59, 71, 72
21					TANF/CN 14+ F	TANF - Cat - 14-21	F	14 - 21							
25						TANF - Cat - 22+		22+							
26					TANF 1+	TANF 0-21	M	14 - 21							
27						TANF - Cat - 22+		22+							
28						TANF - Med - 1-21	B	1 - 21							
65			TANF/MN 1+	TANF 22+		22+									
66				TANF - Med - 22+											
30	HHW	Report 5C SSI/HH with Medicare	SSI & HH	SSI/HH	SSI & HH w Med A	Healthy Horizons w Med A - 0	B	0	Y	Combination 10/04 is applicable for rate cells 30, 31, 32, 40, 46, 47, 42.					
Healthy Horizons w Med A - 1-64						1 - 64									
Healthy Horizons w Med A - 65+						65+									
40	HHN	Report 5D SSI/HH without Medicare	SSI & HH	SSI/HH	SSI & HH w/o Med A 0-21	Healthy Horizons w/o Med A - 0	B	0	N	10	PH	04	00, 30, 80		
Healthy Horizons w/o Med A - 1-21						1 - 21									
Healthy Horizons w/o Med A - 22-64						22 - 64									
Healthy Horizons w/o Med A - 65+						65+									
46															
47															
42															
70	BCC	Report 5E	BCC	N/A	SSI & HH w/o Med A 22+	Breast & Cervical Cancer Prevention & Treatment	F	Under 65	N	10	PH	35	20		

PROMISE Managed Care Payment System Table

Rate Cell	Promise Program Code	PH FRR Report #	PH Rate	Vol Rate	BH Rate	Description	Gen	Age Min/Max	Medicare Part A	Category of Assistance group type	Program Status Code group type		
33	SSW	Report 5C SSI/HH with Medicare			SSI & HH w Med A	SSI w Med A - 0	B	0	Y	Combinations 10/15, 12/20, 13/30, 14/31, 15/32 & 16/33 are applicable for rate cells 33, 34, 35, 43, 48, 49, 45.			
34						1 - 64		10		PH	15	95, 97	
35						65+		12		PAN, PAW, PI, PJN, PJW, PMN, PMW, PW, TA, TAN, TAW, TJ, TJN, TJW	20	00, 22, 66, 80, 81, 83, 84, 85	
43	SSN	Report 5D SSI/HH without Medicare	SSI & HH	SSI/HH	SSI & HH w/o Med A 0-21	SSI w/o Med A - 0	B	0	N	13	A, J, M	30	00, 44, 45, 46, 60, 62, 64
48						1 - 21		14		J	31	31, 32, 33, 34, 35, 36, 37	
49						22 - 64		15		PA, PJ, PM	32	00, 22, 81, 83, 84, 85	
45						65+		16		PJ	33	98	
50	FGA	Report 5D SSI/HH without Medicare	SSI & HH	SSI/HH	SSI & HH w/o Med A 0-20 (Old Fed GA)	Fed GA Cat/Med - 0	B	0	N	Combination 07/01 is applicable for rate cells 50, 51, 52. Combination 07/02 is applicable for rate cell 53.			
51						1-20		07		D, PD, TD	01	00, 02, 05, 15, 22, 29, 50	
52						65+		07		See Revision #1 below.	02	02, 05, 15, 50	
53						21-64 (Old Fed GA)							Fed GA Cat/Med - 21-64
54	CGA	Report 5F State GA Cat Needy	GA-CNO	CN State 21-64	GA-CNO	State GA Cat	B	21 - 64	N/A	Combination 23/03 is applicable for rate cell 54.			
										23	D, PD	03	00, 22, 29
56	MGA	Report 5G State GA Med Needy	GA-MNO	MN State 21-58	GA-MNO	State GA Med - 21-58	B	21-58	N/A	Combination 22/03 is applicable for rate cells 56, 55.			
55						MN State 59-64		State GA Med - 59-64		22	TD	03	00, 22, 29

Note the highlighted text for category/program status combinations that are applicable for each rate cell.

Revisions:

1. With the elimination of the Federal GA rating group as of 7-1-12, the majority of the Fed GA recipients (Cat/PSC D00, D15, D50) were moved to the SSI/HH rating group. Of the remaining recipients, most were moved to the TANF and Healthy Beginnings rating groups. The very few Federal GA recipients remaining in rate cells 50, 51, 52 and 53 (Cat/PSC D02, D05, PD00, PD22, TD00, TD22) will be paid at the SSI/HH rate and be merged with the SSI/HH rating group.

2. A new Rate Cell, #70, has been added for the Breast & Cervical Cancer PH20 recipient group. This group was previously excluded from Managed Care, but as of 3-1-13 will be covered in the HealthChoices managed care program.

BEHAVIORAL HEALTH APPENDIX V

- **HealthChoices Behavioral Health Services Reporting and Classification Chart**
- **Attachment A - ~~Crosswalk of Local Codes~~**
- **Attachment B - ~~Diagnostic Related Group (DRG) Descriptions~~**
- **Attachment C - ~~International Classification of Disease~~**
- **Attachment D - Listing of providers with CDC (Co-occurring Disorder Competency) special indicator**
- **Attachment E - ~~Revenue Code Descriptions for Behavioral Health Covered Services~~**
- **Attachment F - ~~Resource Coordination (RC) Provider Listing
Intensive Case Management (ICM) Provider Listing
ICM – CTT Provider Listing
Blended Model Program Provider Listing~~**
- **Attachment G - Procedure Code Detail**
- **Attachment H - Procedure Code Detail from Attachment G sorted by Procedure Code**
- **Attachment I - ~~CRR Host Homes~~**
- **Attachment J - ~~Office of Medical Assistance Programs
Healthcare Benefits Packages Legend & Chart~~**
- **Attachment K - Desk Chart**
- **Attachment L - ~~Sample CPT Code Request Format~~**
- **Attachment M - ~~Health Care Benefits Packages~~**
- **Attachment N - ~~Category Conversion Chart~~**

**Commonwealth of Pennsylvania
Office of Mental Health & Substance Abuse Services**

January 2, 2013

SUBJECT: Behavioral Health Services Reporting Classification Chart

TO: HealthChoices Behavioral Health Contractors

FROM: Lisa Page
Office of Mental Health and Substance Abuse Services

Enclosed please find an updated Behavioral Health Services Reporting Classification Chart (BHSRCC) to assist you with determining the appropriate coding of services for both financial and encounter data reporting for HealthChoices. The BHSRCC is intended to assist you in establishing edits in your reporting processes; however, it is not in any way intended to limit or expand behavioral health services in the HealthChoices Program. ***It is advisable to keep the previous charts as a reference guide. The BHSRCC is updated and distributed semi-annually.***

There are no changes since the interim update September 2012 version was published.

BHSRCC Chart - No change

Attachment D	Listing of providers with CDC (Co-occurring Disorder Competency) special indicator	No change
Attachment G	Procedure Code Detail	No change
Attachment H	Procedure Code Detail from Attachment G sorted by Procedure Code	No change
Attachment K	Desk Chart	No change

Please see that all users of this chart in your area receive this update.

If you have any questions, please email HC-EligReference@pa.gov

cc: AHCI
CABHC
CBHNP
CCBH
CBH
VBH
SWBH
MBH
NBHCC

Healthchoices Behavioral Health Services Reporting Classification Chart - January 1, 2013

Line Item	Service	Provider Type	Provider Specialty	Provider ID	Identifiers	ENC CAT	FIN CAT
INPATIENT PSYCHIATRIC SERVICES							
1	Inpatient Psychiatric Services	01 - Inpatient Facility	010 - Acute Care Hospital	Any*	DRG's: 424-432 Revenue Codes: 0114, 0124, 0134, 0154, 0204, 0760, 0761, 0762, 0769, 0900, 0901, 0902, 0903, 0904, 0909, 0910, 0911, 0914, 0915, 0916, 0917, 0918, 0919, 0920, 0929, 0949	01	01
2	Inpatient Psychiatric Services	01 - Inpatient Facility	011 - Private Psychiatric Hospital or 022 - Private Psychiatric Unit		Revenue Codes: Same as Line Item 1	01	01
3	Inpatient Psychiatric Services	01 - Inpatient Facility	018 - Extended Acute Psych Inpatient	Any*	Revenue Codes: Same as Line Item 1	01	01
INPATIENT DRUG & ALCOHOL DETOXIFICATION							
4	Inpatient Drug & Alcohol Detox	01 - Inpatient Facility	010 - Acute Care Hospital	Any*	DRG's: 433, 521, 522, 523 Revenue Codes: 0116, 0126, 0136, 0156, 0760, 0761, 0762, 0769, 0949	02	02
5	Inpatient Drug & Alcohol Detox	01 - Inpatient Facility	019 - D&A Rehab Hosp or 441 - D&A Rehab Unit		Revenue Codes: 0116, 0126, 0136, 0156, 0760, 0761, 0762, 0769, 0949	02	02
INPATIENT DRUG & ALCOHOL REHABILITATION							
6	Inpatient Drug & Alcohol Rehab	01 - Inpatient Facility	010 - Acute Care Hospital	Any*	DRG's: 433, 521, 522, 523 Revenue Codes: 0118, 0128, 0138, 0158, 0760, 0761, 0762, 0769, 0944, 0945, 0949	04	02
7	Inpatient Drug & Alcohol Rehab	01 - Inpatient Facility	019 - D&A Rehab Hosp or 441 - D&A Rehab Unit		Revenue Codes: 0118, 0128, 0138, 0158, 0760, 0761, 0762, 0769, 0944, 0945, 0949	04	02
NON-HOSPITAL RESIDENTIAL, DETOXIFICATION & REHABILITATION							
8	Non-Hospital Residential, Detoxification, Rehabilitation, Halfway House Services for D&A Dependence/Addiction	11 - Mental Health / Substance Abuse	131 - D&A Halfway House	Any*	Procedure Code: H2034	05	03
			132 - D&A Medically Monitored Detox		Procedure Code: H0013		
			133 - D&A Medically Monitored Residential, Short Term		Procedure Code: H0018/HF		
			134 - D&A Medically Monitored Residential, Long Term		Procedure Code: T2048/HF		
PSYCHIATRIC OUTPATIENT SERVICES							
9	Psychiatric Outpatient Clinic Services	08 - Clinic	110 - Psychiatric Outpatient	Any	Procedure Codes: See Pages 5, 6, & 7 of Attachment G (excluding H0034/HK, H2010/HK, G0437, 99407)	06	04
		01 - Inpatient	183 - Hospital Based Med Clinic	Any	Procedure Codes: 90870	06	04
43	Psychiatric Outpatient Mobile Services	08 - Clinic	074 - Mobile Mental Health Trtmt	Any	Procedure Codes: See Pages 2 & 3 of Attachment G	06	04
10	Psychiatric Outpatient Services	11 - Mental Health / Substance Abuse	113 - Partial Psych Hosp Children or 114 - Partial Psych Hosp Adult	Any*	Procedure Codes: See Page 9 of Attachment G (excluding H2010/HK)	03	04
11	Psychiatric Outpatient Clinic Services	08 - Clinic	080 - FQHC or 081 - RHC	Any*	Procedure Code: T1015/HE	06	04
12	Psychiatric Outpatient Services	19 - Psychologist	190 - General Psychologist	Any*	Procedure Codes: See Pages 17 & 18 of Attachment G - not equal to procedures listed under Psychologist Wraparound or G0437 or 99407	06	04
		31 - Physician	339 - Psychiatry	Any*	Procedure Codes: See Pages 11 thru 16 of Attachment G, excluding H2010/HK/U1, G0437, 99407 and not equal to procedures listed under Physician	06	04
12	Psychiatric Outpatient Services continued						

Healthchoices Behavioral Health Services Reporting Classification Chart - January 1, 2013

Line Item	Service	Provider Type	Provider Specialty	Provider ID	Identifiers	ENC CAT	FIN CAT
					Wraparound		
		31 - Physician	315 - Emergency Medicine	Any*	Procedure Codes: 99281, 99282, 99283, 99284, 99285	06	04
			316 - Family Practice 322 - Internal Medicine 345 - Pediatrics		Procedure Codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99281 99282, 99283, 99284, 99285		
BEHAVIORAL HEALTH REHABILITATIVE SERVICES - MH							
13	BHRS	08 - Clinic	110 - Psychiatric Outpatient	Any*	ICD-9-CM: 290-316 AND Procedure Codes: 90801, 90802, 96101/HK, 96101/AH, 96101/TF/HK, 96101/TG/HK, 96101/U7, 96101/U7/HA, 96101/U7/TJ, 96116, 96118/HK, 96118/UB	07	06
			800 - FQHC TSS or 804 - RHC TSS or 808 - Psych Outpatient TSS		Procedure Codes: H2014/UB, H2014/UB/HA, H2021/UB		
			801 FQHC MT or 805 - RHC MT or 809 - Psych Outpatient MT		Procedure Codes: H2019/UB		
			802 - FQHC BSC or 806 - RHC BSC or 810 - Psych Outpatient BSC		Procedure Codes: H0032/HP, H0032/HO		
			803 - FQHC STAP or 807 - RHC STAP or 811 - Psych Outpatient STAP		Procedure Codes: H2012/UB		
			340 - Program Exception		Procedure Codes: H0018, H0019/HA, H0019/HQ, H0019/TT, H0046/SC, H2012/SC, H2015, H2017 H2019/HA, H2021/SC, H2021/HQ/SC, H2022, H2033		
		09 - Certified Registered Nurse Practitioner	548 - Therapeutic Staff Support		Procedure Codes: H2014/UB, H2014/UB/HA, H2021/UB		
			549 - Mobile Therapy		Procedure Code: H2019/UB,		
			559 - Behavioral Specialist Consult.		Procedure Codes: H0032/HP, H0032/HO		
		11- Mental Health/ Substance Abuse	113 - Partial Psych Hosp Children or 114 - Partial Psych Hosp Adult or 115 - Family Based Mental Health		Procedure Codes: 90801, 90802, 96101, 96101/AH 96101/TF, 96101/TG, 96101/U7, 96101/U7/HA, 96101/U7/TJ, 96116, 96118, 96118/UB		
			548 - Therapeutic Staff Support or 549 - Mobile Therapy or 559 - Behavioral Specialist Consult.		Procedure Codes: 90801, 90802, 96101/U7, 96101/U7/HA, 96101/U7/TJ, 96116, 96118/UB		
			116 - Licensed Clinical Social Worker or 117 - Licensed Social Worker		Procedure Codes: H0046/UB		
			548 - Therapeutic Staff Support 442 -Partial Psych Hosp Child TSS 446 -Partial Psych Hosp Adult TSS		Procedure Codes: H2014/UB, H2014/UB/HA, H2021/UB		
13	BHRS continued		450 - Family Based MH TSS 549 - Mobile Therapy		Procedure Codes: H2019/UB		

Healthchoices Behavioral Health Services Reporting Classification Chart - January 1, 2013

Line Item	Service	Provider Type	Provider Specialty	Provider ID	Identifiers	ENC CAT	FIN CAT
			443 - Partial Psych Hosp Child MT 447 - Partial Psych Hosp Adult MT 451 - Family Based MH MT				
			559 - Behavioral Specialist Consult 444 -Partial Psych Hosp Child BSC 448-Partial Psych Hosp Adult BSC 452 - Family Based MH BSC		Procedure Codes: H0032/HP, H0032/HO		
			445-Partial Psych Hosp Child STAP 449-Partial Psych Hosp Adult STAP 453 - Family Based MH STAP		Procedure Codes: H2012/UB		
			340 - Program Exception		Procedure Codes: H0018, H0019/HA, H0019/HQ, H0019/TT, H0046/SC, H2012/SC, H2015, H2017 H2019/HA, H2021/SC, H2021/HQ/SC, H2021/U9/SC, H2021/U8/SC, H2021/U7/SC, H2033		
		16 - Nurse	162 - Psychiatric Nurse		Procedure Codes: H0046/UB		
		17 - Therapist	174 - Art Therapist		Procedure Codes: H2032/UB		
		17 - Therapist	175 - Music Therapist		Procedure Codes: G0176/UB		
		19 - Psychologist	548 - Therapeutic Staff Support		Procedure Codes: H2014/UB, H2014/UB/HA, H2021/UB		
			549 - Mobile Therapy		Procedure Codes: H2019/UB		
			559 - Behavioral Specialist Consult.		Procedure Codes: H0032/HP, H0032/HO		
			190 - General Psychologist		Procedure Codes: 90801, 90802, 96101/U7 96101/U7/HA, 96101/U7/TJ, 96116, 96118/UB		
		31 - Physician	548 - Therapeutic Staff Support		Procedure Codes: H2014/UB/U1, H2014/UB/HA/U1, H2021/UB/U1		
			549 - Mobile Therapy		Procedure Code: H2019/UB/U1		
			559 - Behavioral Specialist Consult.		Procedure Codes: H0032/HP/U1, H0032/HO/U1		
		52 - CRR	523 - Host Home/Children		Procedure Code: H0019/HA; H0019/TT		
45	BHRS				ICD-9-CM: 799.9 <u>AND</u>	07	06
		08 - Clinic	110 - Psychiatric Outpatient		Procedure Code: 90801		
		11 - Mental Health/ Substance Abuse	113 - Partial Psych Hosp Children 114 - Partial Psych Hosp Adult or 115 - Family Based Mental Health 548 - Therapeutic Staff Support 549 - Mobile Therapy 559 - Behavioral Specialist Consu		Procedure Code: 90801		
		19 - Psychologist	190 - General Psychologist		Procedure Code: 90801		
14	Behavioral Health Rehabilitation Services (EPSDT) for Children & Adolescents with MR			Any*	ICD-9-CM: 317-319 <u>AND</u>	17	06
		08 - Clinic	110 - Psychiatric Outpatient		Procedure Codes: 90801, 90802, 96101/HK, 96101/AH, 96101/TF/HK, 96101/TG/HK, 96101/U7, 96101/U7/HA, 96101/U7/TJ, 96116, 96118/HK,		
14	BHRS (EPSDT) for Children and Adolesctns with MR continued				96118/UB		
			800 - FQHC TSS or 804 - RHC TSS or		Procedure Codes: H2014/UB, H2014/UB/HA, H2021/UB		

Healthchoices Behavioral Health Services Reporting Classification Chart - January 1, 2013

Line Item	Service	Provider Type	Provider Specialty	Provider ID	Identifiers	ENC CAT	FIN CAT
			808 - Psych Outpatient TSS				
			801 FQHC MT or 805 - RHC MT or 809 - Psych Outpatient MT		Procedure Codes: H2019/UB		
			802 - FQHC BSC or 806 - RHC BSC or 810 - Psych Outpatient BSC		Procedure Codes: H0032/HP, H0032/HO		
			803 - FQHC STAP or 807 - RHC STAP or 811 - Psych Outpatient STAP		Procedure Codes: H2012/UB		
			340 - Program Exception		Procedure Codes: H0018, H0019/HA, H0019/HQ, H0019/TT, H0046/SC, H2012/SC, H2015, H2017 H2019/HA, H2021/SC, H2021/HQ/SC, H2022, H2033		
		09 - Certified Registered Nurse Practitioner	548 - Therapeutic Staff Support		Procedure Codes: H2014/UB, H2014/UB/HA, H2021/UB		
			549 - Mobile Therapy		Procedure Code: H2019/UB,		
			559 - Behavioral Specialist Consult.		Procedure Codes: H0032/HP, H0032/HO		
		11- Mental Health/ Substance Abuse	113 - Partial Psych Hosp Children or 114 - Partial Psych Hosp Adult or 115 - Family Based Mental Health		Procedure Codes: 90801, 90802, 96101, 96101/AH 96101/TF, 96101/TG, 96101/U7, 96101/U7/HA, 96101/U7/TJ, 96116, 96118, 96118/UB		
			548 - Therapeutic Staff Support or 549 - Mobile Therapy or 559 - Behavioral Specialist Consult.		Procedure Codes: 90801, 90802, 96101/U7 96101/U7/HA, 96101/U7/TJ, 96116, 96118/UB		
			116 - Licensed Clinical Social Worker or 117 - Licensed Social Worker		Procedure Codes: H0046/UB		
			548 - Therapeutic Staff Support 442 -Partial Psych Hosp Child TSS 446 -Partial Psych Hosp Adult TSS 450 - Family Based MH TSS		Procedure Codes: H2014/UB, H2014/UB/HA, H2021/UB		
			549 - Mobile Therapy		Procedure Codes: H2019/UB		
			443 - Partial Psych Hosp Child MT 447 - Partial Psych Hosp Adult MT 451 - Family Based MH MT				
			559 - Behavioral Specialist Consult		Procedure Codes: H0032/HP, H0032/HO		
			444 -Partial Psych Hosp Child BSC 448-Partial Psych Hosp Adult BSC 452 - Family Based MH BSC				
			445-Partial Psych Hosp Child STAP 449-Partial Psych Hosp Adult STAP 453 - Family Based MH STAP		Procedure Codes: H2012/UB		
14	BHRS (EPSDT) for Children and Adolesctns with MR continued		340 - Program Exception		Procedure Codes: H0018, H0019/HA, H0019/HQ, H0019/TT, H0046/SC, H2012/SC, H2015, H2017 H2019/HA, H2021/SC, H2021/HQ/SC, H2021/U9/SC, H2021/U8/SC, H2021/U7/SC, H2033		

Healthchoices Behavioral Health Services Reporting Classification Chart - January 1, 2013

Line Item	Service	Provider Type	Provider Specialty	Provider ID	Identifiers	ENC CAT	FIN CAT
		16 - Nurse	162 - Psychiatric Nurse		Procedure Codes: H0046/UB		
		17 - Therapist	174 - Art Therapist		Procedure Codes: H2032/UB		
		17 - Therapist	175 - Music Therapist		Procedure Codes: G0176/UB		
		19 - Psychologist	548 - Therapeutic Staff Support		Procedure Codes: H2014/UB, H2014/UB/HA, H2021/UB		
			549 - Mobile Therapy		Procedure Codes: H2019/UB		
			559 - Behavioral Specialist Consult.		Procedure Codes: H0032/HP, H0032/HO		
			190 - General Psychologist		Procedure Codes: 90801, 90802, 96101/U7, 96101/U7/HA, 96101/U7/TJ, 96116, 96118/UB		
		31 - Physician	548 - Therapeutic Staff Support		Procedure Codes: H2014/UB/U1, H2014/UB/HA/U1, H2021/UB/U1		
			549 - Mobile Therapy		Procedure Code: H2019/UB/U1,		
			559 - Behavioral Specialist Consult.		Procedure Codes: H0032/HP/U1, H0032/HO/U1		
		52 - CRR	523 - Host Home/Children		Procedure Codes: H0019/HA; H0019/TT		
RESIDENTIAL TREATMENT SERVICES FOR CHILDREN & ADOLESCENTS - JCAHO							
15	Residential Treatment Facilities (RTF) for Children & Adolescents - JCAHO	01 - Inpatient	013 - RTF (JCAHO certified) Hospital	Any*	Revenue Codes: 0114, 0124, 0134, 0154, 0185,0204, 0900, 0901, 0902, 0903, 0904, 0909, 0910, 0911, 0914, 0915, 0916, 0917, 0918, 0919, 0920, 0929, 0949	08	07
RESIDENTIAL SERVICES FOR CHILDREN & ADOLESCENTS - NON-JCAHO							
16	Residential Treatment Facilities (RTF) for Children & Adolescents - Non-JCAHO	56 - RTF	560 - RTF (Non-JCAHO certified)	Any*	Procedure Code: H0019/SC	09	08
		52 - CRR	520- C&Y Lic Group Home w/ MH Treatment Component		Procedure Code: H0018, H0019/HQ		

Healthchoices Behavioral Health Services Reporting Classification Chart - January 1, 2013

Line Item	Service	Provider Type	Provider Specialty	Provider ID	Identifiers	ENC CAT	FIN CAT
OUTPATIENT DRUG & ALCOHOL SERVICES							
17	Outpatient Drug & Alcohol	08 - Clinic	184 - D&A Outpatient	Any*	Procedure Codes: See Page 4, and 5 of Attachment G excluding G0437 and 99407	10	05
		08 - Clinic	084 - Methadone Maintenance	Any*			
18	Outpatient Drug & Alcohol	08 - Clinic	080 - FQHC or 081 - RHC	Any*	Procedure Codes: T1015/HF		
ANCILLARY SERVICES							
19	Laboratory Studies/Diagnostic Radiology/ Medical Diagnostic Ordered by BH Physicians	01 - Inpatient Facility	183 - Hospital Based Med Clinic	Any*	Refer to the MA Reference File for available CPT codes.	12	09
		28 - Laboratory	280 - Independent Laboratory				
20	Laboratory Studies/Diagnostic Radiology/ Medical Diagnostic Ordered by BH Physicians	31 - Physician	339 - Psychiatry	Any*	Refer to the MA Reference File for available CPT codes.	12	09
21	Clozapine	01 - Inpatient Facility	010 - Acute Care Hospital	Any* w/special enroll	N/A	13	09
22	Clozapine Support Services	31 - Physician	339 - Psychiatry	Any*	Procedure Code: H2010//HK/U1	13	09
		08 - Clinic	110 - Psychiatric Outpatient		Procedure Code: H0034/HK, H2010/HK	13	09
		11 - Mental Health/ Substance Abuse	113 - Partial Psych Hosp Children or 114 - Partial Psych Hosp Adult		Procedure Code: H2010/HK		
COMMUNITY SUPPORT SERVICES							
23	Crisis Intervention	11 - Mental Health/ Substance Abuse	118 - MH Crisis Intervention	Any*	Procedure Codes: H0030, H2011, H2011/UB/HE, H2011/U9/HK, H2011/U7/HT, S9484, S9485	14	10
24	Family Based Services for Children & Adolescents	11 - Mental Health/ Substance Abuse	115 - Family Based MH	Any*	Procedure Codes: H0004/UB/HE, H0004/UB/HK, H0004/UB/HT, H0004/UB/UK, H0004/UB/HE/HK, T1016/UB, T1016/UB/HK, T1016/UB/HT, T1016/UB/UK	15	10
25	Targeted MH Case Management - Intensive Case Management	21 - Case Manager	222 - MH TCM, Intensive	Any*	Procedure Codes: T1017/UB, T1017/UB/HK, T1017/UB/HE/HK	16	10
26	Targeted MH Case Management - ICM-CTT	21 - Case Manager	222 - MH TCM, Intensive	1000017440121	Procedure Codes: T1017/HT, T1017/HK/HT, T1017/HE/HK/HT	16	10
27	Targeted MH Case Management - Blended Case Management	21 - Case Manager	222 - MH TCM, Intensive	Any*	Procedure Codes: T1017/UB/UC, T1017/UB/HK/UC, T1017UB/HE/HK/UC	16	10
28	Targeted MH Case Management - Resource Coordination	21 - Case Manager	221 - MH TCM, Resource Coordination	Any*	Procedure Codes: T1017/TF, T1017/TF/HK, T1017/TF/HE/HK	16	10
44	Peer Support Services	08 - Clinic	076 - Peer Specialist	Any	Procedure Codes: H0038, H0038/GT	19	98
		11 - Mental Health/ Substance Abuse					
		21 - Case Manager					
OTHER SERVICES (Defined Supplemental)							
Outpatient Psychiatric (Defined Supplemental)							
29	Rehabilitative Services	11 - Mental Health/ Substance Abuse	123 - Psychiatric Rehab	Any*	Procedure Codes: H0036/HB, H2030,	18	98
30	Mental Health General	11 - Mental Health/ Substance Abuse	110 - Psychiatric Outpatient	Any*	Procedure Code: H0031	98/96	98
31	Residential & Housing Support Services	11 - Mental Health/ Substance Abuse	110 - Psychiatric Outpatient	Any*	Procedure Codes: H0018/HE, T2048/HE	98/96	98
Community Support (Defined Supplemental)							

Healthchoices Behavioral Health Services Reporting Classification Chart - January 1, 2013

Line Item	Service	Provider Type	Provider Specialty	Provider ID	Identifiers	ENC CAT	FIN CAT
33	Mental Health General	11 - Mental Health/ Substance Abuse	111 - Community Mental Health	Any*	Procedure Code: H0039/HB	98/96	98
Outpatient Drug and Alcohol (Defined Supplemental)							
34	Outpatient Drug & Alcohol	11 - Mental Health/ Substance Abuse	129 - D&A Partial Hospitalization	Any*	Procedure Codes: H0020, H2035	98/97	98
			184 - Outpatient D&A	Any*	Procedure Codes: H0001, H0022		
		21 - Case Manager	138 - D&A Targeted Case Mgmt	Any*	Procedure Codes: H0006, H0006/TF	98/97	98
35	Outpatient Drug & Alcohol	11 - Mental Health/ Substance Abuse	128 - D&A Intensive Outpatient	Any*	Procedure Code: H0015	98/97	98
Supplemental Other (Defined Supplemental)							
36	Mental Health General	11 - Mental Health/ Substance Abuse	112 -OP Practitioner - MH	Any*	Procedure Code: H0004/HE	98/96	98
			119 - MH - OMHSAS	Any*	Procedure Code: H0046/HW	98/96	98
			110 - Psychiatric Outpatient	Any*	Procedure Code: H0037	98/96	98
37	Outpatient Drug & Alcohol	11 - Mental Health/ Substance Abuse	127 - D&A OP	Any*	Procedure Code: H0004/HF	98/97	98
			184 - Outpatient D&A	Any*	Procedure Code: H0047/HA, H0047/HW	98/97	98
OTHER SERVICES (MA Defined - Non-Behavioral Health)							
38	Case Management Services	21 - Case Manager	212 - MA Case Management for under 21 years of age	Any*	Procedure Code: T1016/U8	98/96	98
OTHER SERVICES (MA Defined - Behavioral Health)							
39	Outpatient Behavioral Health	17 - Therapist	171 - Occupational Therapist		Procedure Code: 97150/GO	98/96	98
40	Tobacco Cessation	01 - Inpatient Facility	370 - Tobacco Cessation	Any* w/special enroll	Procedure Code: G0437, 99407	98/96	98
		05 - Home Health					
		08 - Clinic					
		09 - CRNP					
		19 - Psychologist					
		27 - Dentist					
		31 - Physician					
		37 - Tobacco Cessation					
OTHER SERVICES (MA Defined - Behavioral Health - Supplemental)							
41	Ancillary Services	31 - Physician	339 - Psychiatry	Any*	Procedure Codes: 90862/UB	98/96	98
OTHER SERVICES (Non-MA Behavioral Health)							
42	Other - Outpatient	31 - Physician	339 - Psychiatry	Any*	CPT Codes: 90801/HE, 90816/HE, 90817/HE, 90818/HE, 90819/HE, 90821/HE, 90822/HE, 90862/HE	98/96	98
		19 - Psychologist	190 - General Psychologist	Any*	CPT Codes: 90801/HE, 90802/HE	98/96	98
		01 - Inpatient Facility	010 - Acute Care Hospital	Any*	CPT Codes: 90801/HE, 90804/HE, 90806/HE, 90846/HE, 90847/HE, 90853/HE, 90862/HE	98/96	98
		01 - Inpatient Facility	011 - Private Psych Hosp or 022 - Private Psych Unit	Any*	CPT Codes: 90801/HE, 90804/HE, 90806/HE, 90846/HE, 90847/HE, 90853/HE, 90862/HE, 90870	98/96	98
		08 - Clinic	080 - FQHC or 081 - RHC	Any*	CPT Codes: 90801/HE, 90846/HE, 90847/HE, 90853/HE, 90862/HE	98/96	98
		08 - Clinic	110 - Psychiatric Outpatient	Any*	CPT Codes: 90816/HE, 90817/HE, 90818/HE, 90819/HE, 90821/HE, 90822/HE, 99347/HE, 99348/HE,	98/96	98
42	Other - Outpatient continued				99349/HE		
		08 - Clinic	110 - Psychiatric Outpatient	Any* with OMHSAS	CPT Codes: 90801/GT, 90802/GT, 90804/GT,	98/96	98

Healthchoices Behavioral Health Services Reporting Classification Chart - January 1, 2013

Line Item	Service	Provider Type	Provider Specialty	Provider ID	Identifiers	ENC CAT	FIN CAT
				approval	90805/GT, 90806/GT, 90807/GT, 90808/GT, 90809/GT, 90810/GT, 90811/GT, 90812/GT, 90813/GT, 90814/GT, 90815/GT, 90862/GT, 99201/GT, 99202/GT, 99203/GT, 99204/GT, 99205/GT, 99211/GT, 99212/GT, 99213/GT, 99214/GT, 99215/GT, 99241/GT, 99242/GT, 99243/GT, 99244/GT, 99245/GT, Q3014/GT		
		09 - CRNP	103 - Family & Adult Psychiatric Mental Health	Any*	CPT Codes: 90801/HE, 90804/UB/U1, 90805/UB/U1, 90806/UB/U1, 90807/UB/U1, 90808/UB/U1, 90809/UB/U1, 90810/U1, 90811/U1, 90812/U1, 90813/U1, 90814/U1, 90815/U1, 90846/UB/U1, 90847/UB/U1, 90853/UB/U1, 90862/HE, 90870, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99281, 99282, 99283, 99284, 99285, 99291, 99292, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99341, 99342, 99343, H2010/HK/U1	06	04

Lines 2 and 3 - Code combinations listed in Lines 2 and 3 are allowed with either no DRG or any valid DRG other than 424 through 432.

Lines 5 and 7 - Code combinations listed in Lines 5 and 7 are allowed with either no DRG or any valid DRG other than 433, 521, 522, or 523.

Line 15 - Code combinations listed in Line 15 are allowed with either no DRG or any valid DRG

Providers Enrolled With CDC (Co-occurring Disorder Competency) Special Indicator

Provider ID	Service Location	Provider	Effective Date
001620056	0001	Good Friends Inc	09/04/08
001627736	0001	Libertae Inc	01/15/10
100001584	0057	Path Inc - Drug and Alcohol Clinic	01/25/08
100001996	0004	Penn del Mental Health Center	05/01/08
100228589	0012	Gaudenzia Outpatient Services	10/31/06
100228589	0041	Gaudenzia - Common Ground	10/31/06
100715523	0047	Consortium Drug and Alcohol	01/25/08
100715523	0061	Consortium Drug and Alcohol	01/25/08
100715523	0084	Consortium - University City	01/25/08
100715523	0085	Consortium Inc	01/25/08
100732892	0039	Family Services Association of Bucks Co	09/15/08
100742567	0002	UHS Recovery Foundation Inc (Keystone)	03/24/08
100752071	0008	Psychological Services Clinic	10/31/06
100752071	0012	Psychological Services Clinic - New Hope	10/31/06
100755761	0019	Penn Foundation Recovery Center	01/25/08
100762505	0007	Pyramid Healthcare Inc	11/28/06
100772252	0012	Lenape Valley Foundation	01/02/08
100777929	0005	Eagleville Hospital	12/07/07

PT, PC w/ DESCRIPTIONS, MODIFIER, UOS, AND POS

Attachment G

Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
CASE MANAGER - MA CASE MANAGEMENT FOR UNDER 21 YEARS OF AGE								
21	212*	T1016	U8		Case Management (CM)	15 min	11, 12, 21	38
CASE MANAGER - MH TARGETED CASE MANAGEMENT, INTENSIVE								
21	222	T1017		HT	Targeted Case Management (ICM- CTT - MH/MR CM)	15 min	11, 12, 99	26
21	222	T1017		HK; HT	Targeted Case Management (ICM- CTT - MH Svc During Psych Inpatient Admission)	15 min	21	26
21	222	T1017		HE; HK; HT	Targeted Case Management (ICM- CTT - MH Svc During Non-Psych Inpatient Admission)	15 min	21, 31, 32	26
21	222	T1017	UB		Targeted Case Management (ICM - MH/MR Case Mgmt)	15 min	11, 12, 99	25
21	222	T1017	UB	HK	Targeted Case Management (ICM - MH Svc During Psych Inpatient Admission)	15 min	21	25
21	222	T1017	UB	HE; HK	Targeted Case Management (ICM - MH Svc During Non-Psych Inpatient Admission)	15 min	21, 31, 32	25
21	222	T1017	UB	UC	Targeted Case Management (BCM - MH ICM Svc)	15 min	11, 12, 99	27
21	222	T1017	UB	HK; UC	Targeted Case Management (BCM - MH Svc During Psych Inpatient Admission)	15 min	21	27
21	222	T1017	UB	HE; HK; UC	Targeted Case Management (BCM - MH Svc During Non-Psych Inpatient Admission)	15 min	21, 31, 32	27
CASE MANAGER - MH TARGETED CASE MANAGEMENT, RESOURCE COORDINATION								
21	221	T1017	TF		Targeted Case Management (RC- Resource Coordination)	15 min	11, 12, 99	28
21	221	T1017	TF	HK	Targeted Case Management (RC - MH Svc During Psych Inpatient Admission)	15 min	21	28
21	221	T1017	TF	HE; HK	Targeted Case Management (RC - MH Svc During Non-Psych Inpatient Admission)	15 min	21, 31, 32	28
CASE MANAGER - PEER SPECIALIST								
21	076	H0038			Self help/peer services, per 15 minutes	15 min	12, 21, 31, 32, 99	44
21	076	H0038		GT	Self help/peer services, per 15 minutes (Self-help/peer services - interactive telecommunication systems)	15 min	12, 21, 31, 32, 99	44
CLINIC - FAMILY PLANNING								
08	370	99407		FP	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	per visit	22, 49	40
08	370	G0437		FP	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	per visit	22, 49	40
CLINIC - FEDERALLY QUALIFIED HEALTH CENTER OR RURAL HEALTH CLINIC								
08	080 or 081	T1015		HE	Clinic Visit/Encounter, All-inclusive (Rural Health Clinic Visit)	visit	12, 21, 31, 32, 50, 72, 99	11
08	080 or 081	T1015		HF	Clinic Visit/Encounter, All-inclusive (Rural Health Clinic Visit)	visit	50, 72	18
08	802 or 806	H0032	HP		Mental Health Service Plan Development by Non-physician (BSC - Doctoral Level)	15 min	12, 23, 50, 99	13, 14
08	802 or 806	H0032		HO	Mental Health Service Plan Development by Non-physician (BSC - Master's Level)	15 min	12, 23, 72, 99	13, 14
08	800 or 804	H2014	UB		Skills Training & Development (6 or more months)	15 min	12, 99	13, 14
08	800 or 804	H2014	UB	HA	Skills Training & Development (Less than 6 months)	15 min	12, 99	13, 14

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
08	801 or 805	H2019	UB		Therapeutic Behavioral Svcs (MT)	15 min	12, 99	13, 14
08	800 or 804	H2021	UB		Community-based Wraparound Svcs (TSS)	15 min	12, 23, 99	13, 14
08	803 or 807	H2012	UB		Behavioral Health Day Treatment (STAP)	per hour	99	13, 14
08	370	99407			Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	per visit	12, 49, 99	40
08	370	G0437			Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	per visit	12, 49, 99	40
CLINIC - INDEPENDENT MEDICAL/SURGICAL CLINIC								
08	370	99407			Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	per visit	49	40
08	370	G0437			Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	per visit	49	40
CLINIC - METHADONE MAINTENANCE								
08	084	H0020	HG		Alcohol and/or Drug Svcs; Methadone Administration and/or Svc (take-home)	One unit per day	57	17
08	084	H0020	UB		Alcohol and/or Drug Svcs; Methadone Administration and/or Svc (provision of the drug by a licensed program)	15 min	57	17
08	084	T1015	HG		Clinic Visit/Encounter, All-Inclusive (Methadone Maintenance Comprehensive Svcs - incl transportation)	visit	57	17
CLINIC - MOBILE MENTAL HEALTH TREATMENT								
08	074	90801	UB	HB	Psychiatric diagnostic interview examination (Psychiatric Eval; Exam & Eval of Patient)	Occurrence	15	43
08	074	90802	UB	HB	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication (Psychiatric Eval; Exam & Eval of Patient)	Occurrence	15	43
08	074	90804	UB	HB	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	30 min	15	43
08	074	90806	UB	HB	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	45 min	15	43
08	074	90808	UB	HB	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	75 min	15	43
08	074	90810		HB	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	30 min	15	43
08	074	90812		HB	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	45 min	15	43

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
08	074	90814		HB	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	75 min	15	43
08	074	90846	UB	HB	Family Psychotherapy (without the patient present)	15 min	15	43
08	074	90847	UB	HB	Family Psychotherapy (conjoint psychotherapy) w/ patient present	15 min	15	43
08	074	90853	UB	HB	Group Psychotherapy (other than of a multiple-family group)	15 min	15	43
08	074	90862	UB	HB	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy (Psychiatric Clinic Med Visit for Drug Admin & Eval)	15 min	15	43
08	074	90875		HB	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg. Insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes	Occurrence	15	43
08	074	96101		HB	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Graphic Technique)	per occurrence	15	43
08	074	96101	TF	HB	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Projective Technique)	per occurrence	15	43
08	074	96101	TG	HB	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Any Combination of Four or More Intellectual or Personality Evals Listed)	per occurrence	15	43
08	074	96101	UB	HB	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements or Generally Accepted Personality Inventories)	per occurrence	15	43
08	074	96118		HB	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements for Organicity)	per occurrence	15	43
08	074	H0034		HB	Medication training & support (Medication Mgmt Visit)	15 min	15	43

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
08	074	H0034		HB/HK	Medication training & support (Clozaril Monitor & Eval Visit)	15 min	15	43
CLINIC - OUTPATIENT DRUG AND ALCOHOL								
08	184	90801	UB		Psychiatric diagnostic interview examination (Psychiatric Eval; Exam & Eval of Patient)	Occurrence	12, 57	17
08	184	90802	UB		Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication (Psychiatric Eval; Exam & Eval of Patient)	Occurrence	12, 57	17
08	184	90804	UB		Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	30 min	12, 57	17
08	184	90806	UB		Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	45 min	12, 57	17
08	184	90808	UB		Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	75 min	12, 57	17
08	184	90810			Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	30 min	12, 57	17
08	184	90812			Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	45 min	12, 57	17
08	184	90814			Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	75 min	12, 57	17
08	184	90847	UB		Family Psychotherapy (conjoint psychotherapy) w/ patient present	15 min	12, 57	17
08	184	90853	UB		Group Psychotherapy (other than of a multiple-family group)	15 min	57	17
08	184	90862	U7		Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy (Chemotherapy Visit for Admin & Eval of Drugs other than Methadone or Drugs for Opiate Detox)	15 min	57	17
08	184	90875			Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg. Insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes	Occurrence	57	17
08	184	96101			Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Graphic Technique)	per occurrence	12, 57	17
08	184	96101	TF		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Projective Technique)	per occurrence	12, 57	17

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
08	184	96101	TG		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Any Combination of Four or More Intellectual or Personality Evals Listed)	per occurrence	12, 57	17
08	184	96101	UB		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements or Generally Accepted Personality Inventories)	per occurrence	12, 57	17
08	184	96118			Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements for Organicity)	per occurrence	12, 57	17
08	184	99204	U7		OV/OP Visit for Eval & Mgmt of New Patient, Problem Moderate to High, face to face w/ patient and/or family (Comprehensive Medical Exam & Eval)	45 min visit	12, 57	17
08	184	99215	U7		OV/OP Visit for Eval & Mgmt of Established Patient, Problem Moderate to High, face to face w/ patient and/or family (Comprehensive Medical Exam & Eval)	40 min visit	12, 57	17
08	184	H0014	HG		Alcohol and/or Drug Svcs; Ambulatory Detoxification (Opiate Detox Visit for Admin & Eval of Drugs for Ambulatory Opiate Detox)	15 min	57	17
08	184	H0034			Medication training & support (Medication Mgmt Visit)	15 min	57	17
08	370	99407			Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	per visit	12, 57, 99	40
08	370	G0437			Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	per visit	12, 57, 99	40
08	184	T1015	UB		Clinic Visit/Encounter, All-Inclusive (Drug Free Clinic Visit)	visit	57	17
CLINIC - PEER SPECIALIST								
08	076	H0038			Self help/peer services, per 15 minutes	15 min	12, 21, 23, 49, 99	44
08	076	H0038		GT	Self help/peer services, per 15 minutes (Self-help/peer services - interactive telecommunication systems)	15 min	12, 21, 23, 49, 99	44
CLINIC - PSYCHIATRIC OUTPATIENT								
08	110	00104			Anesthesia for Electroconvulsive Therapy		49	9
08	110	90801	UB		Psychiatric diagnostic interview examination (Psychiatric Eval; Exam & Eval of Patient)	Occurrence	12, 49	9
08	110	90802	UB		Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication (Psychiatric Eval; Exam & Eval of Patient)	Occurrence	12, 49	9

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
08	110	90804	UB		Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	30 min	12, 49	9
08	110	90806	UB		Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	45 min	12, 49	9
08	110	90808	UB		Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	75 min	12, 49	9
08	110	90810			Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	30 min	12, 49	9
08	110	90812			Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	45 min	12, 49	9
08	110	90814			Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	75 min	12, 49	9
08	110	90846	UB		Family Psychotherapy (without the patient present)	15 min	12, 49	9
08	110	90847	UB		Family Psychotherapy (conjoint psychotherapy) w/ patient present	15 min	12, 49	9
08	110	90853	UB		Group Psychotherapy (other than of a multiple-family group)	15 min	49	9
08	110	90862	UB		Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy (Psychiatric Clinic Med Visit for Drug Admin & Eval)	15 min	49	9
08	110	90870			ECT Therapy (includes necessary monitoring)	1 treatment	49	9
08	110	90875			Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg. Insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes	Occurrence	12, 49	9
08	110	95816			EEG including recording awake & drowsy	1 treatment	49	9
08	110	95819			EEG including recording awake & asleep	1 treatment	49	9
08	110	95822			EEG recording in coma or sleep only	1 treatment	49	9
08	110	95827			EEG all night recording	1 treatment	49	9
08	110	96101			Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Graphic Technique)	per occurrence	12, 49	9
08	110	96101	TF		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Projective Technique)	per occurrence	12, 49	9

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
08	110	96101	TG		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Any Combination of Four or More Intellectual or Personality Evals Listed)	per occurrence	12, 49	9
08	110	96101	UB		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements or Generally Accepted Personality Inventories)	per occurrence	12, 49	9
08	110	96118			Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements for Organicity)	per occurrence	12, 49	9
08	110	H0034			Medication training & support (Medication Mgmt Visit)	15 min	49	9
08	370	99407			Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	per visit	49	40
08	370	G0437			Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	per visit	49	40
CLINIC - PSYCHIATRIC OUTPATIENT - CLOZAPINE								
08	110	H0034		HK	Medication training & support (Clozaril Monitor & Eval Visit)	15 min	49	22
08	110	H2010		HK	Comprehensive Medication Svcs (Clozapine Support Svc)	15 min	12, 49	22
CRNP								
09	370	99407			Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	per visit	11, 12, 31, 32, 99	40
09	370	G0437			Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	per visit	11, 12, 31, 32, 99	40
CRNP WRAPAROUND - BEHAVIORAL SPECIALIST CONSULTANT								
09	559	H0032	HP		Mental Health Service Plan Development by Non-physician (BSC - Doctoral Level)	15 min	11, 12, 23, 99	13, 14
09	559	H0032		HO	Mental Health Service Plan Development by Non-physician (BSC - Master's Level)	15 min	11, 12, 23, 99	13, 14
CRNP WRAPAROUND - MOBILE THERAPY								
09	549	H2019	UB		Therapeutic Behavioral Svcs (MT)	15 min	12, 99	13, 14
CRNP WRAPAROUND - THERAPEUTIC STAFF SUPPORT								
09	548	H2014	UB		Skills Training & Development (6 or more months)	15 min	12, 99	13, 14

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09	548	H2014	UB	HA	Skills Training & Development (<i>Less than 6 months</i>)	15 min	12, 99	13, 14
09	548	H2021	UB		Community-based Wraparound Svcs (<i>TSS</i>)	15 min	12, 23, 99	13, 14
DENTIST								
27	370	99407			Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	per visit	11, 12, 31, 32, 99	40
27	370	G0437			Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	per visit	11, 12, 31, 32, 99	40
HOME HEALTH								
05	370	99407			Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	per visit	12	40
05	370	G0437			Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	per visit	12	40
INPATIENT FACILITY - ACUTE CARE HOSPITAL								
01	010	N/A			Inpatient Psych Svcs	N/A	N/A	1
01	010	N/A			Inpatient D&A Detox	N/A	N/A	4
01	010	N/A			Inpatient D&A Rehab	N/A	N/A	6
01	010	N/A			Clozapine	N/A	N/A	21
01	370	99407			Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	per visit	22	40
01	370	G0437			Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	per visit	22	40

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INPATIENT FACILITY - DRUG AND ALCOHOL REHABILITATION HOSPITAL/UNIT								
01	019 or 441	N/A			Inpatient D&A Detox	N/A	N/A	5
01	019 or 441	N/A			Inpatient D&A Rehab	N/A	N/A	7
01	370	99407			Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	per visit	22	40
01	370	G0437			Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	per visit	22	40
INPATIENT FACILITY - EXTENDED ACUTE PSYCHIATRIC CARE								
01	018	N/A			Inpatient Psych Svcs	N/A	N/A	3
INPATIENT FACILITY - HOSPITAL BASED MEDICAL CLINIC								
01	183	Refer to the MA reference file			Studies Ordered by Behavioral Health Physicians	Refer to the MA reference file	Refer to the MA reference file	19
01	183	90870			ECT Therapy (includes necessary monitoring)	1 treatment	22	9
INPATIENT FACILITY - PRIVATE PSYCHIATRIC HOSPITAL/UNIT								
01	011 or 022	N/A			Inpatient Psych Svcs	N/A	N/A	2
INPATIENT FACILITY - RESIDENTIAL TREATMENT FACILITY - JCAHO								
01	013	N/A			RTF for Children & Adolescent	N/A	N/A	15
LABORATORY								
28	280	Refer to the MA reference file			Laboratory Studies Ordered by Behavioral Health Physicians	Refer to the MA reference file	Refer to the MA reference file	19
MENTAL HEALTH - CRISIS INTERVENTION								
11	118	H0030			Behavioral Health Hotline Svc (Telephone Crisis)	15 min	11	23
11	118	H2011			Crisis Intervention Svc (Walk-in Crisis)	15 min	11	23
11	118	H2011	UB	HE	Crisis Intervention Svc (Mobile Crisis - Individual Delivered)	15 min	15	23
11	118	H2011	U9	HK	Crisis Intervention Svc (Medical Mobile Crisis - Team Delivered)	15 min	15	23
11	118	H2011	U7	HT	Crisis Intervention Svc (Mobile Crisis - Team Delivered)	15 min	15	23
11	118	S9484			Crisis Intervention Svc, MH svcs (Crisis In-Home Support)	per hour	12, 99	23
11	118	S9485			Crisis Intervention Svc, MH svcs (Crisis Residential)	per diem	12	23
MENTAL HEALTH - FAMILY BASED REHAB SERVICES								
11	115	H0004	UB	HE	Behavioral Health Counseling and Therapy (Team member w/ Consumer)	15 min	12, 99	24
11	115	H0004	UB	HE; HK	Behavioral Health Counseling and Therapy (MH Svc During Non-Psych Inpatient Admission)	15 min	21, 31, 32	24
11	115	H0004	UB	HK	Behavioral Health Counseling and Therapy (MH Svc During Psych Inpatient Admission)	15 min	21	24

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11	115	H0004	UB	HT	Behavioral Health Counseling and Therapy (Team w/ Consumer and/or Family)	15 min	12, 99	24
11	115	H0004	UB	UK	Behavioral Health Counseling and Therapy (Team Member w/ Family of Consumer)	15 min	12, 99	24
11	115	T1016	UB		Case Management (MH Svc During Non-Psych Inpatient Admission)	15 min	21, 31, 32	24
11	115	T1016	UB	HK	Case Management (MH Svc During Psych Inpatient Admission)	15 min	21	24
11	115	T1016	UB	HT	Case Management (Team w/ Collateral and/or Other Agencies)	15 min	12, 99	24
11	115	T1016	UB	UK	Case Management (Team Member w/ Collateral and/or Other Agencies)	15 min	12, 99	24
MENTAL HEALTH - PARTIAL PSYCH HOSPITALIZATION								
11	114	H0035	U7		Mental health partial hospitalization, treatment, less than 24 hrs (Licensed Adult Psych Partial Program - Adult)	1 hour	52	10
11	114	H0035	UB	HA	Mental health partial hospitalization, treatment, less than 24 hrs (Licensed Adult Psych Partial Program - Child or Licensed Adult Psych Partial Hosp Program - Child 0-20 years of age, services beyond 270 hours)	1 hour	52	10
11	114	H0035	U7	U2	Mental health partial hospitalization, treatment, less than 24 hrs (Psych Partial Program - Non-Covered Medicare Hours - Adult)	1 hour	52	10
11	113	H0035		U2; UA	Mental health partial hospitalization, treatment, less than 24 hrs (Psych Partial Program - Non-Covered Medicare Hours - Child age 0-14)	1 hour	52	10
11	113	H0035	U7	HB; UA	Mental health partial hospitalization, treatment, less than 24 hrs (Licensed Child Psych Partial Program - Adult)	1 hour	52	10
11	113	H0035	UB	UA	Mental health partial hospitalization, treatment, less than 24 hrs (Licensed Child Psych Partial Program - Child or Licensed Child Psych Partial Hosp Program - Child 15 thru 20 years of age or Licensed Child Psych Partial Hosp Program - Child 0-14 years of age, services beyond 720 hours or Licensed Child Psych Partial Hosp Program - Child 15-20 years of age, services beyond 720 hours)	1 hour	52	10
MENTAL HEALTH - PARTIAL PSYCH HOSPITALIZATION - CLOZAPINE SUPPORT								
11	113 or 114	H2010		HK	Comprehensive Medication Svcs (Clozapine Support Svc)	15 min	52	22
MENTAL HEALTH - PEER SPECIALIST								
11	076	H0038			Self help/peer services, per 15 minutes	15 min	11, 12, 21, 52, 99	44
11	076	H0038		GT	Self help/peer services, per 15 minutes (Self-help/peer services - interactive telecommunication systems)	15 min	11, 12, 21, 52, 99	44
MENTAL HEALTH / SUBSTANCE ABUSE - SUPPLEMENTAL								
11	184	H0001			Alcohol and/or Drug Assessment (D&A Level of Care Assessment)	15 min	99	34
11	112	H0004		HE	Behavioral health counseling and therapy (MH Outpatient Practitioner)	15 min	99	36
11	127	H0004		HF	Behavioral health counseling and therapy (D&A Outpatient Practitioner)	15 min	99	37
21	138	H0006			Alcohol and/or drug services; case management (D&A ICM)	15 min	99	34
21	138	H0006		TF	Alcohol and/or drug services; case management (D&A RC)	15 min	99	34
11	132	H0013			Alcohol and/or Drug Svcs; acute detox (residential addiction outpatient) (Detoxification)	per diem	99	8

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
11	128*	H0015			Alcohol and/or Drug Svcs; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, & activity therapies or education (Intensive Outpatient D&A Clinic)	15 min	99	35
11	110	H0018		HE	Behavioral health; short-term residential (non-hospital residential treatment program) without room and board (Adult Residential Treatment Facility)	per diem	99	31
11	133	H0018		HF	Behavioral health; short-term residential (non-hospital residential treatment program) without room and board (Drug Free Residential)	per diem	99	8
11	129	H0020			Alcohol and/or Drug Svcs; Methadone administration and/or svc (provision of the drug by a licensed program) (Methadone Maintenance)	15 min	99	34
11	184	H0022			Alcohol and/or Drug Intervention Svc (planned facilitation) (D&A - Intervention)	30 min	99	34
11	110	H0031			Mental Health Assessment, by non-physician (MH Diagnostic Assessment)	15 min	99	30
11	123	H0036		HB	Community psychiatric supportive treatment, face to face (Psych Rehab - Site Based or Mobile)	15 min	15, 99	29
11	110	H0037			Community psychiatric supportive treatment program, per diem (Adult Outpatient Services in an Alternative Setting)	per diem	99	36
11	111	H0039		HB	Assertive Community Treatment, face to face (Community Treatment Teams)	15 min	99	33
11	119	H0046		HW	Mental health services, not otherwise specified (Community MH Svc - Other - Requires Service Description Approved by OMHSAS)	15 min	99	36
11	184	H0047		HA	Alcohol and/or other drug abuse svcs, not otherwise specified (D&A Outpatient Treatment in an Alternative Setting)	15 min	03, 99	37
11	184	H0047		HW	Alcohol and/or other drug abuse svcs, not otherwise specified (D&A - Other - Requires Service Description Approved by OMHSAS)	15 min	99	37
11	123	H2030			Mental Health Clubhouse Svcs (Psych Rehab - Clubhouse)	15 min	99	29
11	131	H2034			Alcohol and/or Drug Abuse Halfway House Svcs (Drug Free Halfway House)	per diem	99	8
11	129	H2035			Alcohol and/or Drug Treatment Program (Drug Free)	per hour	99	34
11	110	T2048		HE	Behavioral Health; Long-term care residential (non-acute care in a residential treatment program where stay is typically longer than 30 days) with room and board, per diem (Long Term Structured Residential)	per diem	99	31
11	134	T2048		HF	Behavioral Health; Long-term care residential (non-acute care in a residential treatment program where stay is typically longer than 30 days) with room and board, per diem (Drug Free Residential)	per diem	99	8
PHYSICIAN								
31	339	00104		U1	Anesthesia for Electroconvulsive Therapy		11, 21, 99	12
31	339	90804	UB	U1	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	30 min	11	12
31	339	90805	UB	U1	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, with medical evaluation and management services, face to face w/ patient	30 min	11	12

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
31	339	90806	UB	U1	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	45 min	11	12
31	339	90807	UB	U1	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, with medical evaluation and management services, face to face w/ patient	45 min	11	12
31	339	90808	UB	U1	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	75 min	11	12
31	339	90809	UB	U1	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, with medical evaluation and management services, face to face w/ patient	75 min	11	12
31	339	90810		U1	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	30 min	11	12
31	339	90811		U1	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, with medical evaluation and management services, face to face w/ patient	30 min	11	12
31	339	90812		U1	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	45 min	11	12
31	339	90813		U1	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, with medical evaluation and management services, face to face w/ patient	45 min	11	12
31	339	90814		U1	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	75 min	11	12
31	339	90815		U1	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, with medical evaluation and management services, face to face w/ patient	75 min	11	12
31	339	90846	UB	U1	Family Psychotherapy (without the patient present)	15 min	11	12
31	339	90847	UB	U1	Family Psychotherapy (conjoint psychotherapy) w/ patient present	15 min	11	12
31	339	90853	UB	U1	Group Psychotherapy (other than of a multiple-family group)	15 min	11	12
31	339	90870			ECT Therapy (includes necessary monitoring) (POS 99 - Special Treatment Room)	1 treatment	11, 21, 99	12
31	339	90875			Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg. Insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes	Occurrence	11, 21	12

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
31	339	96101		U1	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering test to the patient and time interpreting these test results and preparing the report (Generally Accepted Graphic Technique)	per occurrence	11, 21	12
31	339	96101	TF	U1	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Projective Technique)	per occurrence	11, 21	12
31	339	96101	TG	U1	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Any Combination of Four or More Intellectual or Personality Evals Listed)	per occurrence	11, 21	12
31	339	96101	UB	U1	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements or Generally Accepted Personality Inventories)	per occurrence	11, 21	12
31	339	96118		U1	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements for Organicity)	per occurrence	11, 21	12
31	316, 322, 339, 345	99201			OV/OP Visit for Eval & Mgmt of New Patient, Problem Self Ltd or Minor, face to face w/ patient and/or family	10 min	11	12
31	316, 322, 339, 345	99202			OV/OP Visit for Eval & Mgmt of New Patient, Problem Low to Moderate, face to face w/ patient and/or family	20 min	11	12
31	316, 322, 339, 345	99203			OV/OP Visit for Eval & Mgmt of New Patient, Problem Moderate, face to face w/ patient and/or family	30 min	11	12
31	339	99203		U1	OV/OP Visit for Eval & Mgmt of New Patient, Problem Moderate, face to face w/ patient and/or family (Comprehensive Medical Exam by General Practitioner when Requested by the Department to Determine Eligibility)	30 min	11	12
31	316, 322, 339, 345	99204			OV/OP Visit for Eval & Mgmt of New Patient, Problem Moderate to High, face to face w/ patient and/or family	45 min	11	12

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
31	339	99204		U1	OV/OP Visit for Eval & Mgmt of New Patient, Problem Moderate to High, face to face w/ patient and/or family (Comprehensive Medical Exam by General Practitioner when Requested by the Department to Determine Eligibility)	45 min	11	12
31	316, 322, 339, 345	99205			OV/OP Visit for Eval & Mgmt of New Patient, Problem Moderate to High, face to face w/ patient and/or family	60 min	11	12
31	339	99205		U1	OV/OP Visit for Eval & Mgmt of New Patient, Problem Moderate to High, face to face w/ patient and/or family (Comprehensive Medical Exam by General Practitioner when Requested by the Department to Determine Eligibility)	60 min	11	12
31	316, 322, 339, 345	99211			OV/OP Visit for Eval & Mgmt of Established Patient, Problem Minimal, face to face w/ patient and/or family	5 min	11	12
31	339	99211		U1	OV/OP Visit for Eval & Mgmt of Established Patient, Problem Minimal, face to face w/ patient and/or family	5 min	11	12
31	316, 322, 339, 345	99212			OV/OP Visit for Eval & Mgmt of Established Patient, Problem Self Ltd or Minor, face to face w/ patient and/or family	10 min	11	12
31	339	99212		U1	OV/OP Visit for Eval & Mgmt of Established Patient, Problem Self Ltd or Minor, face to face w/ patient and/or family	10 min	11	12
31	316, 322, 339, 345	99213			OV/OP Visit for Eval & Mgmt of Established Patient, Problem Low to Moderate, face to face w/ patient and/or family	15 min	11	12
31	339	99213		U1	OV/OP Visit for Eval & Mgmt of Established Patient, Problem Low to Moderate, face to face w/ patient and/or family	15 min	11	12
31	316, 322, 339, 345	99214			OV/OP Visit for Eval & Mgmt of Established Patient, Problem Moderate to High, face to face w/ patient and/or family	25 min	11	12
31	339	99214		U1	OV/OP Visit for Eval & Mgmt of Established Patient, Problem Moderate to High, face to face w/ patient and/or family	25 min	11	12
31	316, 322, 339, 345	99215			OV/OP Visit for Eval & Mgmt of Established Patient, Problem Moderate to High, face to face w/ patient and/or family	40 min	11	12
31	339	99215		U1	OV/OP Visit for Eval & Mgmt of Established Patient, Problem Moderate to High, face to face w/ patient and/or family	40 min	11	12
31	339	99221			Initial Hospital Care, per Day, for Eval & Mgmt of Patient, Problem Low, at bedside	30 min	21	12
31	339	99222			Initial Hospital Care, per Day, for Eval & Mgmt of Patient, Problem Moderate, at bedside	50 min	21	12
31	339	99223			Initial Hospital Care, per Day, for Eval & Mgmt of Patient, Problem High, at bedside	70 min	21	12
31	339	99231			Subsequent hospital care, per day, for eval & mgmt of a patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem focused exam; medical decision making that is straightforward or of low complexity	15 min	21	12
31	339	99232			Subsequent hospital care, per day, for eval & mgmt of a patient, which requires at least 2 of these 3 key components: an expanded problem focused interval history; an expanded problem focused exam; medical decision making of moderate complexity	25 min	21	12

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
31	339	99233			Subsequent hospital care, per day, for eval & mgmt of a patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed exam; medical decision making of high complexity	35 min	21	12
31	339	99238			Hospital Discharge Day Mgmt, 30 minutes or less	Visit	21	12
31	339	99241			Office Consult for New or Established Patient, Problem Self Ltd or Minor, face to face w/ patient and/or family	15 min	11, 12, 23, 24, 31, 32, 54, 65	12
31	339	99241		GT	Office Consult for New or Established Patient, Problem Self Ltd or Minor, face to face w/ patient and/or family (Effective 12/1/07)	15 min	11	12
31	339	99242			Office Consult for New or Established Patient, Problem Low, face to face w/ patient and/or family	30 min	11, 12, 23, 24, 31, 32, 54, 65	12
31	339	99242		GT	Office Consult for New or Established Patient, Problem Low, face to face w/ patient and/or family (Effective 12/1/07)	30 min	11	12
31	339	99243			Office Consult for New or Established Patient, Problem Moderate, face to face w/ patient and/or family	40 min	11, 12, 23, 24, 31, 32, 54, 65	12
31	339	99243		GT	Office Consult for New or Established Patient, Problem Moderate, face to face w/ patient and/or family (Effective 12/1/07)	40 min	11	12
31	339	99244			Office Consult for New or Established Patient, Problem Moderate to High, face to face w/ patient and/or family	60 min	11, 12, 23, 24, 31, 32, 54, 65	12
31	339	99244		GT	Office Consult for New or Established Patient, Problem Moderate to High, face to face w/ patient and/or family (Effective 12/1/07)	60 min	11	12
31	339	99245			Office Consult for New or Established Patient, Problem Moderate to High, face to face w/ patient and/or family	80 min	11, 12, 23, 24, 31, 32, 54, 65	12
31	339	99245		GT	Office Consult for New or Established Patient, Problem Moderate to High, face to face w/ patient and/or family (Effective 12/1/07)	80 min	11	12
31	339	99251			Initial Inpatient Consult for New or Established Patient, Problem Self Ltd or Minor, at bedside	20 min	21, 31, 32	12
31	339	99252			Initial Inpatient Consult for New or Established Patient, Problem Low, at bedside	40 min	21, 31, 32	12
31	339	99253			Initial Inpatient Consult for New or Established Patient, Problem Moderate, at bedside	55 min	21, 31, 32	12
31	339	99254			Initial Inpatient Consult for New or Established Patient, Problem Moderate to High, at bedside	80 min	21, 31, 32	12
31	339	99255			Initial Inpatient Consult for New or Established Patient, Problem Moderate to High, at bedside	110 min	21, 31, 32	12
31	315, 316, 322, 339, 345	99281			ER Visit for Eval & Mgmt of Patient, Problem Self Ltd or Minor	Visit	23	12

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
31	315, 316, 322, 339, 345	99282			ER Visit for Eval & Mgmt of Patient, Problem Low to Moderate	Visit	23	12
31	315, 316, 322, 339, 345	99283			ER Visit for Eval & Mgmt of Patient, Problem Moderate	Visit	23	12
31	315, 316, 322, 339, 345	99284			ER Visit for Eval & Mgmt of Patient, Problem High/Urgent	Visit	23	12
31	315, 316, 322, 339, 345	99285			ER Visit for Eval & Mgmt of Patient, Problem High/Threat to Life	Visit	23	12
31	339	99291			Critical Care, eval & mgmt, first hour	1 hour	21, 23	12
31	339	99292			Critical Care, eval & mgmt, each additional 30 minutes	30 min	21, 23	12
31	339	99304			Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and a medical decision making that is straightforward or of low complexity	visit	31, 32	12
31	339	99305			Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity	Visit	31, 32	12
31	339	99306			Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity	Visit	31, 32	12
31	339	99307			Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; straightforward medical decision making	Visit	31, 32	12
31	339	99308			Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity	Visit	31, 32	12
31	339	99309			Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity	Visit	31, 32	12
31	339	99310			Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; medical decision making of high complexity	Visit	31, 32	12

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
31	339	99341			Home Visit for Eval & Mgmt of New Patient, Problem Low, face to face with the patient and/or family	20 min	12	12
31	339	99342			Home Visit for Eval & Mgmt of New Patient, Problem Moderate, face to face with the patient and/or family	30 min	12	12
31	339	99343			Home Visit for Eval & Mgmt of New Patient, Problem High, face to face with the patient and/or family	45 min	12	12
31	370	99407			Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	per visit	11, 12, 31, 32, 99	40
31	370	G0437			Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	per visit	11, 12, 31, 32, 99	40
31	339	Refer to the MA reference file			Studies Ordered by a Behavioral Health Physician Refer to Line 20 of the BHSRCC	Refer to the MA reference file	Refer to the MA reference file	20
PHYSICIAN WRAPAROUND - BEHAVIORAL SPECIALIST CONSULTANT								
31	559	H0032	HP	U1	Mental Health Service Plan Development by Non-physician (BSC - Doctoral Level)	15 min	11, 12, 23, 99	13, 14
31	559	H0032		HO; U1	Mental Health Service Plan Development by Non-physician (BSC - Master's Level)	15 min	11, 12, 23, 99	13, 14
PHYSICIAN WRAPAROUND - MOBILE THERAPY								
31	549	H2019	UB	U1	Therapeutic Behavioral Services (MT)	15 min	12, 99	13, 14
PHYSICIAN WRAPAROUND - THERAPEUTIC STAFF SUPPORT								
31	548	H2014	UB	U1	Skills Training & Development (6 or more months)	15 min	12, 99	13, 14
31	548	H2014	UB	HA; U1	Skills Training & Development (Less than 6 months)	15 min	12, 99	13, 14
31	548	H2021	UB	U1	Community-based Wraparound Services (TSS)	15 min	12, 23, 99	13, 14
PHYSICIAN/CLOZAPINE SUPPORT								
31	339	H2010		HK: U1	Comprehensive Medication Services (Clozapine Support Svc)	15 min	11, 12	22
PHYSICIAN BH - SUPPLEMENTAL								
31	339	90862	UB		Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy (Psychiatric Clinic Med Visit for Drug Admin & Eval)	15 min	11	41
PSYCHOLOGIST								
19	190	90804	UB		Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	30 min	11	12
19	190	90806	UB		Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	45 min	11	12
19	190	90808	UB		Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	75 min	11	12

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
19	190	90810			Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	30 min	11	12
19	190	90812			Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	45 min	11	12
19	190	90814			Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	75 min	11	12
19	190	90846	UB		Family Psychotherapy (without the patient present)	15 min	11	12
19	190	90847	UB		Family Psychotherapy (conjoint psychotherapy) w/ patient present	15 min	11	12
19	190	90853	UB		Group Psychotherapy (other than of a multiple-family group)	15 min	11	12
19	190	90875			Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg. Insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes	Occurrence	11	12
19	190	96101			Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements or Generally Accepted Graphic Technique)	per occurrence	11, 12, 21	12
19*	190	96101	AH		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Personality Inventories)	per occurrence	11, 12, 21	12
19*	190	96101	TF		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Projective Technique)	per occurrence	11, 12, 21	12
19*	190	96101	TG		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Any Combination of Four or More Intellectual or Personality Evals Listed)	per occurrence	11, 12, 21	12

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
19*	190	96118			Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements for Organicity)	per occurrence	11, 12, 21	12
19	370	99407			Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	per visit	11, 12, 31, 32, 99	40
19	370	G0437			Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	per visit	11, 12, 31, 32, 99	40
PSYCHOLOGIST WRAPAROUND								
19	190	90801			Psychiatric diagnostic interview examination (Psychological Eval)	30 min	11, 12, 21, 99	13, 14
19	190	90802			Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication (Psychological Eval)	30 min	11, 12, 21, 99	13, 14
19	190	96101	U7		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Diagnostic Intellectual Eval)	per hour	11, 12, 21, 99	13, 14
19	190	96101	U7	HA	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Individual Diagnostic Personality Eval)	per hour	11, 12, 21, 99	13, 14
19	190	96101	U7	TJ	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Comprehensive Diagnostic Psychological Eval)	per hour	11, 12, 21, 99	13, 14
19	190	96116			Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning an problem solving, and visual spatial abilities) per hour of the psychologist's or physician's time, both face to face time with the patient and time interpreting test results and preparing the report (Comprehensive Neuropsychological Eval w/ Personality Assessment)	per hour	11, 12, 21, 99	13, 14
19	190	96118	UB		Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Comprehensive Neuropsychological Eval)	per hour	11, 12, 21, 99	13, 14

Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
PSYCHOLOGIST WRAPAROUND - BEHAVIORAL SPECIALIST CONSULTANT								
19	559	H0032	HP		Mental Health Service Plan Development by Non-physician (BSC - Doctoral Level)	15 min	11, 12, 23, 99	13, 14
19	559	H0032		HO	Mental Health Service Plan Development by Non-physician (BSC - Master's Level)	15 min	11, 12, 23, 99	13, 14
PSYCHOLOGIST WRAPAROUND - MOBILE THERAPY								
19	549	H2019	UB		Therapeutic Behavioral Svcs (MT)	15 min	12, 99	13, 14
PSYCHOLOGIST WRAPAROUND - THERAPEUTIC STAFF SUPPORT								
19	548	H2014	UB		Skills Training & Development (6 or more months)	15 min	12, 99	13, 14
19	548	H2014	UB	HA	Skills Training & Development (Less than 6 months)	15 min	12, 99	13, 14
19	548	H2021	UB		Community-based Wraparound Svcs (TSS)	15 min	12, 23, 99	13, 14
THERAPIST								
17	171	97150		GO	Therapeutic procedure(s), group (2 or more individuals) (Collage Program)	15 min	11	39
TOBACCO CESSATION								
37	370	99407			Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	per visit	11, 12, 31, 32, 99	40
37	370	G0437			Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	per visit	11, 12, 31, 32, 99	40
EPSDT WRAPAROUND								
EPSDT WRAPAROUND - BEHAVIORAL SPECIALIST CONSULTANT								
08	810	H0032	HP		Mental Health Service Plan Development by Non-physician (BSC - Doctoral Level)	15 min	11, 12, 23, 99	13, 14
11	559, 444, 448, or 452	H0032	HP		Mental Health Service Plan Development by Non-physician (BSC - Doctoral Level)	15 min	11, 12, 23, 99	13, 14
08	810	H0032		HO	Mental Health Service Plan Development by Non-physician (BSC - Master's Level)	15 min	11, 12, 23, 99	13, 14
11	559, 444, 448, or 452	H0032		HO	Mental Health Service Plan Development by Non-physician (BSC - Master's Level)	15 min	11, 12, 23, 99	13, 14

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
EPSDT WRAPAROUND - MOBILE THERAPY								
08	809	H2019	UB		Therapeutic Behavioral Svcs (MT)	15 min	12, 99	13, 14
11	549, 443, 447, or 451	H2019	UB		Therapeutic Behavioral Svcs (MT)	15 min	12, 99	13, 14
EPSDT WRAPAROUND - THERAPEUTIC STAFF SUPPORT								
08	808	H2014	UB		Skills Training & Development (6 or more months)	15 min	12, 99	13, 14
11	548, 442, 446, or 450	H2014	UB		Skills Training & Development (6 or more months)	15 min	12, 99	13, 14
08	808	H2014	UB	HA	Skills Training & Development (Less than 6 months)	15 min	12, 99	13, 14
11	548, 442, 446, or 450	H2014	UB	HA	Skills Training & Development (Less than 6 months)	15 min	12, 99	13, 14
08	808	H2021	UB		Community-based Wraparound Svcs (TSS)	15 min	12, 23, 99	13, 14
11	548, 442, 446, or 450	H2021	UB		Community-based Wraparound Svcs (TSS)	15 min	12, 23, 99	13, 14
ALL OTHER EPSDT SERVICES								
08	110	90801			Psychiatric diagnostic interview examination (Psychological Eval)	30 min	11, 12, 99	13, 14
11	113, 114, 548, 549, or 559	90801			Psychiatric diagnostic interview examination (Psychological Eval)	30 min	11, 12, 99	13, 14
11	115	90801			Psychiatric diagnostic interview examination (Psychological Eval)	30 min	12, 99	13, 14
08	110	90802			Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication (Psychological Eval)	30 min	11, 12, 99	13, 14
11	113, 114, 548, 549, or 559	90802			Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication (Psychological Eval)	30 min	11, 12, 99	13, 14
11	115	90802			Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication (Psychological Eval)	30 min	12, 99	13, 14
08	110	96101		HK	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements or Generally Accepted Graphic Technique)	per occurrence	11, 12	13, 14

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
11	113 or 114	96101			Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements or Generally Accepted Graphic Technique)	per occurrence	11, 12	13, 14
11	115	96101			Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements or Generally Accepted Graphic Technique)	per occurrence	12, 99	13, 14
08	110	96101	AH		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Personality Inventories)	per occurrence	11, 12	13, 14
11	113 or 114	96101	AH		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Personality Inventories)	per occurrence	11, 12	13, 14
11	115	96101	AH		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Personality Inventories)	per occurrence	12, 99	13, 14
08	110	96101	U7		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Diagnostic Intellectual Eval)	per hour	11, 12, 99	13, 14
11	113, 114, 548, 549, or 559	96101	U7		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Diagnostic Intellectual Eval)	per hour	11, 12, 99	13, 14

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
11	115	96101	U7		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report <i>(Diagnostic Intellectual Eval)</i>	per hour	12, 99	13, 14
08	110	96101	U7	HA	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report <i>(Individual Diagnostic Personality Eval)</i>	per hour	11, 12, 99	13, 14
11	113, 114, 548, 549, or 559	96101	U7	HA	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report <i>(Individual Diagnostic Personality Eval)</i>	per hour	11, 12, 99	13, 14
11	115	96101	U7	HA	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report <i>(Individual Diagnostic Personality Eval)</i>	per hour	12, 99	13, 14
08	110	96101	U7	TJ	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report <i>(Comprehensive Diagnostic Psychological Eval)</i>	per hour	11, 12, 99	13, 14
11	113, 114, 548, 549, or 559	96101	U7	TJ	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report <i>(Comprehensive Diagnostic Psychological Eval)</i>	per hour	11, 12, 99	13, 14
11	115	96101	U7	TJ	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report <i>(Comprehensive Diagnostic Psychological Eval)</i>	per hour	12, 99	13, 14
08	110	96101	TF	HK	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report <i>(Generally Accepted Projective Technique)</i>	per occurrence	11, 12	13, 14

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
11	113 or 114	96101	TF		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Projective Technique)	per occurrence	11, 12	13, 14
11	115	96101	TF		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Projective Technique)	per occurrence	12, 99	13, 14
08	110	96101	TG	HK	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Any Combination of Four or More Intellectual or Personality Evals Listed)	per occurrence	11, 12	13, 14
11	113 or 114	96101	TG		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Any Combination of Four or More Intellectual or Personality Evals Listed)	per occurrence	11, 12	13, 14
11	115	96101	TG		Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Any Combination of Four or More Intellectual or Personality Evals Listed)	per occurrence	12, 99	13, 14
08	110	96116			Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning an problem solving, and visual spatial abilities) per hour of the psychologist's or physician's time, both face to face time with the patient and time interpreting test results and preparing the report (Comprehensive Neuropsychological Eval w/ Personality Assessment)	per hour	11, 12, 99	13, 14
11	113, 114, 548, 549, or 559	96116			Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning an problem solving, and visual spatial abilities) per hour of the psychologist's or physician's time, both face to face time with the patient and time interpreting test results and preparing the report (Comprehensive Neuropsychological Eval w/ Personality Assessment)	per hour	11, 12, 99	13, 14

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
11	115	96116			Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning an problem solving, and visual spatial abilities) per hour of the psychologist's or physician's time, both face to face time with the patient and time interpreting test results and preparing the report (Comprehensive Neuropsychological Eval w/ Personality Assessment)	per hour	12, 99	13, 14
08	110	96118		HK	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements for Organicity)	per occurrence	11, 12	13, 14
11	113 or 114	96118			Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements for Organicity)	per occurrence	11, 12	13, 14
11	115	96118			Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements for Organicity)	per occurrence	12, 99	13, 14
08	110	96118	UB		Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Comprehensive Neuropsychological Eval)	per hour	11, 12, 99	13, 14
11	113, 114, 548, 549, or 559	96118	UB		Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Comprehensive Neuropsychological Eval)	per hour	11, 12, 99	13, 14
11	115	96118	UB		Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Comprehensive Neuropsychological Eval)	per hour	12, 99	13, 14
17	175	G0176	UB		Activity therapy, such as music, dance, art, or play therapies not for recreation, related to the care & treatment of patient's disabling mental health problems, per session (45 minutes or more) (use for Music Therapy)	1 hour	11	13, 14

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
08, or 11	340	H0018^			Behavioral health; short-term residential (non-hospital residential treatment program) without room and board (BH Waiver Service - Other Short Term Residential Service not listed elsewhere)	per diem	12	13, 14
52	520	H0018^			Behavioral health; short-term residential (non-hospital residential treatment program) without room and board (BH Waiver Service - Other Short Term Residential Service not listed elsewhere)	per diem	12	16
52	523	H0019^		HA	Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days) without room and board (Host Home)	per diem	12	13, 14
08, or 11	340	H0019^		HA	Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days) without room and board (BH Waiver Service - Other Long Term Residential Service not listed elsewhere)	per diem	12	13, 14
52	520	H0019^		HQ	Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days) without room and board (Group Home)	per diem	12	16
08, or 11	340	H0019^		HQ	Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days) without room and board (BH Waiver Service - Other Long Term Residential Service not listed elsewhere)	per diem	12	13, 14
56	560	H0019^		SC	Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days) without room and board (RTF - Non-JCAHO - No R&B)	per diem	56	16
52	523	H0019^		TT	Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days) without room and board (Therapeutic Family Care)	per diem	12	13, 14
08, or 11	340	H0019^		TT	Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days) without room and board (BH Waiver Service - Other Long Term Residential Service not listed elsewhere)	per diem	12	13, 14
11	116 or 117	H0046^	UB		MH Svcs, not otherwise specified (Other Services by Social Worker, Psychiatric Nurse, etc.)	15 min	11, 12, 99	13, 14
16	162	H0046^	UB		MH Svcs, not otherwise specified (Other Services by Social Worker, Psychiatric Nurse, etc.)	15 min	11, 12, 99	13, 14
08, or 11	340	H0046^		SC	MH Svcs, not otherwise specified (BH Waiver Svc that cannot appropriately be reflected in another PE)	15 min	12, 99	13, 14
08	811	H2012	UB		Behavioral Health Day Treatment (STAP)	per hour	99	13, 14
11	445, 449, or 453	H2012	UB		Behavioral Health Day Treatment (STAP)	per hour	99	13, 14
08, or 11	340	H2012^		SC	Behavioral Health Day Treatment (Day Treatment)	per hour	99	13, 14
08, or 11	340	H2015^			Comprehensive Community Support Svcs (After School Program)	15 min	12, 99	13, 14

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifie	Service Description	Units	Place of Service	Refer to Line Item
08, or 11	340	H2017^			Psychosocial Rehabilitation Svcs (Psychosocial Rehab)	15 min	12, 99	13, 14
08, or 11	340	H2019^		HA	Therapeutic Behavioral Services (Functional Family Therapy)	15 min	12, 99	13, 14
11	340	H2021^	U9	SC	Community-based Wraparound Svcs (EIBS)	15 min	99	13, 14
11	340	H2021^	U8	SC	Community-based Wraparound Svcs (EIBS)	15 min	99	13, 14
11	340	H2021^	U7	SC	Community-based Wraparound Svcs (EIBS)	15 min	99	13, 14
08, or 11	340	H2021^		SC	Community-based Wraparound Svcs (TSS Aide)	15 min	12, 99	13, 14
08, or 11	340	H2021^		SC; HQ	Community-based Wraparound Svcs (One to One Svcs in RTF)	15 min	12, 99	13, 14
08, or 11	340	H2022^			Community-based wrap-around svcs (Other PE svcs with a per diem rate)	per diem	99	13, 14
17	174	H2032	UB		Activity therapy (use for Art Therapy)	15 min	11	13, 14
08 or 11	340	H2033^			Multisystemic therapy for juveniles, per 15 minutes, effective 10/1/2005	15 min	12, 99	13, 14
*ONLY if notification has been given to OMHSAS that MCO will be authorizing and reporting services of this nature.								
^Program Exception Codes								
Provider type 19 with an * can bill for clients under 21 only, except for Medicare Crossover								
The national code definitions listed above are not verbatim for all entries. Please refer to the Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) Manuals for the full national definitions								

Procedure Code Detail From Attachment G Sorted By Procedure Code

Attachment H

Proc. Code	Price Mod.	Info Modifie	Pvr Type	Specialty	Service Description	Units	Place of Service	Refer to Line Item
90801	UB	HB	08	074	Psychiatric diagnostic interview examination (Psychiatric Eval; Exam & Eval of Patient)	Occurrence	15	43
90801	UB		08	184	Psychiatric diagnostic interview examination (Psychiatric Eval; Exam & Eval of Patient)	Occurrence	12, 57	17
90801	UB		08	110	Psychiatric diagnostic interview examination (Psychiatric Eval; Exam & Eval of Patient)	Occurrence	12, 49	9
90801			19	190	Psychiatric diagnostic interview examination (Psychological Eval)	30 min	11, 12, 21, 99	13, 14
90801			08	110	Psychiatric diagnostic interview examination (Psychological Eval)	30 min	11, 12, 99	13, 14
90801			11	113, 114, 548, 549, or 559	Psychiatric diagnostic interview examination (Psychological Eval)	30 min	11, 12, 99	13, 14
90801			11	115	Psychiatric diagnostic interview examination (Psychological Eval)	30 min	12, 99	13, 14
90802	UB	HB	08	074	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication (Psychiatric Eval; Exam & Eval of Patient)	Occurrence	15	43
90802	UB		08	184	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication (Psychiatric Eval; Exam & Eval of Patient)	Occurrence	12, 57	17
90802	UB		08	110	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication (Psychiatric Eval; Exam & Eval of Patient)	Occurrence	12, 49	9
90802			19	190	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication (Psychological Eval)	30 min	11, 12, 21, 99	13, 14
90802			08	110	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication (Psychological Eval)	30 min	11, 12, 99	13, 14
90802			11	113, 114, 548, 549, or 559	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication (Psychological Eval)	30 min	11, 12, 99	13, 14
90802			11	115	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication (Psychological Eval)	30 min	12, 99	13, 14
90804	UB		08	110	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	30 min	12, 49	9
90804	UB		08	184	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	30 min	12, 57	17
90804	UB		19	190	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	30 min	11	12
90804	UB	HB	08	074	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	30 min	15	43

Procedure Code Detail From Attachment G Sorted By Procedure Code

Attachment H

90804	UB	U1	31	339	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	30 min	11	12
90805	UB	U1	31	339	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, with medical evaluation and management services, face to face w/ patient	30 min	11	12
90806	UB		08	110	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	45 min	12, 49	9
90806	UB		08	184	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	45 min	12, 57	17
90806	UB		19	190	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	45 min	11	12
90806	UB	HB	08	074	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	45 min	15	43
90806	UB	U1	31	339	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	45 min	11	12
90807	UB	U1	31	339	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, with medical evaluation and management services, face to face w/ patient	45 min	11	12
90808	UB		08	110	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	75 min	12, 49	9
90808	UB		08	184	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	75 min	12, 57	17
90808	UB		19	190	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	75 min	11	12
90808	UB	HB	08	074	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	75 min	15	43
90808	UB	U1	31	339	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face to face with the patient	75 min	11	12
90809	UB	U1	31	339	Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, with medical evaluation and management services, face to face w/ patient	75 min	11	12
90810			08	110	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	30 min	12, 49	9
90810			08	184	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	30 min	12, 57	17
90810			19	190	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	30 min	11	12

Procedure Code Detail From Attachment G Sorted By Procedure Code

Attachment H

90810		HB	08	074	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	30 min	15	43
90810		U1	31	339	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	30 min	11	12
90811		U1	31	339	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, with medical evaluation and management services, face to face w/ patient	30 min	11	12
90812			08	110	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	45 min	12, 49	9
90812			08	184	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	45 min	12, 57	17
90812			19	190	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	45 min	11	12
90812		HB	08	074	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	45 min	15	43
90812		U1	31	339	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	45 min	11	12
90813		U1	31	339	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, with medical evaluation and management services, face to face w/ patient	45 min	11	12
90814			08	110	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	75 min	12, 49	9
90814			08	184	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	75 min	12, 57	17
90814			19	190	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	75 min	11	12
90814		HB	08	074	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	75 min	15	43

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90814		U1	31	339	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, face to face with the patient	75 min	11	12
90815		U1	31	339	Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, with medical evaluation and management services, face to face w/ patient	75 min	11	12
90846	UB		08	110	Family Psychotherapy (without the patient present)	15 min	12, 49	9
90846	UB		19	190	Family Psychotherapy (without the patient present)	15 min	11	12
90846	UB	HB	08	074	Family Psychotherapy (without the patient present)	15 min	15	43
90846	UB	U1	31	339	Family Psychotherapy (without the patient present)	15 min	11	12
90847	UB		08	110	Family Psychotherapy (conjoint psychotherapy) w/ patient present	15 min	12, 49	9
90847	UB		08	184	Family Psychotherapy (conjoint psychotherapy) w/ patient present	15 min	12, 57	17
90847	UB		19	190	Family Psychotherapy (conjoint psychotherapy) w/ patient present	15 min	11	12
90847	UB	HB	08	074	Family Psychotherapy (conjoint psychotherapy) w/ patient present	15 min	15	43
90847	UB	U1	31	339	Family Psychotherapy (conjoint psychotherapy) w/ patient present	15 min	11	12
90853	UB		08	110	Group Psychotherapy (other than of a multiple-family group)	15 min	49	9
90853	UB		08	184	Group Psychotherapy (other than of a multiple-family group)	15 min	57	17
90853	UB		19	190	Group Psychotherapy (other than of a multiple-family group)	15 min	11	12
90853	UB	HB	08	074	Group Psychotherapy (other than of a multiple-family group)	15 min	15	43
90853	UB	U1	31	339	Group Psychotherapy (other than of a multiple-family group)	15 min	11	12
90862	UB		08	110	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy (Psychiatric Clinic Med Visit for Drug Admin & Eval)	15 min	49	9
90862	UB		31	339	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy (Psychiatric Clinic Med Visit for Drug Admin & Eval)	15 min	11	41
90862	U7		08	184	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy (Chemotherapy Visit for Admin & Eval of Drugs other than Methadone or Drugs for Opiate Detox)	15 min	57	17
90862	UB	HB	08	074	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy (Psychiatric Clinic Med Visit for Drug Admin & Eval)	15 min	15	43
90870			01	183	ECT Therapy (includes necessary monitoring)	1 treatment	22	9
90870			08	110	ECT Therapy (includes necessary monitoring)	1 treatment	49	9
90870			31	339	ECT Therapy (includes necessary monitoring) (POS 99 - Special Treatment Room)	1 treatment	11, 21, 99	12
90875			08	110	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg. Insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes	Occurrence	12, 49	9
90875			08	184	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg. Insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes	Occurrence	57	17

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90875			19	190	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg. Insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes	Occurrence	11	12
90875			31	339	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg. Insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes	Occurrence	11, 21	12
90875		HB	08	074	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg. Insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes	Occurrence	15	43
95816			08	110	EEG including recording awake & drowsy	1 treatment	49	9
95819			08	110	EEG including recording awake & asleep	1 treatment	49	9
95822			08	110	EEG recording in coma or sleep only	1 treatment	49	9
95827			08	110	EEG all night recording	1 treatment	49	9
96101			08	110	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report <i>(Generally Accepted Graphic Technique)</i>	per occurrence	12, 49	9
96101			08	184	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report <i>(Generally Accepted Graphic Technique)</i>	per occurrence	12, 57	17
96101			11	113 or 114	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report <i>(Generally Accepted Individual Measurements or Generally Accepted Graphic Technique)</i>	per occurrence	11, 12	13, 14
96101			11	115	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report <i>(Generally Accepted Individual Measurements or Generally Accepted Graphic Technique)</i>	per occurrence	12, 99	13, 14
96101			19	190	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report <i>(Generally Accepted Individual Measurements or Generally Accepted Graphic Technique)</i>	per occurrence	11, 12, 21	12

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96101	AH		08	110	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Personality Inventories)	per occurrence	11, 12	13, 14
96101	AH		11	113 or 114	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Personality Inventories)	per occurrence	11, 12	13, 14
96101	AH		11	115	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Personality Inventories)	per occurrence	12, 99	13, 14
96101	AH		19*	190	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Personality Inventories)	per occurrence	11, 12, 21	12
96101	TF		08	110	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Projective Technique)	per occurrence	12, 49	9
96101	TF		08	184	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Projective Technique)	per occurrence	12, 57	17
96101	TF		11	113 or 114	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Projective Technique)	per occurrence	11, 12	13, 14
96101	TF		11	115	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Projective Technique)	per occurrence	12, 99	13, 14

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96101	TF		19*	190	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report <i>(Generally Accepted Projective Technique)</i>	per occurrence	11, 12, 21	12
96101	TF	HB	08	074	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report <i>(Generally Accepted Projective Technique)</i>	per occurrence	15	43
96101	TF	HK	08	110	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report <i>(Generally Accepted Projective Technique)</i>	per occurrence	11, 12	13, 14
96101	TF	U1	31	339	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report <i>(Generally Accepted Projective Technique)</i>	per occurrence	11, 21	12
96101	TG		08	110	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report <i>(Any Combination of Four or More Intellectual or Personality Evals Listed)</i>	per occurrence	12, 49	9
96101	TG		08	184	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report <i>(Any Combination of Four or More Intellectual or Personality Evals Listed)</i>	per occurrence	12, 57	17
96101	TG		11	113 or 114	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report <i>(Any Combination of Four or More Intellectual or Personality Evals Listed)</i>	per occurrence	11, 12	13, 14

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96101	TG		11	115	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Any Combination of Four or More Intellectual or Personality Evals Listed)	per occurrence	12, 99	13, 14
96101	TG		19*	190	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Any Combination of Four or More Intellectual or Personality Evals Listed)	per occurrence	11, 12, 21	12
96101	TG	HB	08	074	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Any Combination of Four or More Intellectual or Personality Evals Listed)	per occurrence	15	43
96101	TG	HK	08	110	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Any Combination of Four or More Intellectual or Personality Evals Listed)	per occurrence	11, 12	13, 14
96101	TG	U1	31	339	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Any Combination of Four or More Intellectual or Personality Evals Listed)	per occurrence	11, 21	12
96101	U7		08	110	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Diagnostic Intellectual Eval)	per hour	11, 12, 99	13, 14
96101	U7		11	113, 114, 548, 549, or 559	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Diagnostic Intellectual Eval)	per hour	11, 12, 99	13, 14

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96101	U7		11	115	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Diagnostic Intellectual Eval)	per hour	12, 99	13, 14
96101	U7		19	190	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Diagnostic Intellectual Eval)	per hour	11, 12, 21, 99	13, 14
96101	U7	HA	08	110	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Individual Diagnostic Personality Eval)	per hour	11, 12, 99	13, 14
96101	U7	HA	11	113, 114, 548, 549, or 559	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Individual Diagnostic Personality Eval)	per hour	11, 12, 99	13, 14
96101	U7	HA	11	115	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Individual Diagnostic Personality Eval)	per hour	12, 99	13, 14
96101	U7	HA	19	190	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Individual Diagnostic Personality Eval)	per hour	11, 12, 21, 99	13, 14
96101	U7	TJ	08	110	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Comprehensive Diagnostic Psychological Eval)	per hour	11, 12, 99	13, 14
96101	U7	TJ	11	113, 114, 548, 549, or 559	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Comprehensive Diagnostic Psychological Eval)	per hour	11, 12, 99	13, 14

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96101	U7	TJ	11	115	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Comprehensive Diagnostic Psychological Eval)	per hour	12, 99	13, 14
96101	U7	TJ	19	190	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Comprehensive Diagnostic Psychological Eval)	per hour	11, 12, 21, 99	13, 14
96101	UB		08	110	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements or Generally Accepted Personality Inventories)	per occurrence	12, 49	9
96101	UB		08	184	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements or Generally Accepted Personality Inventories)	per occurrence	12, 57	17
96101	UB	HB	08	074	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements or Generally Accepted Personality Inventories)	per occurrence	15	43
96101	UB	U1	31	339	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements or Generally Accepted Personality Inventories)	per occurrence	11, 21	12
96101		HB	08	074	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Graphic Technique)	per occurrence	15	43

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96101		HK	08	110	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements or Generally Accepted Graphic Technique)	per occurrence	11, 12	13, 14
96101		U1	31	339	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face to face time administering test to the patient and time interpreting these test results and preparing the report (Generally Accepted Graphic Technique)	per occurrence	11, 21	12
96116			08	110	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning an problem solving, and visual spatial abilities) per hour of the psychologist's or physician's time, both face to face time with the patient and time interpreting test results and preparing the report (Comprehensive Neuropsychological Eval w/ Personality Assessment)	per hour	11, 12, 99	13, 14
96116			11	113, 114, 548, 549, or 559	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning an problem solving, and visual spatial abilities) per hour of the psychologist's or physician's time, both face to face time with the patient and time interpreting test results and preparing the report (Comprehensive Neuropsychological Eval w/ Personality Assessment)	per hour	11, 12, 99	13, 14
96116			11	115	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning an problem solving, and visual spatial abilities) per hour of the psychologist's or physician's time, both face to face time with the patient and time interpreting test results and preparing the report (Comprehensive Neuropsychological Eval w/ Personality Assessment)	per hour	12, 99	13, 14
96116			19	190	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning an problem solving, and visual spatial abilities) per hour of the psychologist's or physician's time, both face to face time with the patient and time interpreting test results and preparing the report (Comprehensive Neuropsychological Eval w/ Personality Assessment)	per hour	11, 12, 21, 99	13, 14
96118			08	110	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements for Organicity)	per occurrence	12, 49	9
96118			08	184	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements for Organicity)	per occurrence	12, 57	17

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96118			11	113 or 114	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements for Organicity)	per occurrence	11, 12	13, 14
96118			11	115	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements for Organicity)	per occurrence	12, 99	13, 14
96118			19*	190	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements for Organicity)	per occurrence	11, 12, 21	12
96118	UB		08	110	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Comprehensive Neuropsychological Eval)	per hour	11, 12, 99	13, 14
96118	UB		11	113, 114, 548, 549, or 559	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Comprehensive Neuropsychological Eval)	per hour	11, 12, 99	13, 14
96118	UB		11	115	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Comprehensive Neuropsychological Eval)	per hour	12, 99	13, 14
96118	UB		19	190	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Comprehensive Neuropsychological Eval)	per hour	11, 12, 21, 99	13, 14
96118		HB	08	074	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements for Organicity)	per occurrence	15	43

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96118		HK	08	110	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements for Organicity)	per occurrence	11, 12	13, 14
96118		U1	31	339	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face to face time administering tests to the patient and time interpreting these test results and preparing the report (Generally Accepted Individual Measurements for Organicity)	per occurrence	11, 21	12
97150		GO	17	171	Therapeutic procedure(s), group (2 or more individuals) (Collage Program)	15 min	11	39
99201			31	316, 322, 339, 345	OV/OP Visit for Eval & Mgmt of New Patient, Problem Self Ltd or Minor, face to face w/ patient and/or family	10 min	11	12
99202			31	316, 322, 339, 345	OV/OP Visit for Eval & Mgmt of New Patient, Problem Low to Moderate, face to face w/ patient and/or family	20 min	11	12
99203			31	316, 322, 339, 345	OV/OP Visit for Eval & Mgmt of New Patient, Problem Moderate, face to face w/ patient and/or family	30 min	11	12
99203		U1	31	339	OV/OP Visit for Eval & Mgmt of New Patient, Problem Moderate, face to face w/ patient and/or family (Comprehensive Medical Exam by General Practitioner when Requested by the Department to Determine Eligibility)	30 min	11	12
99204	U7		08	184	OV/OP Visit for Eval & Mgmt of New Patient, Problem Moderate to High, face to face w/ patient and/or family (Comprehensive Medical Exam & Eval)	45 min visit	12, 57	17
99204			31	316, 322, 339, 345	OV/OP Visit for Eval & Mgmt of New Patient, Problem Moderate to High, face to face w/ patient and/or family	45 min	11	12
99204		U1	31	339	OV/OP Visit for Eval & Mgmt of New Patient, Problem Moderate to High, face to face w/ patient and/or family (Comprehensive Medical Exam by General Practitioner when Requested by the Department to Determine Eligibility)	45 min	11	12
99205			31	316, 322, 339, 345	OV/OP Visit for Eval & Mgmt of New Patient, Problem Moderate to High, face to face w/ patient and/or family	60 min	11	12
99205		U1	31	339	OV/OP Visit for Eval & Mgmt of New Patient, Problem Moderate to High, face to face w/ patient and/or family (Comprehensive Medical Exam by General Practitioner when Requested by the Department to Determine Eligibility)	60 min	11	12
99211			31	316, 322, 339, 345	OV/OP Visit for Eval & Mgmt of Established Patient, Problem Minimal, face to face w/ patient and/or family	5 min	11	12
99211		U1	31	339	OV/OP Visit for Eval & Mgmt of Established Patient, Problem Minimal, face to face w/ patient and/or family	5 min	11	12
99212			31	316, 322, 339, 345	OV/OP Visit for Eval & Mgmt of Established Patient, Problem Self Ltd or Minor, face to face w/ patient and/or family	10 min	11	12
99212		U1	31	339	OV/OP Visit for Eval & Mgmt of Established Patient, Problem Self Ltd or Minor, face to face w/ patient and/or family	10 min	11	12
99213			31	316, 322, 339, 345	OV/OP Visit for Eval & Mgmt of Established Patient, Problem Low to Moderate, face to face w/ patient and/or family	15 min	11	12

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99213		U1	31	339	OV/OP Visit for Eval & Mgmt of Established Patient, Problem Low to Moderate, face to face w/ patient and/or family	15 min	11	12
99214			31	316, 322, 339, 345	OV/OP Visit for Eval & Mgmt of Established Patient, Problem Moderate to High, face to face w/ patient and/or family	25 min	11	12
99214		U1	31	339	OV/OP Visit for Eval & Mgmt of Established Patient, Problem Moderate to High, face to face w/ patient and/or family	25 min	11	12
99215	U7		08	184	OV/OP Visit for Eval & Mgmt of Established Patient, Problem Moderate to High, face to face w/ patient and/or family (Comprehensive Medical Exam & Eval)	40 min visit	12, 57	17
99215			31	316, 322, 339, 345	OV/OP Visit for Eval & Mgmt of Established Patient, Problem Moderate to High, face to face w/ patient and/or family	40 min	11	12
99215		U1	31	339	OV/OP Visit for Eval & Mgmt of Established Patient, Problem Moderate to High, face to face w/ patient and/or family	40 min	11	12
99221			31	339	Initial Hospital Care, per Day, for Eval & Mgmt of Patient, Problem Low, at bedside	30 min	21	12
99222			31	339	Initial Hospital Care, per Day, for Eval & Mgmt of Patient, Problem Moderate, at bedside	50 min	21	12
99223			31	339	Initial Hospital Care, per Day, for Eval & Mgmt of Patient, Problem High, at bedside	70 min	21	12
99231			31	339	Subsequent hospital care, per day, for eval & mgmt of a patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem focused exam; medical decision making that is straightforward or of low complexity	15 min	21	12
99232			31	339	Subsequent hospital care, per day, for eval & mgmt of a patient, which requires at least 2 of these 3 key components: an expanded problem focused interval history; an expanded problem focused exam; medical decision making of moderate complexity	25 min	21	12
99233			31	339	Subsequent hospital care, per day, for eval & mgmt of a patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed exam; medical decision making of high complexity	35 min	21	12
99238			31	339	Hospital Discharge Day Mgmt, 30 minutes or less	Visit	21	12
99241			31	339	Office Consult for New or Established Patient, Problem Self Ltd or Minor, face to face w/ patient and/or family	15 min	11, 12, 23, 24, 31, 32, 54, 65	12
99241		GT	31	339	Office Consult for New or Established Patient, Problem Self Ltd or Minor, face to face w/ patient and/or family (Effective 12/1/07)	15 min	11	12
99242			31	339	Office Consult for New or Established Patient, Problem Low, face to face w/ patient and/or family	30 min	11, 12, 23, 24, 31, 32, 54, 65	12
99242		GT	31	339	Office Consult for New or Established Patient, Problem Low, face to face w/ patient and/or family (Effective 12/1/07)	30 min	11	12
99243			31	339	Office Consult for New or Established Patient, Problem Moderate, face to face w/ patient and/or family	40 min	11, 12, 23, 24, 31, 32, 54, 65	12
99243		GT	31	339	Office Consult for New or Established Patient, Problem Moderate, face to face w/ patient and/or family (Effective 12/1/07)	40 min	11	12

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99244			31	339	Office Consult for New or Established Patient, Problem Moderate to High, face to face w/ patient and/or family	60 min	11, 12, 23, 24, 31, 32, 54, 65	12
99244		GT	31	339	Office Consult for New or Established Patient, Problem Moderate to High, face to face w/ patient and/or family (Effective 12/1/07)	60 min	11	12
99245			31	339	Office Consult for New or Established Patient, Problem Moderate to High, face to face w/ patient and/or family	80 min	11, 12, 23, 24, 31, 32, 54, 65	12
99245		GT	31	339	Office Consult for New or Established Patient, Problem Moderate to High, face to face w/ patient and/or family (Effective 12/1/07)	80 min	11	12
99251			31	339	Initial Inpatient Consult for New or Established Patient, Problem Self Ltd or Minor, at bedside	20 min	21, 31, 32	12
99252			31	339	Initial Inpatient Consult for New or Established Patient, Problem Low, at bedside	40 min	21, 31, 32	12
99253			31	339	Initial Inpatient Consult for New or Established Patient, Problem Moderate, at bedside	55 min	21, 31, 32	12
99254			31	339	Initial Inpatient Consult for New or Established Patient, Problem Moderate to High, at bedside	80 min	21, 31, 32	12
99255			31	339	Initial Inpatient Consult for New or Established Patient, Problem Moderate to High, at bedside	110 min	21, 31, 32	12
99281			31	315, 316, 322, 339, 345	ER Visit for Eval & Mgmt of Patient, Problem Self Ltd or Minor	Visit	23	12
99282			31	315, 316, 322, 339, 345	ER Visit for Eval & Mgmt of Patient, Problem Low to Moderate	Visit	23	12
99283			31	315, 316, 322, 339, 345	ER Visit for Eval & Mgmt of Patient, Problem Moderate	Visit	23	12
99284			31	315, 316, 322, 339, 345	ER Visit for Eval & Mgmt of Patient, Problem High/Urgent	Visit	23	12
99285			31	315, 316, 322, 339, 345	ER Visit for Eval & Mgmt of Patient, Problem High/Threat to Life	Visit	23	12
99291			31	339	Critical Care, eval & mgmt, first hour	1 hour	21, 23	12
99292			31	339	Critical Care, eval & mgmt, each additional 30 minutes	30 min	21, 23	12
99304			31	339	Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and a medical decision making that is straightforward or of low complexity	visit	31, 32	12
99305			31	339	Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity	Visit	31, 32	12

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99306			31	339	Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity	Visit	31, 32	12
99307			31	339	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; straightforward medical decision making	Visit	31, 32	12
99308			31	339	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity	Visit	31, 32	12
99309			31	339	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity	Visit	31, 32	12
99310			31	339	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; medical decision making of high complexity	Visit	31, 32	12
99341			31	339	Home Visit for Eval & Mgmt of New Patient, Problem Low, face to face with the patient and/or family	20 min	12	12
99342			31	339	Home Visit for Eval & Mgmt of New Patient, Problem Moderate, face to face with the patient and/or family	30 min	12	12
99343			31	339	Home Visit for Eval & Mgmt of New Patient, Problem High, face to face with the patient and/or family	45 min	12	12
99407			01	370	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	per visit	22	40
99407			05	370	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	per visit	12	40
99407			08	370	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	per visit	12, 49, 57, 99	40
99407		FP	08	370	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	per visit	22, 49	40
99407			09	370	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	per visit	11, 12, 31, 32, 99	40
99407			19	370	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	per visit	11, 12, 31, 32, 99	40
99407			27	370	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	per visit	11, 12, 31, 32, 99	40
99407			31	370	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	per visit	11, 12, 31, 32, 99	40
99407			37	370	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	per visit	11, 12, 31, 32, 99	40

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00104			08	110	Anesthesia for Electroconvulsive Therapy		49	9
00104		U1	31	339	Anesthesia for Electroconvulsive Therapy		11, 21, 99	12
G0176	UB		17	175	Activity therapy, such as music, dance, art, or play therapies not for recreation, related to the care & treatment of patient's disabling mental health problems, per session (45 minutes or more) (use for Music Therapy)	1 hour	11	13, 14
G0437			01	370	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	per visit	22	40
G0437			05	370	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	per visit	12	40
G0437			08	370	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	per visit	12, 49, 57, 99	40
G0437		FP	08	370	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	per visit	22, 49	40
G0437			09	370	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	per visit	11, 12, 31, 32, 99	40
G0437			19	370	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	per visit	11, 12, 31, 32, 99	40
G0437			27	370	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	per visit	11, 12, 31, 32, 99	40
G0437			31	370	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	per visit	11, 12, 31, 32, 99	40
G0437			37	370	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes	per visit	11, 12, 31, 32, 99	40
H0001			11	184	Alcohol and/or Drug Assessment (D&A Level of Care Assessment)	15 min	99	34
H0004	UB	HE	11	115	Behavioral Health Counseling and Therapy (Team member w/ Consumer)	15 min	12, 99	24
H0004	UB	HE; HK	11	115	Behavioral Health Counseling and Therapy (MH Svc During Non-Psych Inpatient Admission)	15 min	21, 31, 32	24
H0004	UB	HK	11	115	Behavioral Health Counseling and Therapy (MH Svc During Psych Inpatient Admission)	15 min	21	24
H0004	UB	HT	11	115	Behavioral Health Counseling and Therapy (Team w/ Consumer and/or Family)	15 min	12, 99	24
H0004	UB	UK	11	115	Behavioral Health Counseling and Therapy (Team Member w/ Family of Consumer)	15 min	12, 99	24
H0004		HE	11	112	Behavioral health counseling and therapy (MH Outpatient Practitioner)	15 min	99	36
H0004		HF	11	127	Behavioral health counseling and therapy (D&A Outpatient Practitioner)	15 min	99	37
H0006		TF	21	138	Alcohol and/or drug services; case management (D&A RC)	15 min	99	34
H0006			21	138	Alcohol and/or drug services; case management (D&A ICM)	15 min	99	34
H0013			11	132	Alcohol and/or Drug Svcs; acute detox (residential addiction outpatient) (Detoxification)	per diem	99	8
H0014	HG		08	184	Alcohol and/or Drug Svcs; Ambulatory Detoxification (Opiate Detox Visit for Admin & Eval of Drugs for Ambulatory Opiate Detox)	15 min	57	17
H0015			11	128*	Alcohol and/or Drug Svcs; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, & activity therapies or education (Intensive Outpatient D&A Clinic)	15 min	99	35

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H0018^			08, or 11	340	Behavioral health; short-term residential (non-hospital residential treatment program) without room and board (BH Waiver Service - Other Short Term Residential Service not listed elsewhere)	per diem	12	13, 14
H0018^			52	520	Behavioral health; short-term residential (non-hospital residential treatment program) without room and board (BH Waiver Service - Other Short Term Residential Service not listed elsewhere)	per diem	12	16
H0018		HE	11	110	Behavioral health; short-term residential (non-hospital residential treatment program) without room and board (Adult Residential Treatment Facility)	per diem	99	31
H0018		HF	11	133	Behavioral health; short-term residential (non-hospital residential treatment program) without room and board (Drug Free Residential)	per diem	99	8
H0019^		HA	52	523	Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days) without room and board (Host Home)	per diem	12	13, 14
H0019^		HA	08, or 11	340	Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days) without room and board (BH Waiver Service - Other Long Term Residential Service not listed elsewhere)	per diem	12	13, 14
H0019^		HQ	52	520	Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days) without room and board (Group Home)	per diem	12	16
H0019^		HQ	08, or 11	340	Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days) without room and board (BH Waiver Service - Other Long Term Residential Service not listed elsewhere)	per diem	12	13, 14
H0019^		SC	56	560	Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days) without room and board (RTF - Non-JCAHO - No R&B)	per diem	56	16
H0019^		TT	52	523	Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days) without room and board (Therapeutic Family Care)	per diem	12	13, 14
H0019^		TT	08, or 11	340	Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days) without room and board (BH Waiver Service - Other Long Term Residential Service not listed elsewhere)	per diem	12	13, 14
H0020			11	129	Alcohol and/or Drug Svcs; Methadone administration and/or svc (provision of the drug by a licensed program) (Methadone Maintenance)	15 min	99	34
H0020	HG		08	084	Alcohol and/or Drug Svcs; Methadone Administration and/or Svc (take-home)	One unit per day	57	17
H0020	UB		08	084	Alcohol and/or Drug Svcs; Methadone Administration and/or Svc (provision of the drug by a licensed program)	15 min	57	17
H0022			11	184	Alcohol and/or Drug Intervention Svc (planned facilitation) (D&A - Intervention)	30 min	99	34
H0030			11	118	Behavioral Health Hotline Svc (Telephone Crisis)	15 min	11	23
H0031			11	110	Mental Health Assessment, by non-physician (MH Diagnostic Assessment)	15 min	99	30
H0032	HP		08	802 or 806	Mental Health Service Plan Development by Non-physician (BSC - Doctoral Level)	15 min	12, 23, 50, 99	13, 14

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H0032	HP		09	559	Mental Health Service Plan Development by Non-physician (BSC - Doctoral Level)	15 min	11, 12, 23, 99	13, 14
H0032	HP		19	559	Mental Health Service Plan Development by Non-physician (BSC - Doctoral Level)	15 min	11, 12, 23, 99	13, 14
H0032	HP		08	810	Mental Health Service Plan Development by Non-physician (BSC - Doctoral Level)	15 min	11, 12, 23, 99	13, 14
H0032	HP		11	559, 444, 448, or 452	Mental Health Service Plan Development by Non-physician (BSC - Doctoral Level)	15 min	11, 12, 23, 99	13, 14
H0032	HP	U1	31	559	Mental Health Service Plan Development by Non-physician (BSC - Doctoral Level)	15 min	11, 12, 23, 99	13, 14
H0032		HO	08	802 or 806	Mental Health Service Plan Development by Non-physician (BSC - Master's Level)	15 min	12, 23, 72, 99	13, 14
H0032		HO	09	559	Mental Health Service Plan Development by Non-physician (BSC - Master's Level)	15 min	11, 12, 23, 99	13, 14
H0032		HO	19	559	Mental Health Service Plan Development by Non-physician (BSC - Master's Level)	15 min	11, 12, 23, 99	13, 14
H0032		HO	08	810	Mental Health Service Plan Development by Non-physician (BSC - Master's Level)	15 min	11, 12, 23, 99	13, 14
H0032		HO	11	559, 444, 448, or 452	Mental Health Service Plan Development by Non-physician (BSC - Master's Level)	15 min	11, 12, 23, 99	13, 14
H0032		HO; U1	31	559	Mental Health Service Plan Development by Non-physician (BSC - Master's Level)	15 min	11, 12, 23, 99	13, 14
H0034			08	110	Medication training & support (Medication Mgmt Visit)	15 min	49	9
H0034			08	184	Medication training & support (Medication Mgmt Visit)	15 min	57	17
H0034		HB	08	074	Medication training & support (Medication Mgmt Visit)	15 min	15	43
H0034		HB/HK	08	074	Medication training & support (Clozaril Monitor & Eval Visit)	15 min	15	43
H0034		HK	08	110	Medication training & support (Clozaril Monitor & Eval Visit)	15 min	49	22
H0035	U7		11	114	Mental health partial hospitalization, treatment, less than 24 hrs (Licensed Adult Psych Partial Program - Adult)	1 hour	52	10
H0035	U7	HB; UA	11	113	Mental health partial hospitalization, treatment, less than 24 hrs (Licensed Child Psych Partial Program - Adult)	1 hour	52	10
H0035	U7	U2	11	114	Mental health partial hospitalization, treatment, less than 24 hrs (Psych Partial Program - Non-Covered Medicare Hours - Adult)	1 hour	52	10
H0035	UB	HA	11	114	Mental health partial hospitalization, treatment, less than 24 hrs (Licensed Adult Psych Partial Program - Child or Licensed Adult Psych Partial Hosp Program - Child 0-20 years of age, services beyond 270 hours)	1 hour	52	10

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H0035	UB	UA	11	113	Mental health partial hospitalization, treatment, less than 24 hrs (Licensed Child Psych Partial Program - Child or Licensed Child Psych Partial Hosp Program - Child 15 thru 20 years of age or Licensed Child Psych Partial Hosp Program - Child 0-14 years of age, services beyond 720 hours or Licensed Child Psych Partial Hosp Program - Child 15-20 years of age, services beyond 720 hours)	1 hour	52	10
H0035		U2; UA	11	113	Mental health partial hospitalization, treatment, less than 24 hrs (Psych Partial Program - Non-Covered Medicare Hours - Child age 0-14)	1 hour	52	10
H0036		HB	11	123	Community psychiatric supportive treatment, face to face (Psych Rehab - Site Based or Mobile)	15 min	15, 99	29
H0037			11	110	Community psychiatric supportive treatment program, per diem (Adult Outpatient Services in an Alternative Setting)	per diem	99	36
H0038			08	076	Self help/peer services, per 15 minutes	15 min	12, 21, 23, 49, 99	44
H0038			11	076	Self help/peer services, per 15 minutes	15 min	11, 12, 21, 52, 99	44
H0038			21	076	Self help/peer services, per 15 minutes	15 min	12, 21, 31, 32, 99	44
H0038		GT	08	076	Self help/peer services, per 15 minutes (Self-help/peer services - interactive telecommunication systems)	15 min	12, 21, 23, 49, 99	44
H0038		GT	11	076	Self help/peer services, per 15 minutes (Self-help/peer services - interactive telecommunication systems)	15 min	11, 12, 21, 52, 99	44
H0038		GT	21	076	Self help/peer services, per 15 minutes (Self-help/peer services - interactive telecommunication systems)	15 min	12, 21, 31, 32, 99	44
H0039		HB	11	111	Assertive Community Treatment, face to face (Community Treatment Teams)	15 min	99	33
H0046		HW	11	119	Mental health services, not otherwise specified (Community MH Svc - Other - Requires Service Description Approved by OMHSAS)	15 min	99	36
H0046^	UB		11	116 or 117	MH Svcs, not otherwise specified (Other Services by Social Worker, Psychiatric Nurse, etc.)	15 min	11, 12, 99	13, 14
H0046^	UB		16	162	MH Svcs, not otherwise specified (Other Services by Social Worker, Psychiatric Nurse, etc.)	15 min	11, 12, 99	13, 14
H0046^		SC	08, or 11	340	MH Svcs, not otherwise specified (BH Waiver Svc that cannot appropriately be reflected in another PE)	15 min	12, 99	13, 14
H0047		HA	11	184	Alcohol and/or other drug abuse svcs, not otherwise specified (D&A Outpatient Treatment in an Alternative Setting)	15 min	03, 99	37
H0047		HW	11	184	Alcohol and/or other drug abuse svcs, not otherwise specified (D&A - Other - Requires Service Description Approved by OMHSAS)	15 min	99	37
H2010		HK	08	110	Comprehensive Medication Svcs (Clozapine Support Svc)	15 min	12, 49	22
H2010		HK	11	113 or 114	Comprehensive Medication Svcs (Clozapine Support Svc)	15 min	52	22
H2010		HK: U1	31	339	Comprehensive Medication Services (Clozapine Support Svc)	15 min	11, 12	22
H2011			11	118	Crisis Intervention Svc (Walk-in Crisis)	15 min	11	23
H2011	U7	HT	11	118	Crisis Intervention Svc (Mobile Crisis - Team Delivered)	15 min	15	23
H2011	U9	HK	11	118	Crisis Intervention Svc (Medical Mobile Crisis - Team Delivered)	15 min	15	23

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H2011	UB	HE	11	118	Crisis Intervention Svc (Mobile Crisis - Individual Delivered)	15 min	15	23
H2012	UB		08	803 or 807	Behavioral Health Day Treatment (STAP)	per hour	99	13, 14
H2012	UB		08	811	Behavioral Health Day Treatment (STAP)	per hour	99	13, 14
H2012	UB		11	445, 449, or 453	Behavioral Health Day Treatment (STAP)	per hour	99	13, 14
H2012^		SC	08, or 11	340	Behavioral Health Day Treatment (Day Treatment)	per hour	99	13, 14
H2014	UB		08	800 or 804	Skills Training & Development (6 or more months)	15 min	12, 99	13, 14
H2014	UB		08	808	Skills Training & Development (6 or more months)	15 min	12, 99	13, 14
H2014	UB		09	548	Skills Training & Development (6 or more months)	15 min	12, 99	13, 14
H2014	UB		11	548, 442, 446, or 450	Skills Training & Development (6 or more months)	15 min	12, 99	13, 14
H2014	UB		19	548	Skills Training & Development (6 or more months)	15 min	12, 99	13, 14
H2014	UB	HA	08	800 or 804	Skills Training & Development (Less than 6 months)	15 min	12, 99	13, 14
H2014	UB	HA	08	808	Skills Training & Development (Less than 6 months)	15 min	12, 99	13, 14
H2014	UB	HA	09	548	Skills Training & Development (Less than 6 months)	15 min	12, 99	13, 14
H2014	UB	HA	11	548, 442, 446, or 450	Skills Training & Development (Less than 6 months)	15 min	12, 99	13, 14
H2014	UB	HA	19	548	Skills Training & Development (Less than 6 months)	15 min	12, 99	13, 14
H2014	UB	HA; U1	31	548	Skills Training & Development (Less than 6 months)	15 min	12, 99	13, 14
H2014	UB	U1	31	548	Skills Training & Development (6 or more months)	15 min	12, 99	13, 14
H2015^			08, or 11	340	Comprehensive Community Support Svcs (After School Program)	15 min	12, 99	13, 14
H2017^			08, or 11	340	Psychosocial Rehabilitation Svcs (Psychosocial Rehab)	15 min	12, 99	13, 14
H2019	UB		08	801 or 805	Therapeutic Behavioral Svcs (MT)	15 min	12, 99	13, 14
H2019	UB		08	809	Therapeutic Behavioral Svcs (MT)	15 min	12, 99	13, 14
H2019	UB		09	549	Therapeutic Behavioral Svcs (MT)	15 min	12, 99	13, 14
H2019	UB		11	549, 443, 447, or 451	Therapeutic Behavioral Svcs (MT)	15 min	12, 99	13, 14
H2019	UB		19	549	Therapeutic Behavioral Svcs (MT)	15 min	12, 99	13, 14
H2019	UB	U1	31	549	Therapeutic Behavioral Services (MT)	15 min	12, 99	13, 14
H2019^		HA	08, or 11	340	Therapeutic Behavioral Services (Functional Family Therapy)	15 min	12, 99	13, 14
H2021	UB		08	800 or 804	Community-based Wraparound Svcs (TSS)	15 min	12, 23, 99	13, 14
H2021	UB		08	808	Community-based Wraparound Svcs (TSS)	15 min	12, 23, 99	13, 14
H2021	UB		09	548	Community-based Wraparound Svcs (TSS)	15 min	12, 23, 99	13, 14

Procedure Code Detail From Attachment G Sorted By Procedure Code

Attachment H

H2021	UB		11	548, 442, 446, or 450	Community-based Wraparound Svcs (TSS)	15 min	12, 23, 99	13, 14
H2021	UB		19	548	Community-based Wraparound Svcs (TSS)	15 min	12, 23, 99	13, 14
H2021	UB	U1	31	548	Community-based Wraparound Services (TSS)	15 min	12, 23, 99	13, 14
H2021^	U7	SC	11	340	Community-based Wraparound Svcs (EIBS)	15 min	99	13, 14
H2021^	U8	SC	11	340	Community-based Wraparound Svcs (EIBS)	15 min	99	13, 14
H2021^	U9	SC	11	340	Community-based Wraparound Svcs (EIBS)	15 min	99	13, 14
H2021^		SC	08, or 11	340	Community-based Wraparound Svcs (TSS Aide)	15 min	12, 99	13, 14
H2021^		SC; HQ	08, or 11	340	Community-based Wraparound Svcs (One to One Svcs in RTF)	15 min	12, 99	13, 14
H2022^			08, or 11	340	Community-based wrap-around svcs (Other PE svcs with a per diem rate)	per diem	99	13, 14
H2030			11	123	Mental Health Clubhouse Svcs (Psych Rehab - Clubhouse)	15 min	99	29
H2032	UB		17	174	Activity therapy (use for Art Therapy)	15 min	11	13, 14
H2033^			08 or 11	340	Multisystemic therapy for juveniles, per 15 minutes, effective 10/1/2005	15 min	12, 99	13, 14
H2034			11	131	Alcohol and/or Drug Abuse Halfway House Svcs (Drug Free Halfway House)	per diem	99	8
H2035			11	129	Alcohol and/or Drug Treatment Program (Drug Free)	per hour	99	34

Procedure Code Detail From Attachment G Sorted By Procedure Code

Attachment H

S9484			11	118	Crisis Intervention Svc, MH svcs (Crisis In-Home Support)	per hour	12, 99	23
S9485			11	118	Crisis Intervention Svc, MH svcs (Crisis Residential)	per diem	12	23
T1015	HG		08	084	Clinic Visit/Encounter, All-Inclusive (Methadone Maintenance Comprehensive Svcs - incl transportation)	visit	57	17
T1015	UB		08	184	Clinic Visit/Encounter, All-Inclusive (Drug Free Clinic Visit)	visit	57	17
T1015		HE	08	080 or 081	Clinic Visit/Encounter, All-inclusive (Rural Health Clinic Visit)	visit	12, 21, 31, 32, 50, 72, 99	11
T1015		HF	08	080 or 081	Clinic Visit/Encounter, All-inclusive (Rural Health Clinic Visit)	visit	50, 72	18
T1016	U8		21	212*	Case Management (CM)	15 min	11, 12, 21	38
T1016	UB		11	115	Case Management (MH Svc During Non-Psych Inpatient Admission)	15 min	21, 31, 32	24
T1016	UB	HK	11	115	Case Management (MH Svc During Psych Inpatient Admission)	15 min	21	24
T1016	UB	HT	11	115	Case Management (Team w/ Collateral and/or Other Agencies)	15 min	12, 99	24
T1016	UB	UK	11	115	Case Management (Team Member w/ Collateral and/or Other Agencies)	15 min	12, 99	24
T1017	TF		21	221	Targeted Case Management (RC- Resource Coordination)	15 min	11, 12, 99	28
T1017	TF	HE; HK	21	221	Targeted Case Management (RC - MH Svc During Non-Psych Inpatient Admission)	15 min	21, 31, 32	28
T1017	TF	HK	21	221	Targeted Case Management (RC - MH Svc During Psych Inpatient Admission)	15 min	21	28
T1017	UB		21	222	Targeted Case Management (ICM - MH/MR Case Mgmt)	15 min	11, 12, 99	25
T1017	UB	HE; HK	21	222	Targeted Case Management (ICM - MH Svc During Non-Psych Inpatient Admission)	15 min	21, 31, 32	25
T1017	UB	HE; HK; UC	21	222	Targeted Case Management (BCM - MH Svc During Non-Psych Inpatient Admission)	15 min	21, 31, 32	27
T1017	UB	HK	21	222	Targeted Case Management (ICM - MH Svc During Psych Inpatient Admission)	15 min	21	25
T1017	UB	HK; UC	21	222	Targeted Case Management (BCM - MH Svc During Psych Inpatient Admission)	15 min	21	27
T1017	UB	UC	21	222	Targeted Case Management (BCM - MH ICM Svc)	15 min	11, 12, 99	27
T1017		HE; HK; HT	21	222	Targeted Case Management (ICM- CTT - MH Svc During Non-Psych Inpatient Admission)	15 min	21, 31, 32	26
T1017		HK; HT	21	222	Targeted Case Management (ICM- CTT - MH Svc During Psych Inpatient Admission)	15 min	21	26
T1017		HT	21	222	Targeted Case Management (ICM- CTT - MH/MR CM)	15 min	11, 12, 99	26
T2048		HE	11	110	Behavioral Health; Long-term care residential (non-acute care in a residential treatment program where stay is typically longer than 30 days) with room and board, per diem (Long Term Structured Residential)	per diem	99	31
T2048		HF	11	134	Behavioral Health; Long-term care residential (non-acute care in a residential treatment program where stay is typically longer than 30 days) with room and board, per diem (Drug Free Residential)	per diem	99	8
Identifies supplemental services								

Provider Type	Provider Type Description	Provider Specialty	Provider Specialty Description
01	Inpatient Facility	010	Acute Care Hospital
		011	Private Psych Hosp
		013	RTF (JCAHO Certified) Hospital
		018	Extended Acute Psych Inpatient Unit
		019	D&A Rehab Hosp
		022	Private Psych Unit
		183	Hospital Based Medical Clinic
		370	Tobacco Cessation
		441	D&A Rehab Unit
05	Home Health	370	Tobacco Cessation
07	Capitation	072	MCO - BH
08	Clinic	074	Mobile Mental Health Treatment
		076	Peer Specialist
		080	Federally Qualified Health Center
		081	Rural Health Clinic
		082	Independent Medical/Surgical Clinic
		083	Family Planning Clinic
		084	Methadone Maintenance
		110	Psychiatric Outpatient
		184	D&A Outpatient
		340	Program Exception
		370	Tobacco Cessation
		800	FQHC Therapeutic Staff Support
		801	FQHC Mobile Therapy
		802	FQHC Behavioral Specialist Consultant
		803	FQHC Summer Therapeutic Activity Program
		804	RHC Therapeutic Staff Support
		805	RHC Mobile Therapy
		806	RHC Behavioral Specialist Consultant
		807	RHC Summer Therapeutic Activity Program
		808	Psychiatric Outpatient Therapeutic Staff Support
		809	Psychiatric Outpatient Mobile Therapy
810	Psychiatric Outpatient Behavioral Specialist Consultant		
811	Psychiatric Outpatient Summer Therapeutic Activity Program		
09	CRNP	093	CRNP
		103	Family and Adult Psychiatric Mental Health
		370	Tobacco Cessation
		548	Therapeutic Staff Support
		549	Mobile Therapy
		559	Behavioral Specialist Consultant
11	Mental Health/Substance Abuse	076	Peer Specialist
		110	Psychiatric Outpatient
		111	Community Mental Health
		112	Outpatient Practitioner - MH
		113	Partial Psych Hosp - Children
		114	Partial Psych Hosp - Adult
		115	Family Based Mental Health
		116	Licensed Clinical Social Worker
		117	Licensed Social Worker
		118	Mental Health Crisis Intervention
		119	MH - OMHSAS
		123	Psychiatric Rehabilitation

OMHSAS Desk Reference

Attachment K

11	Mental Health/Substance Abuse continued	127	D&A Outpatient
		128	D&A Intensive Outpatient
		129	D&A Partial Hospitalization
		131	D&A Halfway House
		132	D&A Medically Monitored Detox
		133	D&A Medically Monitored Residential, Short Term
		134	D&A Medically Monitored Residential, Long Term
		184	Outpatient D&A
		340	Program Exception
		442	Partial Psych Hosp Children Therapeutic Staff Support
		443	Partial Psych Hosp Children Mobile Therapy
		444	Partial Psych Hosp Children Behavioral Specialist Consultant
		445	Partial Psych Hosp Children Summer Therapeutic Activity Program
		446	Partial Psych Hosp Adult Therapeutic Staff Support
		447	Partial Psych Hosp Adult Mobile Therapy
		448	Partial Psych Hosp Adult Behavioral Specialist Consultant
		449	Partial Psych Hosp Adult Summer Therapeutic Activity Program
		450	Family Based MH Therapeutic Staff Support
		451	Family Based MH Mobile Therapy
		16	Nurse
453	Family Based MH Summer Therapeutic Activity Program		
548	Therapeutic Staff Support		
549	Mobile Therapy		
559	Behavioral Specialist Consultant		
162	Psychiatric Nurse		
171	Occupational Therapist		
17	Therapist	174	Art Therapist
		175	Music Therapist
		190	General Psychologist
19	Psychologist	370	Tobacco Cessation
		548	Therapeutic Staff Support
		549	Mobile Therapy
		559	Behavioral Specialist Consultant
		076	Peer Specialist
21	Case Manager	138	D&A Targeted Case Management
		212	MA Case Management for under 21 years of age
		221	MH TCM - Resource Coordination
		222	MH TCM - Intensive
		370	Tobacco Cessation
24	Pharmacy	370	Tobacco Cessation
27	Dentist	370	Tobacco Cessation
28	Laboratory	280	Independent Laboratory

OMHSAS Desk Reference

Attachment K

31	Physician	315	Emergency Medicine
		316	Family Practice
		322	Internal Medicine
		339	Psychiatry
		345	Pediatrics
		370	Tobacco Cessation
		548	Therapeutic Staff Support
		549	Mobile Therapy
		559	Behavioral Specialist Consultant
37	Tobacco Cessation	370	Tobacco Cessation
52	Community Residential Rehab	520	Children & Youth Licensed Group Home with a Mental Health Treatment Component
		523	Host Home/Children
56	Residential Treatment Facility	560	RTF (Non-JCAHO certified)

Modifiers	Modifier Descriptions	Modifiers	Modifier Descriptions
AH	Clinical psychologist	SC	Medically necessary service or supply
GO	OP Occupational Therapy Service	TF	Intermediate level of care
GT	Via interactive audio and video telecommunication systems	TG	Complex/high tech level of care
		TJ	Program group, child and/or adolescent
HA	Child/adolescent program	TT	Individualized service provided to more than one patient in same setting
HB	Adult program, non geriatric		
HE	Mental health program	UA	Licensed children's program
HF	Substance abuse program	UB	Medicaid Pricing Modifier
HG	Opioid addiction treatment program	UC	Pilot program
HK	Specialized mental health programs for high-risk populations	UK	someone other than the client (collateral)
		U1	Psychiatric
HO	Masters degree level	U2	Medicare/TPL contractual disallowance
HP	Doctoral level	U7	Medicaid Pricing Modifier
HQ	Group setting	U8	Medicaid Pricing Modifier
HT	Multi-disciplinary team	U9	Medicaid Pricing Modifier
HW	Funded by state mental health agency	Pricing Modifiers	

POS	Place of Service Description	POS	Place of Service Description
03	School	49	Independent Clinic
11	Office	50	Federally Qualified Health Ctr
12	Home	52	Psychiatric Facility - PH
15	Mobile Unit	54	ICF/MR
21	Inpatient Hospital	56	Psychiatric RTF
22	Outpatient Hospital	57	Non-Residential Substance Abuse Treatment Fac
23	Emergency Room - Hospital	65	End-Stage Renal Disease Treatment Facility
24	Ambulatory Surgical Center	72	Rural Health Clinic
31	Skilled Nursing Facility	81	Independent Laboratory
32	Nursing Facility	99	Other POS

**BEHAVIORAL HEALTH
APPENDIX VI**

**HealthChoices Zones
Financial Reporting Crosswalk**

HEALTHCHOICES BEHAVIORAL HEALTH FINANCIAL REPORTING

Philadelphia County

Report #	Line #	Line Title	Should Agree With:			Rating Group	In Total?	Special Comments	
			Report #	Line #	Line Title				
REPORT #2 - PRIMARY CONTRACTOR SUMMARY OF TRANSACTIONS									
2	1	Beginning Balance				Y	Y	Should be \$0 for the 1st quarter of each contract year; the Beginning Balance for the 2nd and subsequent quarters should be the Ending Balance of the previous quarter.	
2	3)	Total Distributions to Subcontractor	3	2a)	Capitation Revenue	Y	Y		
2	3a)	Distributions to Subcontractor - Medical Services	3	3a)	Distributions at Subcontractor Level - Medical Services	Y	Y	Philadelphia reimburses Community Behavioral Health on a cash basis.	
			&						
			9A	Total of 5) through 15)	Total Medical Expenses	Y	Y		
2	3b)	Distributions to Subcontractor - Administration	3	4)	Subcontractor Total Administration Expenses	Y	Y	Philadelphia reimburses Community Behavioral Health on a cash basis.	
REPORT #3 - SUBCONTRACTOR SUMMARY OF TRANSACTIONS									
3	1	Beginning Balance				Y	Y	Should be \$0 for the 1st quarter of each contract year; the Beginning Balance for the 2nd and subsequent quarters should be the Ending Balance of the previous quarter.	
3	3a)	Distributions at Subcontractor Level - Medical Services	9A	Total of 5) through 15)	Total Medical Expenses	Y	Y		
REPORT #6 - CLAIMS PAYABLE									
6		Total RBUCs-[45-90 Days + 91+ Days]	8C		Total \$ Amount of Claims				
REPORT #7 - LAG REPORT									
7	27	Expense Reported in Current +1st Prior + 2nd Prior Columns	9A	5) through 15)	Subtotal for each Major Service Grouping		Y	Expense reported for the month/quarter on Report #7 - Other should agree with Report #9A, Line 15b) Other Medical Services.	

HEALTHCHOICES BEHAVIORAL HEALTH FINANCIAL REPORTING

Philadelphia County

Report #	Line #	Line Title	Should Agree With:			Rating Group	In Total?	Special Comments
			Report #	Line #	Line Title			
REPORT #9 - ANALYSIS OF REVENUES & EXPENSES								
9A		Member Month Equivalents	1		Member Month Equivalents for the Quarter	Y	Y	The sum of Member Month Equivalents for the quarter on Report #1 should agree with Report #9A by Rating Group.
			9B		Member Month Equivalents- Current Period	N/A	Y	Total only.
9B		Member Month Equivalents - Year-to-Date	1		Member Month Equivalents - Year-to-Date	N/A	Y	Total only.
9A	1	Capitation	2	2a)	Capitation Revenue	Y	Y	
9A	2	Investment Income	2 & 3	2b)	Investment Revenue	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
9A	3	Other Income	2	2c)	Other Revenue	Y	Y	Total on Report #9A should agree with sum of amounts reported on Report #2.
9A	16a)	Administration - Compensation	2	9a)	Primary Contractor Administrative Expenses - Compensation	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4a)	Subcontractor Administrative Expenses - Compensation			
9A	16b)	Administration - Interest Expense	2	9b)	Primary Contractor Administrative Expenses - Interest	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4b)	Subcontractor Administrative Expenses - Interest			
9A	16c)	Administration - Occupancy, Depreciation, & Amortization	2	9c)	Primary Contractor Administrative Expenses - Occ., Depr., & Amort.	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4c)	Subcontractor Administrative Expenses - Occ., Depr., & Amort.			
9A	16d)	Administration - GRT	2	9d)	Primary Contractor Administrative Expenses - GRT	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4d)	Subcontractor Administrative Expenses - GRT			
9A	16f)	Administration - Clinical Care/Medical Management	2	9f)	Primary Contractor Administrative Expenses - Clinical Care/Medical Mgmt	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4e)	Subcontractor Administrative Expenses - Clinical Care/Medical Mgmt			
9A	16g)	Administration - Other	2	9g)	Primary Contractor Administrative Expenses - Other	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4f)	Subcontractor Administrative Expenses - Other			
9A	16	Total Administration	2	9)	Primary Contractor Administrative Expense Total	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4)	Subcontractor Total Administration Expenses			
9A	All	All Total Column \$ Amounts	9B	All	All Current Quarter \$ Amounts	N/A	Y	Totals only.

HEALTHCHOICES BEHAVIORAL HEALTH FINANCIAL REPORTING

Southwest: Beaver, Fayette and Greene, Lehigh Capital: Cumberland, Dauphin, Lancaster, Lebanon and Perry
 NBHCC, NC State Option, NC County Option: Tuscarora Managed Care Alliance

Report #	Line #	Line Title	Should Agree With:			Rating Group	In Total?	Special Comments
			Report #	Line #	Line Title			
REPORT #2 - PRIMARY CONTRACTOR SUMMARY OF TRANSACTIONS								
2	1	Beginning Balance				Y	Y	Should be \$0 for the 1st quarter of each contract year; the Beginning Balance for the 2nd and subsequent quarters should be the Ending Balance of the previous quarter.
2	7	Distributions for Medical Expenses	9A	Total of 5) through 15)	Total Medical Expenses	Y	Y	
2	9e)	Administration - Distributions to Management Corporation/ASO						Should be the ASO fee specified in the ASO Agreement plus/minus any incentive/sanction.
REPORT #3 - SUBCONTRACTOR SUMMARY OF TRANSACTIONS								
								This report not required for these counties.
REPORT #6 - CLAIMS PAYABLE								
6		Total RBUCs	8B		\$ Amount of Claims not Adjudicated			
6		Total RBUCs-[46-90 Days + 91+ Days]	8C		Total \$ Amount of Claims			
REPORT #7 - LAG REPORT								
7	27	Expense Reported in Current Column (monthly reporting) or Current +1st Prior + 2nd Prior Columns (quarterly reporting)	9A	5) through 15)	Subtotal for each Major Service Grouping		Y	Expense reported for the month/quarter on Report #7 - Other should agree with Report #9A, Line 15b) Other Medical Services.

HEALTHCHOICES BEHAVIORAL HEALTH FINANCIAL REPORTING

Southwest: Beaver, Fayette and Greene, Lehigh Capital: Cumberland, Dauphin, Lancaster, Lebanon and Perry
 NBHCC, NC State Option, NC County Option: Tuscarora Managed Care Alliance

Report #	Line #	Line Title	Should Agree With:			Rating Group	In Total?	Special Comments
			Report #	Line #	Line Title			
REPORT #9 - ANALYSIS OF REVENUES & EXPENSES								
9A		Member Month Equivalents	1		Member Month Equivalents for the Month/Quarter	Y	Y	The sum of Member Month Equivalents for the month/quarter on Report #1 should agree with Report #9A by Rating Group.
	9B				Member Month Equivalents- Current Period	N/A	Y	Total only.
9B		Member Month Equivalents - Year-to-Date	1		Member Month Equivalents - Year-to-Date	N/A	Y	Total only.
9A	1	Capitation	2	2a)	Capitation Revenue	Y	Y	
9A	2	Investment Income	2	2b)	Investment Revenue	Y	Y	
9A	3	Other Income	2	2c)	Other Revenue	Y	Y	
9A	16a)	Administration - Compensation	2	9a)	Primary Contractor Administrative Expenses Compensation	Y	Y	
9A	16b)	Administration - Interest Expense	2	9b)	Primary Contractor Administrative Expenses Interest	Y	Y	
9A	16c)	Administration - Occupancy, Depreciation, & Amortization	2	9c)	Primary Contractor Administrative Expenses Occ., Depr., & Amort.	Y	Y	
9A	16d)	Administration - GRT	2	9d)	Primary Contractor Administrative Expenses GRT	Y	Y	
9A	16e)	Administration - Distributions to Management Corporation/ASO	2	9e)	Primary Contractor Administrative Expenses Dist. to Mgmt. Corp./ASO	Y	Y	N/A to Beaver or Fayette Counties. For these Counties, the sum of Report #9A, Lines 16e) and 16f) should agree with the sum of Report #2, Lines 9e) and 9f).
9A	16f)	Administration - Clinical Care/Medical Management	2	9f)	Primary Contractor Administrative Expenses Clinical Care/Medical Mgmt	Y	Y	N/A to Beaver or Fayette Counties. For these Counties, the sum of Report #9A, Lines 16e) and 16f) should agree with the sum of Report #2, Lines 9e) and 9f).
9A	16g)	Administration - Other	2	9g)	Primary Contractor Administrative Expenses Other	Y	Y	
9A	16	Total Administration	2	9)	Primary Contractor Administrative Expense Total	Y	Y	
9A	All	All Total Column \$ Amounts	9B	All	All Current Quarter \$ Amounts	N/A	Y	Totals only.

HEALTHCHOICES BEHAVIORAL HEALTH FINANCIAL REPORTING

NC County Option: NWBHP

Report #	Line #	Line Title	Should Agree With:			Rating Group	In Total?	Special Comments
			Report #	Line #	Line Title			
REPORT #2 - PRIMARY CONTRACTOR SUMMARY OF TRANSACTIONS								
2	1	Beginning Balance				Y	Y	Should be \$0 for the 1st quarter of each contract year; the Beginning Balance for the 2nd and subsequent quarters should be the Ending Balance of the previous quarter.
2	3a)	Distributions To Subcontractor - Medical Services				Y	Y	Should be % specified for medical expenses in the subcontract
2	3b)	Distributions to Subcontractor - Administration				Y	Y	Should be % or PMPM specified for administrative expenses in the subcontract. NWBHP: specified PMPM plus 2% of Medical less CFST costs
2	3)	Total Distributions to Subcontractor	3	2a) + 2c)	Capitation Revenue Plus Other Revenue	Y	Y	Total Distributions to Subcontractor (Rpt #2, Ln 3) = the sum of Capitation Revenue (Rpt, #3, Ln 2a) and Other Revenue (Rpt #3, Ln 2c)
2	9e)	Administration - Distributions to Management Corporation/ASO						Should be in agreement with the subcontract.
REPORT #3 - SUBCONTRACTOR SUMMARY OF TRANSACTIONS								
3	1	Beginning Balance				Y	Y	Should be \$0 for the 1st quarter of the contract year; the Beginning Balance for the 2nd and subsequent quarters should be the Ending Balance of the previous quarter.
3	3a)	Distributions at Subcontractor Level - Medical Services	9A	Total of 5) through 15)	Total Medical Expenses excluding Stop-Loss Premiums on Ln 15a	Y	Y	
REPORT #6 - CLAIMS PAYABLE								
6		Total RBUCs	8B		\$ Amount of Claims not Adjudicated			
6		Total RBUCs-[46-90 Days + 91+ Days]	8C		Total \$ Amount of Claims			
REPORT #7 - LAG REPORT								
7	27	Expense Reported in Current Column (monthly reporting) or Current +1st Prior + 2nd Prior Columns (quarterly reporting)	9A	5) through 15)	Subtotal for each Major Service Grouping		Y	Expense reported for the month/quarter on Report #7 - Other should agree with Report #9A, Line 15b) Other Medical Services.

HEALTHCHOICES BEHAVIORAL HEALTH FINANCIAL REPORTING

NC County Option: NWBHP

Report #	Line #	Line Title	Should Agree With:			Rating Group	In Total?	Special Comments
			Report #	Line #	Line Title			
REPORT #9 - ANALYSIS OF REVENUES & EXPENSES								
9A		Member Months Equivalent	1		Member Month Equivalents for the Month/Quarter	Y	Y	The sum of Member Month Equivalents for the quarter on Report #1 should agree with Report #9A by Rating Group.
			9B		Member Month Equivalents- Current Period	N/A	Y	Total only.
9B		Member Month Equivalents - Year-to-Date	1		Member Month Equivalents - Year-to-Date	N/A	Y	Total only.
9A	1	Capitation	2	2a)	Capitation Revenue	Y	Y	
9A	2	Investment Income	2 & 3	2b)	Investment Revenue	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
9A	16a)	Administration - Compensation	2	9a)	Primary Contractor Administrative Expenses Compensation	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4a)	Subcontractor Administrative Expenses - Compensation			
9A	16b)	Administration - Interest Expense	2	9b)	Primary Contractor Administrative Expenses Interest	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4b)	Subcontractor Administrative Expenses - Interest			
9A	16c)	Administration - Occupancy, Depreciation, & Amortization	2	9c)	Primary Contractor Administrative Expenses Occ., Depr., & Amort.	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4c)	Subcontractor Administrative Expenses - Occ., Depr., & Amort.			
9A	16d)	Administration - GRT	2	9d)	Primary Contractor Administrative Expenses GRT	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4d)	Subcontractor Administrative Expenses - GRT			
9A	16e)	Administration - Distributions to Management Corporation/ASO	2	9e)	Primary Contractor Administrative Expenses Dist. to Mgmt. Corp./ASO	Y	Y	
9A	16f)	Administration - Clinical Care/Medical Management	2	9f)	Primary Contractor Administrative Expenses Clinical Care/Medical Mgmt	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4e)	Subcontractor Administrative Expenses - Clinical Care/Medical Mgmt			
9A	16g)	Administration - Other	2	9g)	Primary Contractor Administrative Expenses Other	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4f)	Subcontractor Administrative Expenses - Other			
9A	16	Total Administration	2	9)	Primary Contractor Administrative Expense Total	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4)	Subcontractor Total Administration Expenses			
9A	All	All Total Column \$ Amounts	9B	All	All Current Quarter \$ Amounts	N/A	Y	Totals only.

HEALTHCHOICES BEHAVIORAL HEALTH FINANCIAL REPORTING

SE: Bucks, Montgomery
 SW: Allegheny, Armstrong/Indiana, Butler, Lawrence, Washington, Westmoreland
 LC: Adams, Berks, Lehigh, Northampton, York
 NC CO: BHSSBC, Blair, CMP, Erie and LCJB

Report #	Line #	Line Title	Should Agree With:			Rating Group	In Total?	Special Comments
			Report #	Line #	Line Title			
REPORT #2 - PRIMARY CONTRACTOR SUMMARY OF TRANSACTIONS								
2	1	Beginning Balance				Y	Y	Should be \$0 for the 1st quarter of each contract year; the Beginning Balance for the 2nd and subsequent quarters should be the Ending Balance of the previous quarter.
2	3a)	Distributions To Subcontractor - Medical Services				Y	Y	Will be the actual \$ amount paid to Subcontractor each month for medical claims expenses.
2	3b)	Distributions to Subcontractor - Administration				Y	Y	Should be % or PMPM specified for administrative expenses in the subcontract.
2	4	Reserves	3	3a)	Distributions at Subcontractor Level - Medical Services less			Reserves on Report #2 should agree with the Subcontractor's Distribution for Medical Services on Report #3 less the County's Distribution to Subcontractor for Medical Services on Report #2.
			2	3a)	Distributions to Subcontractor - Medical Services			
REPORT #3 - SUBCONTRACTOR SUMMARY OF TRANSACTIONS								
3	1	Beginning Balance				Y	Y	Should be \$0 for the 1st quarter of the contract year; the Beginning Balance for the 2nd and subsequent quarters should be the Ending Balance of the previous quarter.
3	2a)	Capitation Revenue	2	3b)	Distributions to Subcontractor - Administration	Y	Y	Capitation Revenue on Report #3 should agree with the sum of the Administration Distribution to Subcontractor and Subcontractor Distribution for Medical Services. Actual Medical Expenses are used up to the Contract % rate for medical expenses.
			3	3a)	Distributions at Subcontractor Level - Medical Services			
3	3a)	Distributions at Subcontractor Level - Medical Services	9A	Total of 5) through 15)	Total Medical Expenses	Y	Y	N/A to Lehigh, Northampton, BHSSBC or Erie Counties. For these Counties, the sum of Report #2, Line 7) and Report #3, Line 3a) should agree with Report #9, Total of 5) through 15).
REPORT #6 - CLAIMS PAYABLE								
6		Total RBUCs	8B		\$ Amount of Claims not Adjudicated			
6		Total RBUCs-[46-90 Days + 91+ Days]	8C		Total \$ Amount of Claims			
REPORT #7 - LAG REPORT								
7	27	Expense Reported in Current Column (monthly reporting) or Current +1st Prior + 2nd Prior Columns (quarterly reporting)	9A	5) through 15)	Subtotal for each Major Service Grouping		Y	Expense reported for the month/quarter on Report #7 - Other should agree with Report #9A, Line 15b) Other Medical Services.

HEALTHCHOICES BEHAVIORAL HEALTH FINANCIAL REPORTING

SE: Bucks, Montgomery
 SW: Allegheny, Armstrong/Indiana, Butler, Lawrence, Washington, Westmoreland
 LC: Adams, Berks, Lehigh, Northampton, York
 NC CO: BHSSBC, Blair, CMP, Erie and LCJB

Report #	Line #	Line Title	Should Agree With:			Rating Group	In Total?	Special Comments
			Report #	Line #	Line Title			
REPORT #9 - ANALYSIS OF REVENUES & EXPENSES								
9A		Member Months Equivalent	1		Member Month Equivalents for the Month/Quarter	Y	Y	The sum of Member Month Equivalents for the quarter on Report #1 should agree with Report #9A by Rating Group.
			9B		Member Month Equivalents- Current Period	N/A	Y	Total only.
9B		Member Month Equivalents - Year-to-Date	1		Member Month Equivalents - Year-to-Date	N/A	Y	Total only.
9A	1	Capitation	2	2a)	Capitation Revenue	Y	Y	
9A	2	Investment Income	2 & 3	2b)	Investment Revenue	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
9A	16a)	Administration - Compensation	2	9a)	Primary Contractor Administrative Expenses - Compensation	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4a)	Subcontractor Administrative Expenses - Compensation			
9A	16b)	Administration - Interest Expense	2	9b)	Primary Contractor Administrative Expenses - Interest	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4b)	Subcontractor Administrative Expenses - Interest			
9A	16c)	Administration - Occupancy, Depreciation, & Amortization	2	9c)	Primary Contractor Administrative Expenses - Occ., Depr., & Amort.	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4c)	Subcontractor Administrative Expenses - Occ., Depr., & Amort.			
9A	16d)	Administration - GRT	2	9d)	Primary Contractor Administrative Expenses - GRT	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4d)	Subcontractor Administrative Expenses - GRT			
9A	16e)	Administration - Distributions to Management Corporation/ASO	2	9e)	Primary Contractor Administrative Expenses - Dist. to Mgmt. Corp./ASO	Y	Y	Should be \$0
9A	16f)	Administration - Clinical Care/Medical Management	2	9f)	Primary Contractor Administrative Expenses - Clinical Care/Medical Mgmt	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4e)	Subcontractor Administrative Expenses - Clinical Care/Medical Mgmt			
9A	16g)	Administration - Other	2	9g)	Primary Contractor Administrative Expenses - Other	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4f)	Subcontractor Administrative Expenses - Other			
9A	16	Total Administration	2	9)	Primary Contractor Administrative Expense Total	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4)	Subcontractor Total Administration Expenses			
9A	All	All Total Column \$ Amounts	9B	All	All Current Quarter \$ Amounts	N/A	Y	Totals only.

HEALTHCHOICES BEHAVIORAL HEALTH FINANCIAL REPORTING

Southeast Counties: Chester and Delaware
 North Central County Option: Cambria

Report #	Line #	Line Title	Should Agree With:			Rating Group	In Total?	Special Comments
			Report #	Line #	Line Title			
REPORT #2 - PRIMARY CONTRACTOR SUMMARY OF TRANSACTIONS								
2	1	Beginning Balance				Y	Y	Should be \$0 for the 1st quarter of each contract year; the Beginning Balance for the 2nd and subsequent quarters should be the Ending Balance of the previous quarter.
2	3a)	Distributions To Subcontractor - Medical Services				Y	Y	Should be % specified for medical expenses in the subcontract. DE: All remaining Revenue not distributed for Admin or Incentive
2	3b)	Distributions to Subcontractor - Administration				Y	Y	Should be % or a PMPM specified for administrative expenses in the subcontract
REPORT #3 - SUBCONTRACTOR SUMMARY OF TRANSACTIONS								
3	1	Beginning Balance				Y	Y	Should be \$0 for the 1st quarter of the contract year; the Beginning Balance for the 2nd and subsequent quarters should be the Ending Balance of the previous quarter.
3	2a)	Capitation Revenue	2	3)	Total Distribution to Subcontractor less	Y	Y	Capitation Revenue on Report #3 should equal the Total Distribution to Subcontractor less Other Distribution to Subcontractor on Report #2(which would appear on Report #3, Line 2c, Other Revenue).
			2	3e)	Other Distribution to Subcontractor			
3	3a)	Distributions at Subcontractor Level - Medical Services	9A	Total of 5) through 15)	Total Medical Expenses	Y	Y	Actual Medical Expenses reported by Subcontractor
REPORT #6 - CLAIMS PAYABLE								
6		Total RBUCs	8B		\$ Amount of Claims not Adjudicated			
6		Total RBUCs-[46-90 Days + 91+ Days]	8C		Total \$ Amount of Claims			
REPORT #7 - LAG REPORT								
7	27	Expense Reported in Current Column (monthly reporting) or Current +1st Prior + 2nd Prior Columns (quarterly reporting)	9A	5) through 15)	Subtotal for each Major Service Grouping		Y	Expense reported for the month/quarter on Report #7 - Other should agree with Report #9A, Line 15b) Other Medical Services.

HEALTHCHOICES BEHAVIORAL HEALTH FINANCIAL REPORTING

Southeast Counties: Chester and Delaware
North Central County Option: Cambria

Report #	Line #	Line Title	Should Agree With:			Rating Group	In Total?	Special Comments
			Report #	Line #	Line Title			
REPORT #9 - ANALYSIS OF REVENUES & EXPENSES								
9A		Member Months Equivalent	1		Member Month Equivalents for the Month/Quarter	Y	Y	The sum of Member Month Equivalents for the quarter on Report #1 should agree with Report #9A by Rating Group.
			9B		Member Month Equivalents- Current Period	N/A	Y	Total only.
9B		Member Month Equivalents - Year-to-Date	1		Member Month Equivalents - Year-to-Date	N/A	Y	Total only.
9A	1	Capitation	2	2a)	Capitation Revenue	Y	Y	
9A	2	Investment Income	2 & 3	2b)	Investment Revenue	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
9A	16a)	Administration - Compensation	2	9a)	Primary Contractor Administrative Expenses - Compensation	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4a)	Subcontractor Administrative Expenses - Compensation			
9A	16b)	Administration - Interest Expense	2	9b)	Primary Contractor Administrative Expenses - Interest	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4b)	Subcontractor Administrative Expenses - Interest			
9A	16c)	Administration - Occupancy, Depreciation, & Amortization	2	9c)	Primary Contractor Administrative Expenses - Occ., Depr., & Amort.	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4c)	Subcontractor Administrative Expenses - Occ., Depr., & Amort.			
9A	16d)	Administration - GRT	2	9d)	Primary Contractor Administrative Expenses - GRT	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4d)	Subcontractor Administrative Expenses - GRT			
9A	16e)	Administration - Distributions to Management Corporation/ASO	2	9e)	Primary Contractor Administrative Expenses - Dist. to Mgmt. Corp./ASO	Y	Y	
9A	16f)	Administration - Clinical Care/Medical Management	2	9f)	Primary Contractor Administrative Expenses - Clinical Care/Medical Mgmt	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4e)	Subcontractor Administrative Expenses - Clinical Care/Medical Mgmt			
9A	16g)	Administration - Other	2	9g)	Primary Contractor Administrative Expenses - Other	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4f)	Subcontractor Administrative Expenses - Other			
9A	16	Total Administration	2	9)	Primary Contractor Administrative Expense Total	Y	Y	Total on Report #9A should agree with sum of amounts reported individually on Report #2 and Report #3.
			3	4)	Subcontractor Total Administration Expenses			
9A	All	All Total Column \$ Amounts	9B	All	All Current Quarter \$ Amounts	N/A	Y	Totals only.

BEHAVIORAL HEALTH

GLOSSARY

Glossary

AICPA	American Institute of Certified Public Accountants
APA	Alternative Payment Arrangement
ASO	Administrative Services Organization
BDAP	Bureau of Drug and Alcohol Programs (Department of Health)
BH	Behavioral Health
BHRS	Behavioral Health Rehabilitation Services for Children and Adolescents (formerly referenced as EPSDT)
BPI	Bureau of Program Integrity
CFR	Code of Federal Regulations
CIS	Client Information System
COB	Coordination of Benefits
CMS	Center for Medicare & Medicaid Services
DPW	Pennsylvania Department of Public Welfare
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment Program for persons under 21
FRR	Financial Reporting Requirements
GAAS	Generally Accepted Auditing Standards
GAGAS	Generally Accepted <i>Government Auditing Standards</i> (Yellow Book)
HEDIS	Health Employer Data Information System
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
IBNR	Incurred But Not Reported
IPA	Independent Public Accountant

MA	Medical Assistance or Medicaid
MCE	Multi County Entity
MCO	Managed Care Organization
MH/MR	Mental Health/Mental Retardation
MIS	Management Information System
NCQA	National Committee Quality Assurance
OMAP	Office of Medical Assistance Programs
OMHSAS	Office of Mental Health and Substance Abuse Services
PMPM	Per Member Per Month
PPO	Preferred Provider Organization
PROMISe	Provider Reimbursement and Operations Management Information System electronic
RBUC	Received But Unpaid Claims
RFP	Request for Proposal
SSA	Social Security Act
TPL	Third Party Liability
UM	Utilization Management



pennsylvania

DEPARTMENT OF PUBLIC WELFARE

800.692.7462 | www.dpw.state.pa.us

P.O. Box 2675
Harrisburg, Pennsylvania 17105