



PENNSYLVANIA

HealthChoices

Program Audit Guide Behavioral Health

for the
2009
Program Year

DEPARTMENT OF PUBLIC WELFARE

**COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE**

**HEALTHCHOICES AUDIT GUIDE
BEHAVIORAL HEALTH**

For the 2009 Program Year

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

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

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BEHAVIORAL HEALTH

INTRODUCTION

INTRODUCTION

Single Point of Contact

All questions/comments on this Audit Guide and its contents should be submitted to:

Denise Lovejoy
Audit Guide Coordinator
Bureau of Audits
Forum Place
555 Walnut Street – 9th Floor
Harrisburg, Pennsylvania 17101

(717) 425-6433

dlovejoy@state.pa.us

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 Single Point of Contact. The Single Point of Contact will then forward to the IPA this set of reports as the schedules to be examined. It is the responsibility of the IPA to determine if the reports to be examined provided by the Single Point of Contact correspond to the reports to be examined provided by the contractor and to report any variances as an examination adjustment.

Confirmation of Payments

Confirmation of payments received directly from DPW is available from the Comptroller Operations, Special Accounting, Human Services Division, which processes all requests for confirmation. Such requests should always include the number of the contract and or Medical Assistance (MA) Provider Identification number as well as the name of the program (i.e. HealthChoices). Requests must include a list of the amounts to be confirmed along with the total of the payments in question. Amounts to be confirmed

should consist of both gross capitation payments and gross capitation payments less sanctions. The amount to be confirmed should not be reduced by the amount of the MCO Assessment or Gross Receipts Tax.

Confirmation requests should be **emailed** to Tammy Miller at the following email address: tammiller@state.pa.us.

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

Comptroller Operations, Special Accounting, Human Services Division
Attn: Tammy Miller
Forum Place
555 Walnut Street, 9th Floor
Harrisburg, Pennsylvania 17101
Telephone: (717) 425-6598

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 17, 2010 for the Southeast and Southwest Zones
- ♦ November 15, 2010 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:

3 Copies Pennsylvania Office of the Budget
Bureau of Audits
Forum Place
555 Walnut Street – 9th Floor
Harrisburg, Pennsylvania 17101
Attn: Denise Lovejoy

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 "**Courtesy Copy**".

Resolution:

Resolution of the IPA's report package is a two-phase process. Upon receipt of the report package, Bureau of Audits, Special Audit Services Division conducts a technical review of the submission and determines whether the report package meets the requirements as specified in the HealthChoices Audit Guide. Once accepted by Bureau of Audits, Special Audit Services Division, resolution of issues raised in the report package takes place in DPW. **The Contractor and the IPA of record may be contacted during either phase of the resolution process.**

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 transitions its MA program in Pennsylvania from a fee-for-service environment to a managed care environment, it is also fundamentally transforming the focus of its operations. DPW is moving 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 is now moving 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 Government Auditing Standards (commonly referred to as the Yellow Book) issued by the Comptroller General of the United States and audit and accounting 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 judgement.

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 under Chapter 6 sections 6.30 through 6.56 of Generally Accepted Government Auditing Standards. These sections establish 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 Sections 6.30 through 6.56 and with AT 101 Attestation Engagements, sections AT 101.63 to AT 101.85, inclusive and section AT 101.114 for an Examination Engagement. Specifically, AT 101.85 provides the components that should be addressed within the IPA's examination report. Appendix I provides the suggested language for this 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 accounting principles prescribed by the Commonwealth of Pennsylvania, Department of Public Welfare, including 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 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 Sections 6.30 through 6.56 and with AT 601 Compliance Attestation, sections AT 601.01 to AT 601.15, inclusive, and sections AT 601.30 to AT 601.70 for an Examination Engagement. Specifically, AT 601.57 provides the components that should be addressed within the practitioner's examination report. Appendix II provides the suggested language for this 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 MH/MR 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
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	Value Behavioral Health of PA (VBH-PA)	N/A
Lycoming/Clinton Joinder Board	CBHNP Services, Inc. (CSI)	
Northwest Behavioral Health Partnership (Crawford/Mercer/Venango)	Value Behavioral Health of PA (VBH-PA)	N/A
Tuscarora Managed Care Alliance (Franklin/Fulton)	CBHNP Services, Inc. (CSI)	N/A

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. (AHCII)	Community Care Behavioral Health Organization, Inc. (CCBHO)	N/A
Armstrong-Indiana MH/MR 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/MR 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/MR 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
Blair	N/A	Blair HealthChoices	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	Value Behavioral Health of PA (VBH-PA)	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	Franklin/Fulton MH/MR Program	N/A	CBHNP Services, Inc. (CSI)	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.

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**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 pseudo claims 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;
- 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; and

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

Act 62 is new and there are still many unknowns. However, we expect that affected claims may require additional processing time. Consequently, we suggest leniency in evaluating compliance any time Act 62 rules apply.

It should be verified that Act 62 is acknowledged and that appropriate policies and procedures are in place or are being developed. In addition, any deficiencies related to Act 62 should be identified in the attest documentation. However, we suggest deficiencies related to Act 62 be evaluated with leniency when determining the need to report a finding, to report material noncompliance with management's assertions or to modify the auditor's report.

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 for attest documentation sections 6.20 through 6.26.

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 SAS 70 audit, 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.
4. Identify the time period addressed by the third party review.
5. Examine and evaluate the consistency and relevancy of the information in the third party review 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 pseudo claims 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 recipient is not 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, evaluate the adequacy of the general internal control structure of the Contractor. 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 for attest documentation sections 6.20 through 6.26.

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 pseudo claims with health-related insurance.

Test a sample of these pseudo claims to ensure the claim was processed correctly. Verify that these pseudo claims have been sent and received by DPW as an encounter. The information of the pseudo claims 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 pseudo claims are reprocessed correctly. Verify that these claims or pseudo 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.
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 all HealthChoices Behavioral Health Agreements.

Suggested Procedures. Procedures should be adequately documented in accordance with GAGAS for attest documentation sections 6.20 through 6.26.

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

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 for attest documentation sections 6.20 through 6.26.

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. Use AICPA Statement on Auditing Standards (SAS) 70 - Service Organizations goals and objectives when developing procedures to be performed. These procedures would not result in the issuance of a SAS 70 opinion.

C. GAGAS for attest documentation sections 6.20 through 6.26.

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 for attest documentation sections 6.20 through 6.26.

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 pseudo-claims 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 pseudo-claims 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 pseudo-claims 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 pseudo claim to the 837I and 837P record format required by DPW are complete and accurate.
 - a. Evaluate the length of time between the date of service of the actual encounter and the date of its posting to the Contractor's system.
 - b. Compare the sample encounter records to the claims and pseudo-claims 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.

- d. Review the Contractor's documentation of its capabilities to transfer files.
- e. 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 pseudo-claims 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 SAS 70 audit, 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.
4. Identify the time period addressed by the third party review.
5. Examine and evaluate the consistency and relevancy of the information in the third party review 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 for attest documentation sections 6.20 through 6.26.

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.

C. Compliance Requirement

DPW requires the Contractor to submit a separate record or "pseudo claim" 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 for attest documentation sections 6.20 through 6.26.

1. Compare a sample of the pseudo-claims data received by the Contractor from the provider with the records submitted in the Encounter file to ensure that the Contractors are reporting all pseudo-claims 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. Use AICPA Statement on Auditing Standards (SAS) 70 - Service Organizations goals and objectives when developing procedures to be performed. However, these procedures would not result in the issuance of a SAS 70 opinion.

D. GAGAS for attest documentation sections 6.20 through 6.26.

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 for attest documentation sections 6.20 through 6.26.

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 negatively motivate the MCO/MCO Subcontractor/ASO to reduce levels of care or utilization of 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 for attest documentation sections 6.20 through 6.26.

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 for attest documentation sections 6.20 through 6.26.

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. They 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 Single Point of Contact 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
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 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, 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 17, 2010 for the Southeast and Southwest Zones
- ♦ November 15, 2010 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 for attest documentation sections 6.20 through 6.26.

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 for attest documentation sections 6.20 through 6.26.

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 for attest documentation sections 6.20 through 6.26.

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 for attest documentation sections 6.20 through 6.26.

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 for attest documentation sections 6.20 through 6.26.

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 for attest documentation sections 6.20 through 6.26.

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 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 #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.

Effective January 1, 2009 (SE/SW Counties)/July 1, 2009 (LC/NE/NC SO/NC CO), the Department will recoup any reinvestment savings from the Primary Contractor in excess of 3% of total HealthChoices Behavioral Health revenue, net of MCO Assessment and Gross Receipts Tax, from the SE/SW Counties and 5% from the NE/NC SO/NC CO Counties, in accordance with Appendix 1, Reinvestment Sharing Arrangement, of the July 1, 2009 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 for attest documentation sections 6.20 through 6.26.

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 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 for attest documentation sections 6.20 through 6.26.

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 for attest documentation sections 6.20 through 6.26.

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, Special Accounting – Human Services Division 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, if an MCO/MCO Subcontractor operates in more than one County, they 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 for attest documentation sections 6.20 through 6.26.

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 for attest documentation sections 6.20 through 6.26.

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 comingling 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 for attest documentation sections 6.20 through 6.26.

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 for attest documentation sections 6.20 through 6.26.

**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 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 accounting principles prescribed by the Commonwealth of Pennsylvania, Department of Public Welfare as described in Note “X”.

Suggested Language (continued)

[When any of the matters set forth in paragraph 6.31 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.

This report is intended solely for the information and use of ABC and the Pennsylvania Department of Public Welfare (DPW) and is not intended to be and should not be used by anyone other than these specified parties.

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 6.30 through 6.56 and AT 101.63 through 101.85, and 101.114 and AT 9101.56 through 9101.58 for guidance on the issuance of this report.

Behavioral Health Schedule - Report 2 Primary Contractor Summary of Transactions

For Period Ending: _____ (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 FRR 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

For Period Ending: _____ (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) MCO Assessment/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 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 3 Subcontractor Summary of Transactions

For Period Ending: _____ (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 FRR 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

For Period Ending: _____ (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) MCO Assessment/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 4 Related Party Transactions and Obligations

For Period Ending: _____ (Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)

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

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

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)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
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 7(continued)
Lag Report _____ (Major Service Grouping)

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

(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)	(24)	(25)	(26)	(27)	(28)
-----Month In Which Service Was Provided-----													
12 th Prior	13 th Prior	14 th Prior	15 th Prior	16 th Prior	17 th Prior	18 th Prior	19 th Prior	20 th Prior	21 st Prior	22 nd Prior	23 rd Prior	24 th and Prior	*TOTAL

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

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

For Period Ending: _____ (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									
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									
13. Ancillary Support									

* 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**

For Period Ending: _____ (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
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) MCO Assessment/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 12 Reinvestment Report

Statement as of: _____ (Reporting Date)
 County: _____ (County Name)
 Reported By: _____ (Reporting Entity)
 For: _____ (Year of Reinvestment Funds)
 Rating Group: _____ (Rating Group)

Reinvestment Account Activity	Unduplicated Recipients	Current Period Units of Service Provided	Current Period \$ Amount	Year to Date \$ Amount	Contract to Date Units of Service Provided	Contract to Date \$ Amount	Budget Amount
1. Prior Period Balance							
2. Allocations/contributions							
3. Investment/interest income							
4. SUBTOTAL (Lines 2 and 3)							
5. TOTAL (Lines 1 and 4)							
Less: Approved distributions for Reinvestment Services (Identify)							
6. TOTAL							
Ending Balance (Line 5 minus Line 6)							

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

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 Exp: 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 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 paragraph 6.31 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 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.

This report is intended solely for the information and use of ABC and the Pennsylvania Department of Public Welfare (DPW) and is not intended to be and should not be used by anyone other than these specified parties.

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 6.30 through 6.56 and AT 601.57, .58, .61, and .64 and AT 9101.56 through 9101.58 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 6.30 THROUGH 6.56, AND STATEMENTS ON STANDARDS FOR ATTESTATION ENGAGEMENTS AT 601 COMPLIANCE ATTESTATION). 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, 2009 to December 31, 2009 for Southeast/Southwest Zones

July 1, 2009 to June 30, 2010 for Lehigh Capital, Northeast, North Central State Option, and North Central County Option Zones

² December 31, 2009 for Southeast/Southwest Zones

June 30, 2010 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 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
 - 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)

Sample BH Management's Assertion Letter

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

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.

Sample BH Management's Assertion Letter

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.
 - 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.

Sample BH Management's Assertion Letter

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.

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.

Sample BH Management's Assertion Letter

- 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 01/01/09 through 12/31/09**

**HealthChoices Lehigh Capital, Northeast, North
Central State Option, and North Central County Option
Zones Reporting Period 07/01/09 through 06/30/10**

FINANCIAL REPORTING REQUIREMENTS

HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM

Southeast and Southwest Zones

Reporting Period 01/01/09 through 12/31/09

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

Reporting Period 07/01/09 through 06/30/10

January 1, 2009
July 1, 2009

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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 #
M or 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
M or Q		Primary Contractor Summary of Transactions	2
M or Q		Subcontractor Summary of Transactions	3
M or Q		Related Party Transactions and Obligations	4
M or Q		Risk Pool Analysis	5
M		Claims Payable (RBUCs and IBNRs)	6
M		Lag Reports	7
M		Claims Processing Report	8
M or 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 5 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. 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 and Financial Review
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.

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.

Fully Developed Table						
Month Incurred (Date of Service)						
<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 pending 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 pending 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 pending or rejected because they require additional information either from a provider or from internal sources (i.e. claims pending 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 1/01/05 for details of items that should be included on these lines.

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 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.

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. 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 count of unduplicated recipients should be unduplicated by each individual reinvestment service and should reflect unduplicated recipients on a contract to date basis.

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.

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

This report should include all HealthChoices Behavioral Health contract assets and liabilities. IBNRs and RUCs 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.

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 Stmt's (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)		
		FTP*	Hard Copy	Fax
2	Analysis of Revenues & Expenses – Primary Contractor			
3	Analysis of Revenues & Expenses - Subcontractor			
7	Lag Report			
9	Analysis of Revenues & Expenses			
12	Reinvestment Report			
19	Paid Claims to RBUC/IBNR Reconciliation			
20	Annual Counterpart Reports			
21	HealthChoices Contract Audit			
31	Estimated Reinsurance Experience			
32	Actual Reinsurance Experience			

*If files are being submitted via FTP, this form MUST be faxed to Beverly Bordner at (717) 705-8128 concurrently with the FTP transmission. Certification for Hard Copy reports must be mailed with the reports to the address provided in the Financial Reporting Requirements.

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

Page 1

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								

REPORT #2 - Primary Contractor Summary of Transactions

Page 2

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) MCO Assessment/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.

REPORT #3 - Subcontractor Summary of Transactions

Page 1

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								

REPORT #3 - Subcontractor Summary of Transactions
Page 2

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) MCO Assessment/ 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 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				

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

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

	-----Current Period-----			-----Year-To-Date-----		
	\$	Member Months	PMPM	\$	Member Months	PMPM
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 (Line 1 minus Line 14)						
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 #5, Part B - Risk Pool Listing by Participant

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

Participant	Prior Period Balance	Current Period Expense Adj. (+/-)	(Distributions) Contributions	Ending Balance
TOTAL				

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:								
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	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
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) MCO Assessment/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								
--	--	--	--	--	--	--	--	--

THIS REPORT FORMAT SHOULD BE USED FOR REPORTING MONTHS BEGINNING WITH 10/04 for LC and 01/05 for SE/SW.

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:				
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) MCO Assessment/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				
--	--	--	--	--

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.

Reporting Period Begin Date 4/1/2007
 Reporting Period End Date 6/30/2007
 Client CIS # _____
 Client SSN _____
 Client Name _____
 County of Residence _____
 Admission Date 1/1/2007
 Discharge Date 5/22/2007

Provider PROMISe ID# _____
 Provider Name _____

Qtr Length of Stay (days)	52

Service Package	
-----------------	--

Service	Procedure Code/Modifier (if applicable)	Unit Definition	Unit Cost	Units in Reporting Period	Total Dollars
Individual Psychotherapy	90804/UB	30 Minutes			\$ -
Group Psychotherapy	90853/UB	15 Minutes			\$ -
Psychiatric Evaluation	90801/UB	30 Minutes			\$ -
Medication Management	90862/UB	15 Minutes			\$ -
Medication Training & Support	H0034	15 Minutes			\$ -
Psychiatric Rehab Services	H0036/HB	1 Hour			\$ -
Peer Specialist	H0038	15 Minutes			\$ -
MH Crisis Intervention	S9484	1 Hour			\$ -
Additional Service ¹					\$ -
Additional Service ¹					\$ -
Additional Service ¹					\$ -
Total				0.00	\$ -

¹ Include information for additional Medicaid reimbursable services where applicable.

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)
AR	ARMSTRONG COUNTY BEHAVIORAL HEALTH (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)
IN	INDIANA 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
BL	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
100765310 0014	Milton S. Hershey Medical Inpatient Psychiatric
100772000 0016	Philhaven Hospital
100772010 0003	Fairmount BH System
100773760 0004	Kirkbridge 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

Current as of 04/18/08.

Subject to change as providers enroll/disenroll.

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
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

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

Current as of 04/18/08.

Subject to change as providers enroll/disenroll.

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				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				N/A	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.

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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		N/A	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

Revised 07/01/09

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*		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 and Lawrence 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 ⁽²⁾	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***													

⁽²⁾Indiana Only

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

** Each entity must file a separate report.

*** Annual reports must be submitted specific to each County.

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 bebordner@state.pa.us. Due March 1, 2010.

Report #7: Submit extended lag report beginning January 1, 2007 through March 31, 2010 as an Excel file to be submitted via e-mail to bebordner@state.pa.us. Due May 15, 2010.

Revised 01/01/09

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	Q****	A*	A*	A			N/A
CBHNP			N/A	Q**	Q**							Q	Q	Q									N/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 bebordner@state.pa.us. Due September 1, 2010.

**** Dauphin Only

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				Q****	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	

**** York Only

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	A*	A*	A			
MBH-PA			Q	Q**	Q**	M	M	M		Q		Q	Q	Q	M	Q	Q					A	A	A

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

** Each entity must file a separate report.

Revised 07/01/09

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	M	M*	N/A	M**	M	M	M	M	M*	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				M**	M							Q	Q	Q										

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

** Each entity must file a separate report.

*** Annual reports must be submitted specific to each County.

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 bebordner@state.pa.us. Due September 1, 2010.
- Report #7: Submit extended lag report beginning July 1, 2008 through September 30, 2010 as an Excel file to be submitted via e-mail to bebordner@state.pa.us. Due November 15, 2010.

Revised 07/01/09

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	M	M	N/A	M	M	M	M	M	M	Q	M	Q	Q	Q	M	Q	M	N/A	A	A	N/A	A	A	A
UPMC												Q	Q	Q									A	

Revised 07/01/09

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	M	M		M**	M**				M*		M	A	A	A				N/A	A*	A*	A			
CCBH			M	M**	M**	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	M	M*		M**	M**				M*		M	A	A	A				Q	A*	A*	A			
BHoCC		M*																				A		
VBH-PA			M	M**	M**	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	M	M		M**	M**				M*		M	A	A	A				N/A	A*	A*	A			
VBH-PA			M	M**	M**	M	M	M		Q		Q	Q	Q	M	Q	Q					A	A	A
VOI												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	M	M		M**	M**				M*		M	A	A	A				N/A	A*	A*		A		
VBH-PA			M	M**	M**	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 County	M	M*		M**	M**				M*		M	A	A	A				Q	A*	A*	A			
Blair HealthChoices		M*																				A		
CSI			M*	M**	M**	M	M	M		Q		Q	Q	Q	M	Q						A	A	A
Blue Cross Northeast PA												Q	Q	Q								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	M	M		M**	M**				M*		M	A	A	A				Q	A*	A*	A			
CSI			M*	M**	M**	M	M	M		Q		Q	Q	Q	M	Q						A	A	A
Blue Cross Northeast PA												Q	Q	Q								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	M	M		M**	M**				M*		M	A	A	A				Q	A*	A*		A		
CSI			M*	M**	M**	M	M	M		Q		Q	Q	Q	M	Q						A	A	A
Blue Cross Northeast PA												Q	Q	Q								A		
County Specific Reports	A***	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	M	M		M**	M**				M*		M	A	A	A				N/A	A*	A*	A			
CSI			M*	M**	M**	M	M	M		Q		Q	Q	Q	M	Q						A	A	A
Blue Cross Northeast PA												Q	Q	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.

*** Annual reports must be submitted specific to each County.

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- Report #7: Submit extended lag report beginning July 1, 2008 through September 30, 2010 as an Excel file to be submitted via e-mail to bebordner@state.pa.us. Due November 15, 2010.

Revised 07/01/09

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

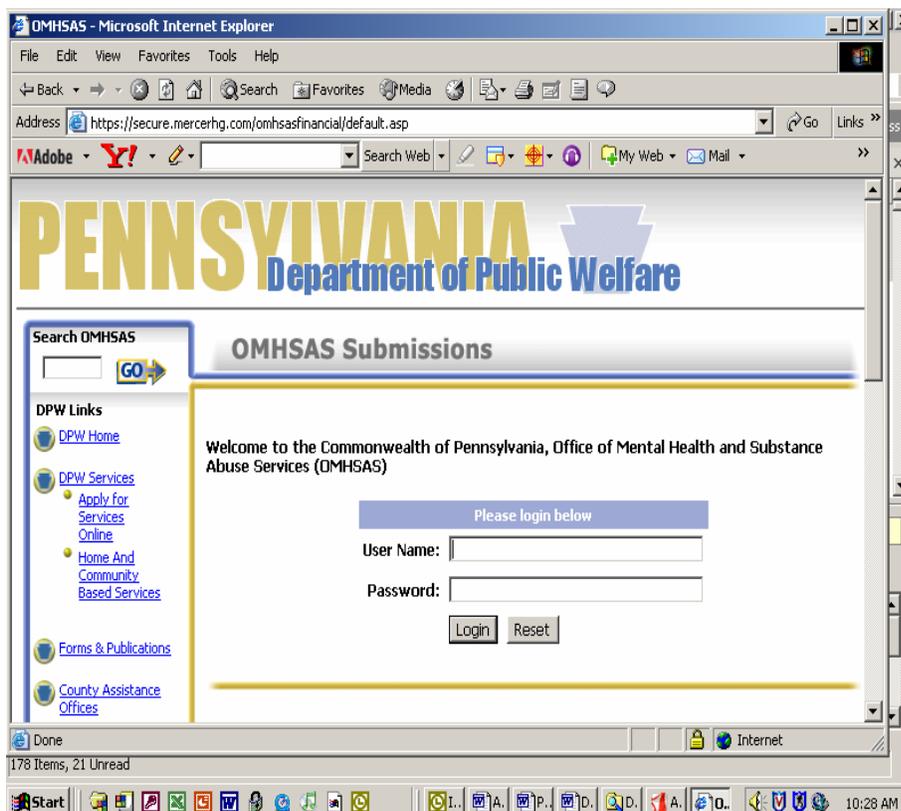
Web-based Financial Report Submission Process

CURRENT YEAR REPORTS

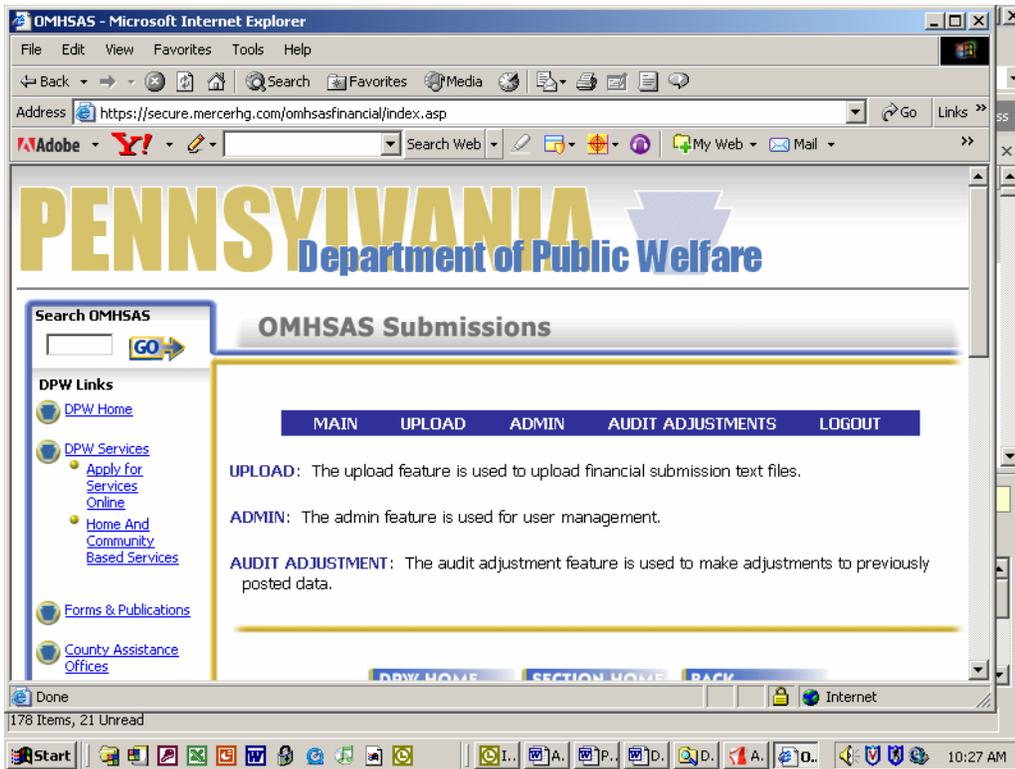
In 1998, OMHSAS designed a finance database for electronic submission of select current year reports. The data was submitted in ASCII format using the HealthChoices Behavioral Health Electronic Financial Data Submission Reporting Specifications Manual for BH MCOs via POSNET. OMHSAS had to finalize the process by downloading the data files into the database.

For current year reports, the contractor has the option of submitting an Original, Resubmission, or Correction file by using an “O,” “R” or “C,” respectively, in the header record. Current year Monthly and Quarterly Reports are submitted in their entirety whether submitting an Original, Resubmission or Correction file. A Resubmission or Correction file replaces the Original file in its entirety.

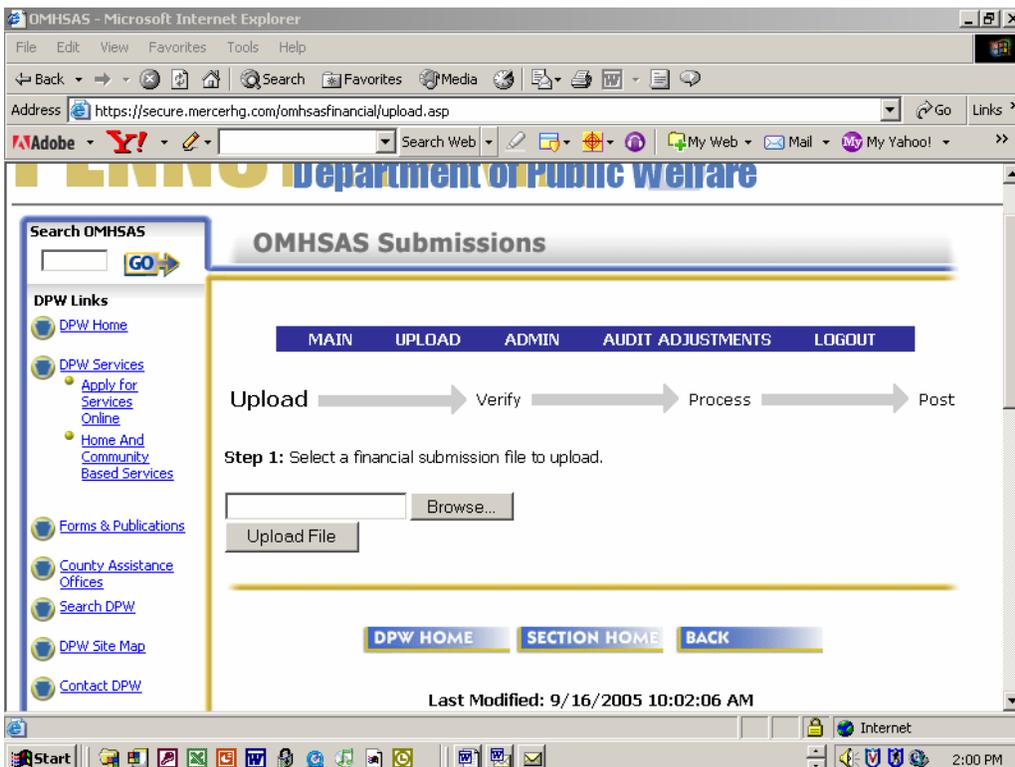
In February 2004, OMHSAS implemented web-based submission of the current year HealthChoices Behavioral Health financial reports directly into their finance database via internet website: <http://secure.mercerhg.com/omhsasfinancial/>. The data continues to be submitted in ASCII format using the HealthChoices Behavioral Health Electronic Financial Data Submission Reporting Specifications Manual for BH MCOs. A User Request Form must be completed and signed by the appropriate staff prior to OMHSAS granting access privileges to the web-based HealthChoices Financial Reporting System.



After logging on to the web-based HealthChoices Financial Reporting System, select “UPLOAD”.



Select the file to be uploaded and Click “Upload File.” Continue following the prompts to Verify, Process and Post the file.



PRIOR YEAR ADJUSTMENTS

January 2006 enhancements were made to the web-based submission process to allow for electronic submission of prior year adjustments.

The adjustments will be submitted in accordance with the HealthChoices Behavioral Health Electronic Financial Data Submission Manual. Character coding must be in the ASCII format. The only revision required to the aforementioned manual is adding Submission Indicator "A" for Adjustments in the Header Record (F00) to Catalog #0006.

Current year Monthly and Quarterly Reports are submitted in their entirety whether submitting an Original, Resubmission or Correction file. A Resubmission or Correction file replaces the Original file in its entirety. **For Prior Year Adjustments, the contractor will only be submitting adjustments to previously submitted data.** On-line 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.

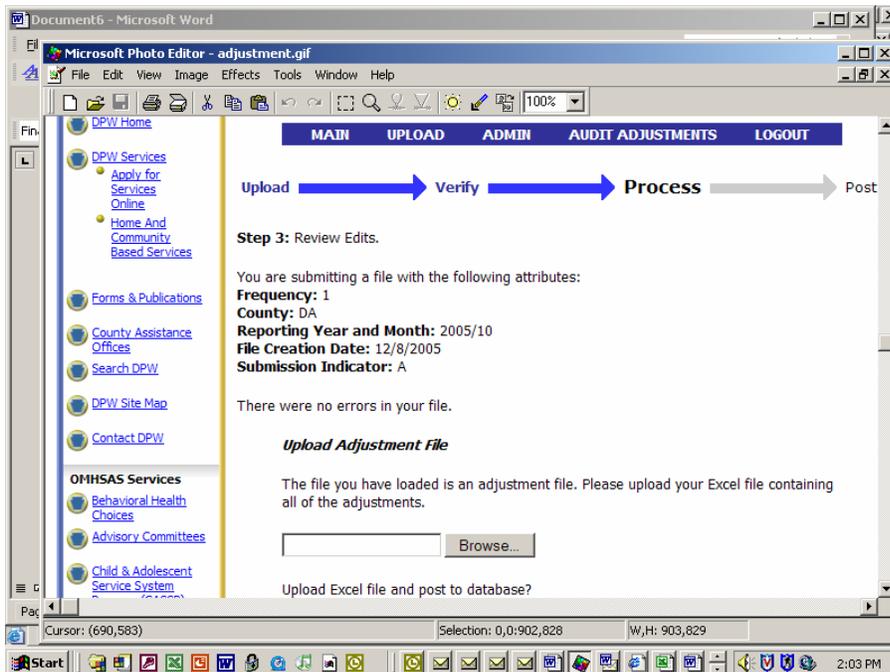
Adjustments to Report #12 must be made in the Current Period columns. Adjustments reported only in the Year to Date and Contract to Date Columns will not be reflected in the ASCII file.

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 hard copy only.

Audit adjustments are due November for the LC Zone and May 15 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 you 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

**BEHAVIORAL HEALTH
APPENDIX IV**

**Recipient Group Chart
Managed Care Payment System Table**

PROMISE Managed Care Payment System Table

Appendix B

Rate Cell	Promise Code	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	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, PL, PSF, PVN, SC, TB, TR, TVN	00	All program status codes	
									00	All categories of assistance	12	17, 20, 21, 47, 48, 49, 55, 65, 67, 68, 86, 87	
13	HB	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. Age further defines each rate cell.				
14		TANF/HB 2 mos - < 1			Healthy Beginnings - 2 mos - < 1		2 - 11 mos		11	PS	16	16, 18	
11		HB 1+	HB 1+		Healthy Beginnings - 1-17		1 - 17						
12					Healthy Beginnings - 18+		18+						
60	TANF	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, & 05/19 are applicable for rate cells 60 & 61. Age further defines each rate cell.				
61		TANF/HB 2 mos - < 1			TANF - Cat_Med - 2 mos - < 1		2 - 11 mos		03	C, U	17	00, 04, 06, 07, 08, 09, 53, 56, 57, 58, 59, 71, 72	
												04	PC, PU, PCW, PCN
21	TNF	TANF 1+	TANF/CN 14+ F	TANF/CN 1-13	TANF - Cat - 1-13	B	1 - 13	N/A	Combinations 03/17 & 04/18 are applicable for rate cells 21, 25, 26, 27, 28. Age & gender further define each rate cell.				
25				TANF/CN 14+ F	TANF - Cat - 14-21		F		14 - 21	03	C, U	17	00, 04, 06, 07, 08, 09, 53, 56, 57, 58, 59, 71, 72
26				TANF/CN 14+ M	TANF - Cat - 14-21				M				
27				TANF/CN 14+ M	TANF - Cat - 22+		M			22+	05	TC, TU	19
28				TANF/CN 14+ M	TANF - Cat - 22+								
65	TANF	TANF/MN 1+	TANF/MN 1+	TANF 0-21	TANF - Med - 1-21	B	1 - 21	N/A	Combination 05/19 is applicable for rate cells 65 & 66. Age further defines each rate cell.				
66				TANF 22+	TANF - Med - 22+		22+		05	TC, TU	19	00, 03, 11, 15, 22	
30	HHW	SSI & HH	SSI/HH	SSI & HH with Medicare	Healthy Horizons w Medicare - 0	B	0	Y	Combinations 11/13 & 10/04 are applicable for rate cells 30, 31, 32, 40, 46, 47, 42. Age and Medicare "A" further define each rate cell.				
31					Healthy Horizons w Medicare - 1-64		1 - 64		11	PS	13	40, 70, 90	
32					Healthy Horizons w Medicare - 65+		65+						
40	HHN	SSI & HH	SSI/HH	SSI & HH without Medicare 0-21	Healthy Horizons w/o Medicare - 0	B	0	N	10	PH	04	00, 30, 80	
46					Healthy Horizons w/o Medicare - 1-21		1 - 21						
47					SSI & HH without Medicare 22-64		22 - 64						
42					Healthy Horizons w/o Medicare - 65+		65+						

PROMISE Managed Care Payment System Table

Rate Cell	Promise Code	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	SSI & HH	SSI/HH	SSI & HH with Medicare	SSI w Medicare - 0	B	0	Y	Combinations 12/20, 11/14, 10/15, 13/30, 14/31, 15/32, & 16/33 are applicable for rate cells 33, 34, 35, 43, 48, 49, 45. Age & Medicare "A" further define each rate cell.			
34					SSI w Medicare - 1-64		12		PI, PW, TA, TJ, PAN, PAW, PJN, PJW, PMN, PMW, TAN, TAW, TJN, TJW	20	00, 22, 66, 80, 81, 83, 84, 85	
35					SSI w Medicare - 65+		11		PS	14	95, 98	
									10	PH	15	95, 97
43	SSN	SSI & HH	SSI/HH	SSI & HH without Medicare 0-21	SSI w/o Medicare - 0	B	0	N	13	A, M, J	30	00, 44, 45, 46, 60, 61, 62, 63
48					SSI w/o Medicare - 1-21		14		J	31	31, 32, 33, 34, 35, 36, 37	
49				SSI & HH without Medicare 22+	SSI w/o Medicare - 22-64		15		PA, PJ, PM	32	00, 22, 40, 66, 80, 81, 83, 84, 85	
45					SSI w/o Medicare - 65+		16		PJ	33	98	
50	FGA	Federal GA	Fed GA 0-20	Federal GA	Federal GA Cat & Med - 0	B	0	N/A	Combination 07/01 is applicable for rate cells 50, 51, 52. Age further defines each rate cell.			
51					Federal GA Cat & Med - 1-20		07		D, PD, TD	01	00, 02, 05, 11, 15, 22, 29, 50	
52			Fed GA 21+		Federal GA Cat & Med - 65+		07		D, PD, TD	02	02, 05, 11, 15, 50	
53					Federal GA Cat & Med - 21-64		07		D, PD, TD	02	02, 05, 11, 15, 50	
54	CGA	GA-CNO	CN State 21-64	GA-CNO	Categorically State-Only GA	B	21 - 64	N/A	23	D, PD	03	00, 22, 29
55	MGA	GA-MNO	MN State 59-64	GA-MNO	Medically State-Only GA - 59-64	B	59 - 64	N/A	Combination 22/03 is applicable for rate cells 55 & 56. Age further defines each rate cell.			
56			MN State 21-58		Medically State-Only GA - 21-58		22		TD	03	00, 22, 29	

NOTES:

Categories and program status codes in rate cell 01 are excluded from the managed care payment process.

The rate cell changes in the first column (A) will be effective 1-1-09 in Promise.

The voluntary rate structure changes in the fourth column (D) are effective 7-1-08.

The PH rate structure in the third column (C) will be effective 7-1-09. Prior to that date, rate cells 13 & 14 and 60 & 61 will be paid at the TANF/HB < 1 rate.

The BH rate structure changes in the fifth column (E) will be effective 1-1-09.

Not all Category of Assistance/Program Status Code combinations listed on this table are active (example, PS/70). They are included for historical reporting purposes.

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 - Provider Type, Type of Service, Procedure Codes w/ Description Units of Service**
- ~~Attachment H - CPT Codes~~
- ~~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**

July 1, 2009

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.***

Changes since the January 1, 2009, version of the chart are in **bold** and/or *italic* throughout and are highlighted here as follows:

BHSRCC Chart

- Line 12 Add provider type 31, provider specialties 315, 316, 322, and 345 with ER procedure codes to allow for reporting of emergency room evaluations for voluntary and involuntary commitments.

- Line 27 Changed "Blended Model" to "Blended Case Management"

- Line 42 Added a line with three identified Psychiatric Outpatient Clinics providers and applicable procedure coding for reporting encounters for Telehealth services.

Attachment B	DRG Descriptions	No Change
Attachment C	ICD-9-CM Codes	No Change
Attachment D	Listing of providers with CDC (Co-occurring Disorder Competency) special indicator	No Change
Attachment E	Revenue Codes	No Change
Attachment G	Procedure Code Detail	Additions/Deletions

Attachment K	Desk Chart	Additions/Deletions
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Please see that all users of this chart in your area receive this update.

If you have any questions, please email HC-EligReference@state.pa.us

- cc: AHCI
- CABHC
- CBHNP
- CCBH
- CBH
- VBH
- SWBH
- MBH

Healthchoices Behavioral Health Services Reporting Classification Chart - July 1, 2009

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 See Attachment E	01	01
3	Inpatient Psychiatric Services	01 - Inpatient Facility	018 - Extended Acute Psych	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		Procedure Code: H0018/HF		
			134 - D&A Medically Monitored Residential, Short 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 of Attachment G (excluding H0034/HK, H2010/HK, S9075)	06	04
		01 - Inpatient	010 - Acute Care Hospital	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 /	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 S9075	06	04

Healthchoices Behavioral Health Services Reporting Classification Chart - July 1, 2009

Line Item	Service	Provider Type	Provider Specialty	Provider ID	Identifiers	ENC CAT	FIN CAT
12	Psychiatric Outpatient Services continued	31 - Physician	339 - Psychiatry	Any*	Procedure Codes: See Pages 10 thru 16 of Attachment G, excluding H2010/HK/U1 and S9075 and not equal to procedures listed under Physician Wraparound	06	04
>>>>		31 - Physician	315 - Emergency Medicine 316 - Family Practice 322 - Internal Medicine 345 - Pediatrics	Any*	Procedure Codes: 99281, 99282, 99283, 99284, 99285	06	04
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		

Healthchoices Behavioral Health Services Reporting Classification Chart - July 1, 2009

Line Item	Service	Provider Type	Provider Specialty	Provider ID	Identifiers	ENC CAT	FIN CAT
13	BHRS continued	11- Mental Health/ Substance Abuse	548 - Therapeutic Staff Support		Procedure Codes: H2014/UB, H2014/UB/HA, H2021/UB		
			442 -Partial Psych Hosp Child TSS		Procedure Codes: H2019/UB		
			446 -Partial Psych Hosp Adult TSS		Procedure Codes: H0032/HP, H0032/HO		
			450 - Family Based MH TSS		Procedure Codes: H2012/UB		
			549 - Mobile Therapy		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		
			443 - Partial Psych Hosp Child MT		Procedure Codes: H0046/UB		
			447 - Partial Psych Hosp Adult MT		Procedure Codes: H2032/UB		
			451 - Family Based MH MT		Procedure Codes: G0176/UB		
			559 - Behavioral Specialist Consult		Procedure Codes: H2014/UB, H2014/UB/HA, H2021/UB		
			444 -Partial Psych Hosp Child BSC		Procedure Codes: H2019/UB		
		448-Partial Psych Hosp Adult BSC	Procedure Codes: H0032/HP, H0032/HO				
		452 - Family Based MH BSC	Procedure Codes: 90801, 90802, 96101/U7 96101/U7/HA, 96101/U7/TJ, 96116, 96118/UB				
		445-Partial Psych Hosp Child STAP	Procedure Codes: H2014/UB/U1, H2014/UB/HA/U1, H2021/UB/U1				
		449-Partial Psych Hosp Adult STAP	Procedure Code: H2019/UB/U1				
		453 - Family Based MH STAP	Procedure Codes: H0032/HP/U1, H0032/HO/U1				
		340 - Program Exception	Procedure Code: H0019/HA; H0019/TT				
		16 - Nurse	162 - Psychiatric Nurse	ICD-9-CM: 799.9 AND			
		17 - Therapist	174 - Art Therapist	Procedure Code: 90801			
		17 - Therapist	175 - Music Therapist	Procedure Code: 90801			
		19 - Psychologist	548 - Therapeutic Staff Support		548 - Therapeutic Staff Support		
549 - Mobile Therapy	ICD-9-CM: 799.9 AND						
559 - Behavioral Specialist Consult.	Procedure Code: 90801						
190 - General Psychologist	Procedure Code: 90801						
31 - Physician	548 - Therapeutic Staff Support		548 - Therapeutic Staff Support	Procedure Code: H0019/HA; H0019/TT			
			549 - Mobile Therapy	ICD-9-CM: 799.9 AND			
			559 - Behavioral Specialist Consult.	Procedure Code: 90801			
52 - CRR	523 - Host Home/Children						
45	BHRS	08 - Clinic	110 - Psychiatric Outpatient		07	06	
		11 - Mental Health/ Substance Abuse	113 - Partial Psych Hosp Children	Procedure Code: 90801			
			114 - Partial Psych Hosp Adult or	Procedure Code: 90801			
			115 - Family Based Mental Health				
19 - Psychologist	548 - Therapeutic Staff Support		548 - Therapeutic Staff Support	Procedure Code: 90801			
			549 - Mobile Therapy				
	559 - Behavioral Specialist Consu						
	190 - General Psychologist			Procedure Code: 90801			

Healthchoices Behavioral Health Services Reporting Classification Chart - July 1, 2009

Line Item	Service	Provider Type	Provider Specialty	Provider ID	Identifiers	ENC CAT	FIN CAT	
14	Behavioral Health Rehabilitation Services (EPSDT) for Children & Adolescents with MR	08 - Clinic	110 - Psychiatric Outpatient	Any*	ICD-9-CM: 317-319 AND	17	06	
			800 - FQHC TSS or 804 - RHC TSS or 808 - Psych Outpatient TSS		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			
			801 FQHC MT or 805 - RHC MT or 809 - Psych Outpatient MT		Procedure Codes: H2014/UB, H2014/UB/HA, H2021/UB			
			802 - FQHC BSC or 806 - RHC BSC or 810 - Psych Outpatient BSC		Procedure Codes: H2019/UB			
			803 - FQHC STAP or 807 - RHC STAP or 811 - Psych Outpatient STAP		Procedure Codes: H0032/HP, H0032/HO			
			340 - Program Exception		Procedure Codes: H2012/UB			
			09 - Certified Nurse Registered		548 - Therapeutic Staff Support			Procedure Codes: H0018, H0019/HA, H0019/HQ, H0019/TT, H0046/SC, H2012/SC, H2015, H2017 H2019/HA, H2021/SC, H2021/HQ/SC, H2022, H2033
					549 - Mobile Therapy			Procedure Codes: H2014/UB, H2014/UB/HA, H2021/UB
					559 - Behavioral Specialist Consult.			Procedure Code: H2019/UB, Procedure Codes: H0032/HP, H0032/HO
			01 - Mental Health/ Practice 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 443 - Partial Psych Hosp Child MT 447 - Partial Psych Hosp Adult MT 451 - Family Based MH MT			Procedure Codes: H2019/UB			

Healthchoices Behavioral Health Services Reporting Classification Chart - July 1, 2009

Line Item	Service	Provider Type	Provider Specialty	Provider ID	Identifiers	ENC CAT	FIN CAT	
14	Behavioral Health Rehabilitation Services (EPSDT) for Children & Adolescents with MR continued	11 - Mental Health/ Substance Abuse	559 - Behavioral Specialist Consult		Procedure Codes: H0032/HP, H0032/HO			
			444 - Partial Psych Hosp Child BSC		Procedure Codes: H2012/UB			
			448 - Partial Psych Hosp Adult BSC		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			
			452 - Family Based MH BSC		Procedure Codes: H0046/UB			
			445 - Partial Psych Hosp Child STAP		Procedure Codes: H2032/UB			
			449 - Partial Psych Hosp Adult STAP		Procedure Codes: G0176/UB			
			453 - Family Based MH STAP		Procedure Codes: H2014/UB, H2014/UB/HA, H2021/UB			
		16 - Nurse	162 - Psychiatric Nurse		Procedure Codes: H2019/UB			
			17 - Therapist		174 - Art Therapist			Procedure Codes: H0032/HP, H0032/HO
					175 - Music Therapist			Procedure Codes: 90801, 90802, 96101/U7, 96101/U7/HA, 96101/U7/TJ, 96116, 96118/UE
		19 - Psychologist	548 - Therapeutic Staff Support		549 - Mobile Therapy			Procedure Codes: H2014/UB/U1, H2014/UB/HA/U1, H2021/UB/U1
					559 - Behavioral Specialist Consult.			Procedure Code: H2019/UB/U1,
					190 - General Psychologist			Procedure Codes: H0032/HP/U1, H0032/HO/U1
		31 - Physician	548 - Therapeutic Staff Support		549 - Mobile Therapy			Procedure Codes: H0019/HA; H0019/TT
559 - Behavioral Specialist Consult.								
52 - CRR	523 - Host Home/Children							
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			
OUTPATIENT DRUG & ALCOHOL SERVICES								
17	Outpatient Drug & Alcohol	08 - Clinic	184 - D&A Outpatient	Any*	Procedure Codes: See Page 3, 4, and 5 of Attachment G excluding S9075	10	05	
		08 - Clinic	084 - Methadone Maintenance	Any*	Procedure Codes: H0020/HG, H0020/UB, T1015/HG			
18	Outpatient Drug & Alcohol	08 - Clinic	080 - FQHC or 081 - RHC	Any*	Procedure Codes: T1015/HF			

Healthchoices Behavioral Health Services Reporting Classification Chart - July 1, 2009

Line Item	Service	Provider Type	Provider Specialty	Provider ID	Identifiers	ENC CAT	FIN CAT
ANCILLARY SERVICES							
19	Laboratory Studies/Diagnostic Radiology/ Medical Diagnostic Ordered by BH Physicians	08 - Clinic	082 - Independent Med/Surg Clinic	Any*	Refer to the MA Reference File for available CPT codes.	12	09
		01 - Inpatient Facility	010- Acute Care Hospital				
		01 - Inpatient Facility	019 - D&A Rehab Hosp or 441 - D&A Rehab Unit				
		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		
		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 Model 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	Any*	Procedure Codes: T1017/TF, T1017/TF/HK, T1017/TF/HE/HK	16	10
44	Peer Support Services	08 - Clinic 11 - Mental Health/ Substance Abuse	076 - Peer Specialist Coordination	Any	Procedure Codes: H0038	19	98

Healthchoices Behavioral Health Services Reporting Classification Chart - July 1, 2009

Line Item	Service	Provider Type	Provider Specialty	Provider ID	Identifiers	ENC CAT	FIN CAT
OTHER SERVICES (Defined Supplemental)							
Outpatient Psychiatric (Defined Supplemental)							
29	Rehabilitative Services	11 - Mental Health/	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)							
32	Family Support Services	11 - Mental Health/ Substance Abuse	110 - Psychiatric Outpatient	Any*	Procedure Code: H2015/HW	98/96	98
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, H2035/HF	98/97	98
		21 - Case Manager Substance Abuse	184 - Outpatient D&A		Procedure Codes: H0001, H0022		
35	Outpatient Drug & Alcohol	11 - Mental Health/ Substance Abuse	138 - D&A Targeted Case Mgmt	Any*	Procedure Codes: H0006, H0006/TF	98/97	98
			128 - D&A Intensive Outpatient		Procedure Code: H0015		
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		Procedure Code: H0046/HW		
			110 - Psychiatric Outpatient		Procedure Code: H0037		
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		Procedure Code: H0047/HW		
OTHER SERVICES (MA Defined - Non-Behavioral Health)							
38	Case Management Services	21 - Case Manager Substance Abuse	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	Oupatient 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: S9075	98/96	98
		05 - Home Health					
		08 - Clinic					
		09 - CRNP					
		19 - Psychologist					
		24 - Pharmacy					
		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

Healthchoices Behavioral Health Services Reporting Classification Chart - July 1, 2009

Line Item	Service	Provider Type	Provider Specialty	Provider ID	Identifiers	ENC CAT	FIN CAT
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	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, 99349/HE	98/96	98
		08 - Clinic	110 - Psychiatric Outpatient	1007323280015 1007415500004 1007324900011	CPT Codes: 90801/GT, 90802/GT, 90804/GT, 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	98/96	98

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

DIAGNOSTIC RELATED GROUP (DRG) DESCRIPTIONS

424 O.R. Procedure with Principal Diagnosis of Mental Illness

Any Operating Room Procedure

425 Acute Adjustment Reaction & Psychosocial Dysfunction

Principal Diagnosis

293.0	Delirium	300.19	Factitious illness NEC/NOS
293.1	Subacute delirium	300.9	Neurotic disorder NOS
293.9	Transient organic mental disorder NOS	308.0	Stress reaction, emotional
300.00	Anxiety state NOS	308.1	Stress reaction, fugue
300.01	Panic disorder	308.2	Stress reaction, psychomotor
300.02	Generalized anxiety disorder	308.3	Acute stress reaction NEC
300.09	Anxiety state NEC	308.4	Stress reaction, mixed disorder
300.10	Hysteria NOS	308.9	Acute stress reaction NOS
300.11	Conversion disorder	780.1	Hallucinations
300.12	Psychogenic amnesia	799.2	Nervousness
300.13	Psychogenic fugue	V710.1	Obsv-adult antisoc behav
300.15	Dissociative reaction NOS	V710.2	Obsv-adolesc antisoc beh
300.16	Factitious illness w symptom		

426 Depressive Neuroses

Principal Diagnosis

300.4	Neurotic depression	309.1	Prolong depressive reaction
301.12	Chronic depressive personality disorder	311.	Depressive disorder NEC
309.0	Brief depressive reaction		

427 Neuroses Except Depressive

Principal Diagnosis

300.20	Phobia NOS	307.89	Psychogenic pain NEC
300.21	Agoraphobia with panic	309.21	Separation anxiety
300.22	Agoraphobia w/o panic	309.22	Emancipation disorder
300.23	Social phobia	309.23	Academic/work inhibition
300.29	Isolated phobias NEC	309.24	Adjustment reaction - anxious mood

- | | | | |
|--------|-------------------------------|--------|--|
| 300.3 | Obsessive-Compulsive disorder | 309.28 | Adjustment reaction - mixed emotion |
| 300.5 | Neurasthenia | 309.29 | Adjustment reaction - emotion NEC |
| 300.6 | Depersonalization syndrome | 309.3 | Adjustment reaction - conduct disorder |
| 300.7 | Hypochondriasis | 309.4 | Adjustment reaction - emotion/conduct |
| 300.81 | Somatization Disorder | 309.81 | Prolong posttraum stress |
| 300.82 | Undiff somatoform disorder | 309.82 | Adjustment reaction - physical symptom |
| 300.89 | Neurotic disorders NEC | 309.83 | Adjust reaction - withdrawal |
| 306.7 | Psychogenic sensory disorder | 309.89 | Adjustment reaction NEC |
| 306.9 | Psychogenic disorder NOS | 309.9 | Adjustment reaction NOS |
| 307.53 | Psychogenic rumination | 313.0 | Overanxious disorder |
| 307.54 | Psychogenic vomiting | 313.1 | Misery & unhappiness disorder |
| 307.80 | Psychogenic pain NOS | | |

428 Disorders of Personality & Impulse Control

Principal Diagnosis

- | | | | |
|--------|----------------------------|--------|------------------------------|
| 300.14 | Multiple personality | 301.7 | Antisocial personality |
| 301.0 | Paranoid personality | 301.81 | Narcissistic personality |
| 301.10 | Affective personality NOS | 301.82 | Avoidant personality |
| 301.11 | Chronic hypomanic person | 301.83 | Borderline personality |
| 301.13 | Cyclothymic disorder | 301.84 | Passive-aggressive person |
| 301.20 | Schizoid personality NOS | 301.89 | Personality disorder NEC |
| 301.21 | Introverted personality | 301.9 | Personality disorder NOS |
| 301.22 | Schizotypal personality | 307.1 | Anorexia nervosa |
| 301.3 | Explosive personality | 312.31 | Pathological gambling |
| 301.4 | Compulsive personality | 312.32 | Kleptomania |
| 301.50 | Histrionic person NOS | 312.34 | Intermitt explosive disorder |
| 301.51 | Chronic factitious illness | 312.35 | Isolated explosive disorder |
| 301.59 | Histrionic person NEC | 312.39 | Impulse control disorder NEC |
| 301.6 | Dependent personality | | |

429 Organic Disturbances & Mental Retardation

Principal Diagnosis

- | | | | |
|--------|-----------------------------------|--------|-----------------------------------|
| 290.0 | Senile dementia uncomplicated | 294.8 | Organic brain syndrome NEC |
| 290.10 | Presenile dementia, uncomplicated | 294.9 | Organic brain syndrome NOS |
| 290.11 | Presenile dementia, delirium | 299.00 | Infantile autism-active |
| 290.12 | Presenile dementia, delusion | 299.01 | Infantile autism-residual |
| 290.13 | Presenile dementia, depression | 299.10 | Disintegrative psychosis-active |
| 290.20 | Senile dementia, delusion | 299.11 | Disintegrative psychosis-residual |
| 290.21 | Senile dementia, depressive | 307.9 | Special symptom NEC/NOS |
| 290.3 | Senile dementia, delirium | 310.0 | Frontal lobe syndrome |

290.40	Arterioscler dementia NOS	310.1	Organic personality syndrome
290.41	Arterioscler dementia, delirium	310.8	Nonpsychotic brain syndrome NEC
290.42	Arterioscler dementia, delusion	310.9	Nonpsychotic brain syndrome NOS
290.43	Arterioscler dementia, depressive	316	Psychic factor w other disorder
290.8	Senile psychosis NEC	317	Mild mental retardation
290.9	Senile psychotic condition NOS	318.0	Moderate mental retardation
293.81	Organic delusional syndrome	318.1	Severe mental retardation
293.82	Organic hallucinosis syndrome	318.2	Profound mental retardation
293.83	Organic affective syndrome	319	Mental retardation NOS
293.84	Organic anxiety syndrome	758.0	Down's syndrome
293.89	Transient organic mental disorder NEC	758.1	Patau's syndrome
294.0	Amnestic syndrome	758.2	Edward's syndrome
294.10	Dementia w/o behavioral dist	758.3	Autosomal deletion syndrome
294.11	Dementia with behavioral dist	797	Senility w/o psychosis

430 Psychoses

Principal Diagnosis

295.00	Simple schizophrenic - unspecified	296.06	Manic disorder - full remission
295.01	Simple schizophrenic - subchronic	296.10	Recurrent manic disorder - unspecified
295.02	Simple schizophrenic - chronic	296.11	Recurrent manic disorder - mild
295.03	Simple schizophrenic - subchronic/exacer	296.12	Recurrent manic disorder - moderate
295.04	Simple schizophrenic - chronic/exacerb	296.13	Recurrent manic disorder - severe
295.05	Simple schizophrenic - remission	296.14	Recurrent manic disorder - sev w psycho
295.10	Hebephrenia - unspecified	296.15	Recurrent manic disorder - part remission
295.11	Hebephrenia - subchronic	296.16	Recurrent manic disorder - full remission
295.12	Hebephrenia - chronic	296.20	Depressive psychosis - unspecified
295.13	Hebephrenia - subchronic/exacerbation	296.21	Depressive psychosis - mild
295.14	Hebephrenia - chronic/exacerbation	296.22	Depressive psychosis - moderate
295.15	Hebephrenia - remission	296.23	Depressive psychosis - severe
295.20	Catatonia - unspecified	296.24	Depressive psychosis - severe w psych
295.21	Catatonia - subchronic	296.25	Depressive psychosis - partial remission
295.22	Catatonia - chronic	296.26	Depressive psychosis - full remission
295.23	Catatonia - subchronic/exacerbation	296.30	Recurrent depressive psych - unspecified
295.24	Catatonia - chronic/exacerbation	296.31	Recurrent depressive psych - mild
295.25	Catatonia - remission	296.32	Recurrent depressive psych - moderate
295.30	Paranoid schizophrenic - unspecified	296.33	Recurrent depressive psych - severe
295.31	Paranoid schizophrenic - subchronic	296.34	Recurrent depressive psych - severe
295.32	Paranoid schizophrenic - chronic	296.35	Recurrent depressive psych - part remiss
295.33	Paranoid schizophrenic - subchronic/exac	296.36	Recurrent depressive psych - full remiss
295.34	Paranoid schizophrenic - chronic/exacerb	296.40	Bipolar affective manic - unspecified
295.35	Paranoid schizophrenic - remission	296.41	Bipolar affective manic - mild
295.40	Acute schizophrenic - unspecified	296.42	Bipolar affective manic - moderate
295.41	Acute schizophrenic - subchronic	296.43	Bipolar affective manic - severe

295.42	Acute schizophrenic - chronic	296.44	Bipolar affective manic - severe w psych
295.43	Acute schizophrenic - subchronic/exacer	296.45	Bipolar affective manic - part remission
295.44	Acute schizophrenic - chronic/exacerb	296.46	Bipolar affective manic - full remission
295.45	Acute schizophrenic - remission	296.50	Bipolar affective depressed - unspecified
295.50	Latent schizophrenia - unspecified	296.51	Bipolar affective depressed - mild
295.51	Latent schizophrenia - subchronic	296.52	Bipolar affective depressed - moderate
295.52	Latent schizophrenia - chronic	296.53	Bipolar affective depressed - severe
295.53	Latent schizophrenia - subchronic/exacer	296.54	Bipolar affective depressed - sev w psych
295.54	Latent schizophrenia - chronic/exacer	296.55	Bipolar affective depressed - part remiss
295.55	Latent schizophrenia - remission	296.56	Bipolar affective depressed - full remiss
295.60	Residual schizophrenia - unspecified	296.60	Bipolar affective mixed - unspecified
295.61	Residual schizophrenia - subchronic	296.61	Bipolar affective mixed - mild
295.62	Residual schizophrenia - chronic	296.62	Bipolar affective mixed - moderate
295.63	Residual schizophrenia - subchronic/exac	296.63	Bipolar affective mixed - severe
295.64	Residual schizophrenia - chronic/exacerb	296.64	Bipolar affective mixed - severe w psych
295.65	Residual schizophrenia - remission	296.65	Bipolar affective mixed - partial remission
295.70	Schizo-affective - unspecified	296.66	Bipolar affective mixed - full remission
295.71	Schizo-affective - subchronic	296.7	Bipolar affective NOS
295.72	Schizo-affective - chronic	296.80	Manic-depressive NOS
295.73	Schizo-affective - subchronic/exacer	296.81	Atypical manic disorder
295.74	Schizo-affective - chronic/exacerbation	296.82	Atypical depressive disorder
295.75	Schizo-affective - remission	296.89	Manic-depressive NEC
295.80	Schizophrenia NEC - unspecified	296.90	Affective psychosis NOS
295.81	Schizophrenia NEC - subchronic	296.99	Affective psychoses NEC
295.82	Schizophrenia NEC - chronic	297.0	Paranoid state, simple
295.83	Schizophrenia NEC - subchronic/exacer	297.1	Paranoia
295.84	Schizophrenia NEC - chronic/exacerb	297.2	Paraphrenia
295.85	Schizophrenia NEC - remission	297.3	Shared paranoid disorder
295.90	Schizophrenia NOS - unspecified	297.8	Paranoid state NEC
295.91	Schizophrenia NOS - subchronic	297.9	Paranoid state NOS
295.92	Schizophrenia NOS - chronic	298.0	React depressive psychosis
295.93	Schizophrenia NOS - subchronic/exacer	298.1	Excitative type psychosis
295.94	Schizophrenia NOS - chronic/exacerb	298.3	Acute paranoid reaction
295.95	Schizophrenia NOS - remission	298.4	Psychogenic paranoid psychosis
296.00	Manic disorder - unspecified	298.8	Reactive psychosis NEC/NOS
296.01	Manic disorder - mild	298.9	Psychosis NOS
296.02	Manic disorder - moderate	299.80	Child psychoses NEC - active
296.03	Manic disorder - severe	299.81	Child psychoses NEC - residual
296.04	Manic disorder - severe w psych	299.90	Child psychoses NOS - active
296.05	Manic disorder - partial remission	299.91	Child psychoses NOS - residual

431 Childhood Mental Disorders

Principal Diagnosis

307.52	Pica	313.81	Oppositional disorder
307.6	Enuresis	313.82	Identity disorder
307.7	Encopresis	313.83	Academic underachievement
312.00	Unsocial aggressive - unspecified	313.89	Emotional disorder child NEC
312.01	Unsocial aggressive - mild	313.9	Emotional disorder child NOS
312.02	Unsocial aggressive - moderate	314.00	Attention deficit nonhyperactivity
312.03	Unsocial aggressive - severe	314.01	Attention deficit w hyperactivity
312.10	Unsocial unaggressive - unspecified	314.1	Hyperkinet w developmental delay
312.11	Unsocial unaggressive - mild	314.2	Hyperkinetic conduct disorder
312.12	Unsocial unaggressive - moderate	314.8	Other hyperkinetic syndrome
312.13	Unsocial unaggressive - severe	314.9	Hyperkinetic syndrome NOS
312.20	Social conduct disorder - unspecified	315.00	Reading disorder NOS
312.21	Social conduct disorder - mild	315.01	Alexia
312.22	Social conduct disorder - moderate	315.02	Developmental dyslexia
312.23	Social conduct disorder - severe	315.09	Reading disorder NEC
312.30	Impulse control disorder NOS	315.1	Arithmetical disorder
312.33	Pyromania	315.2	Other learning difficulty
312.4	Mixed disturbance of conduct/emotion	315.31	Development language disorder
312.81	Conduct disorder childhood onset	315.32	Receptive language disorder
312.82	Conduct disorder adolescent onset	315.39	Speech/language disorder NEC
312.89	Other conduct disorder	315.4	Coordination disorder
312.9	Conduct disturbance NOS	315.5	Mixed development disorder
313.21	Shyness disorder - child	315.8	Development delays NEC
313.22	Introverted disorder - child	315.9	Development delays NOS
313.23	Elective mutism	784.61	Alexia and dyslexia
313.3	Relationship problems	784.69	Symbolic dysfunction NEC

432 Other Mental Disorders Diagnoses

Principal Diagnosis

298.2	Reactive confusion	302.9	Psychosexual disorder NOS
302.0	Ego-dystonic homosexuality	306.8	Psychogenic disorder NEC
302.1	Zoophilia	307.0	Stammering & stuttering
302.2	Pedophilia	307.3	Stereotyped movements
302.3	Transvestism	307.40	Nonorganic sleep disorder NOS
302.4	Exhibitionism	307.41	Transient insomnia
302.50	Trans-sexualism NOS	307.42	Persistent insomnia
302.51	Trans-sexualism, asexual	307.43	Transient hypersomnia
302.52	Trans-sexualism, homosexual	307.44	Persistent hypersomnia
302.53	Trans-sexualism, heterosexual	307.45	Disrupt sleep-wake cycle
302.6	Psychosex identity disorder	307.46	Somnambulism or night terror
302.70	Psychosexual dysfunction NOS	307.47	Sleep stage dysfunction NEC
302.71	Inhibited sexual desire	307.48	Repetitive sleep intrusion
302.72	Inhibited sex excitement	307.49	Nonorganic sleep disorder NEC

302.73	Inhibited female orgasm	307.50	Eating disorder NOS
302.74	Inhibited male orgasm	307.51	Bulimia
302.75	Premature ejaculation	307.59	Eating disorder NEC
302.76	Functional dyspareunia	780.50	Sleep disturbance NOS
302.79	Psychosexual dysfunc NEC	780.52	Insomnia NEC
302.81	Fetishism	780.54	Hypersomnia NEC
302.82	Voyeurism	780.55	Irregular sleep-wake rhythm NOS
302.83	Sexual masochism	780.56	Sleep stage dysfunctions
302.84	Sexual sadism	780.59	Sleep disturbances NEC
302.85	Gender identity disorder, adolescent/adult	784.60	Symbolic dysfunction NOS
302.89	Psychosexual disorder NEC	V710.9	Observ-mental cond NEC

433 Alcohol/Drug Abuse or Dependence, Left AMA

521 Alcohol/Drug Abuse or Dependence w/ cc

Principal Diagnosis

291.0	Delirium tremens	304.61	Drug dependence NEC - continuous
291.1	Alcohol amnestic syndrome	304.62	Drug dependence NEC - episodic
291.2	Alcoholic dementia NEC	304.63	Drug dependence NEC - remission
291.3	Alcohol hallucinosis	304.70	Opioid/other dependence - unspecified
291.4	Pathologic alcohol intoxication	304.71	Opioid/other dependence - continuous
291.5	Alcoholic jealousy	304.72	Opioid/other dependence - episodic
291.81	Alcohol withdrawal	304.73	Opioid/other dependence - remission
291.89	Alcoholic psychosis NEC	304.80	Comb drug dependence NEC - unspecified
291.9	Alcoholic psychosis NOS	304.81	Comb drug dependence NEC - contin
292.0	Drug withdrawal syndrome	304.82	Comb drug dependence NEC - episodic
292.11	Drug paranoid state	304.83	Comb drug dependence NEC - remission
292.12	Drug hallucinosis	304.90	Drug dependence NOS - unspecified
292.2	Pathologic drug intoxication	304.91	Drug dependence NOS - continuous
292.81	Drug-induced delirium	304.92	Drug dependence NOS - episodic
292.82	Drug-induced dementia	304.93	Drug dependence NOS - remission
292.83	Drug amnestic syndrome	305.00	Alcohol abuse - unspecified
292.84	Drug depressive syndrome	305.01	Alcohol abuse - continuous
292.89	Drug mental disorder NEC	305.02	Alcohol abuse - episodic
292.9	Drug mental disorder NOS	305.03	Alcohol abuse - remission
303.00	Acute alcoholic intoxication - unspecified	305.20	Cannabis abuse - unspecified
303.01	Acute alcoholic intoxication - continuous	305.21	Cannabis abuse - continuous
303.02	Acute alcoholic intoxication - episodic	305.22	Cannabis abuse - episodic
303.03	Acute alcoholic intoxication - remission	305.23	Cannabis abuse - remission
303.90	Alcohol dependence NEC/NOS - unspec	305.30	Hallucinogen abuse - unspecified
303.91	Alcohol dependence NEC/NOS - contin	305.31	Hallucinogen abuse - continuous
303.92	Alcohol dependence NEC/NOS - episodic	305.32	Hallucinogen abuse - episodic

303.93	Alcohol dependence NEC/NOS - remission	305.33	Hallucinogen abuse - remission
304.00	Opioid dependence - unspecified	305.40	Barbiturate abuse - unspecified
304.01	Opioid dependence - continuous	305.41	Barbiturate abuse - continuous
304.02	Opioid dependence - episodic	305.42	Barbiturate abuse - episodic
304.03	Opioid dependence - remission	305.43	Barbiturate abuse - remission
304.10	Barbiturate dependence - unspecified	305.50	Opioid abuse - unspecified
304.11	Barbiturate dependence - continuous	305.51	Opioid abuse - continuous
304.12	Barbiturate dependence - episodic	305.52	Opioid abuse - episodic
304.13	Barbiturate dependence - remission	305.53	Opioid abuse - remission
304.20	Cocaine dependence - unspecified	305.60	Cocaine abuse - unspecified
304.21	Cocaine dependence - continuous	305.61	Cocaine abuse - continuous
304.22	Cocaine dependence - episodic	305.62	Cocaine abuse - episodic
304.23	Cocaine dependence - remission	305.63	Cocaine abuse - remission
304.30	Cannabis dependence - unspecified	305.70	Amphetamine abuse - unspecified
304.31	Cannabis dependence - continuous	305.71	Amphetamine abuse - continuous
304.32	Cannabis dependence - episodic	305.72	Amphetamine abuse - episodic
304.33	Cannabis dependence - remission	305.73	Amphetamine abuse - remission
304.40	Amphetamine dependence - unspecified	305.80	Antidepressant abuse - unspecified
304.41	Amphetamine dependence - continuous	305.81	Antidepressant abuse - continuous
304.42	Amphetamine dependence - episodic	305.82	Antidepressant abuse - episodic
304.43	Amphetamine dependence - remission	305.83	Antidepressant abuse - remission
304.50	Hallucinogen dependence - unspecified	305.90	Drug abuse NEC - unspecified
304.51	Hallucinogen dependence - continuous	305.91	Drug abuse NEC - continuous
304.52	Hallucinogen dependence - episodic	305.92	Drug abuse NEC - episodic
304.53	Hallucinogen dependence - remission	305.93	Drug abuse NEC - remission
304.60	Drug dependence NEC - unspecified	790.3	Excess blood-alcohol level

522 Alcohol/Drug Abuse or Dependence with Rehabilitation Therapy w/o cc

Principal Diagnosis

291.0	Delirium tremens	304.61	Drug dependence NEC - continuous
291.1	Alcohol amnestic syndrome	304.62	Drug dependence NEC - episodic
291.2	Alcoholic dementia NEC	304.63	Drug dependence NEC - remission
291.3	Alcohol hallucinosis	304.70	Opioid/other dependence - unspecified
291.4	Pathologic alcohol intoxication	304.71	Opioid/other dependence - continuous
291.5	Alcoholic jealousy	304.72	Opioid/other dependence - episodic
291.81	Alcohol withdrawal	304.73	Opioid/other dependence - remission
291.89	Alcoholic psychosis NEC	304.80	Comb drug dependence NEC - unspecified
291.9	Alcoholic psychosis NOS	304.81	Comb drug dependence NEC - continuous
292.0	Drug withdrawal syndrome	304.82	Comb drug dependence NEC - episodic
292.11	Drug paranoid state	304.83	Comb drug dependence NEC - remission
292.12	Drug hallucinosis	304.90	Drug dependence NOS - unspecified
292.2	Pathologic drug intoxication	304.91	Drug dependence NOS - continuous
292.81	Drug-induced delirium	304.92	Drug dependence NOS - episodic

292.82	Drug-induced dementia	304.93	Drug dependence NOS - remission
292.83	Drug amnestic syndrome	305.00	Alcohol abuse - unspecified
292.84	Drug depressive syndrome	305.01	Alcohol abuse - continuous
292.89	Drug mental disorder NEC	305.02	Alcohol abuse - episodic
292.9	Drug mental disorder NOS	305.03	Alcohol abuse - remission
303.00	Acute alcoholic intox - unspecified	305.20	Cannabis abuse - unspecified
303.01	Acute alcoholic intox - continuous	305.21	Cannabis abuse - continuous
303.02	Acute alcoholic intox - episodic	305.22	Cannabis abuse - episodic
303.03	Acute alcoholic intox - remission	305.23	Cannabis abuse - remission
303.90	Alcohol dependence NEC/NOS - unspec	305.30	Hallucinogen abuse - unspecified
303.91	Alcohol dependence NEC/NOS - contin	305.31	Hallucinogen abuse - continuous
303.92	Alcohol dependence NEC/NOS - episodic	305.32	Hallucinogen abuse - episodic
303.93	Alcohol dependence NEC/NOS - remiss	305.33	Hallucinogen abuse - remission
304.00	Opioid dependence - unspecified	305.40	Barbiturate abuse - unspecified
304.01	Opioid dependence - continuous	305.41	Barbiturate abuse - continuous
304.02	Opioid dependence - episodic	305.42	Barbiturate abuse - episodic
304.03	Opioid dependence - remission	305.43	Barbiturate abuse - remission
304.10	Barbiturate dependence - unspecified	305.50	Opioid abuse - unspecified
304.11	Barbiturate dependence - continuous	305.51	Opioid abuse - continuous
304.12	Barbiturate dependence - episodic	305.52	Opioid abuse - episodic
304.13	Barbituraet dependence - remission	305.53	Opioid abuse - remission
304.20	Cocaine dependence - unspecified	305.60	Cocaine abuse - unspecified
304.21	Cocaine dependence - continuous	305.61	Cocaine abuse - continuous
304.22	Cocaine dependence - episodic	305.62	Cocaine abuse - episodic
304.23	Cocaine dependence - remission	305.63	Cocaine abuse - remission
304.30	Cannabis dependence - unspecified	305.70	Amphetamine abuse - unspecified
304.31	Cannabis dependence - continuous	305.71	Amphetamine abuse - continuous
304.32	Cannabis dependence - episodic	305.72	Amphetamine abuse - episodic
304.33	Cannabis dependence - remission	305.73	Amphetamine abuse - remission
304.40	Amphetamine dependence - unspecified	305.80	Antidepressant abuse - unspecified
304.41	Amphetamine dependence -continuous	305.81	Antidepressant abuse - continuous
304.42	Amphetamine dependence - episodic	305.82	Antidepressant abuse - episodic
304.43	Amphetamine dependence - remission	305.83	Antidepressant abuse - remission
304.50	Hallucinogen dependence - unspecified	305.90	Drug abuse NEC - unspecified
304.51	Hallucinogen dependence - continuous	305.91	Drug abuse NEC - continuous
304.52	Hallucinogen dependence - episodic	305.92	Drug abuse NEC - episodic
304.53	Hallucinogen dependence - remission	305.93	Drug abuse NEC - remission
304.60	Drug dependence NEC - unspecified	790.3	Excess blood-alcohol level

And

Non-Operating Room Procedures

946.1	Alcohol rehabilitation	946.6	Drug rehab/detox
946.3	Alcohol rehab/detox	946.7	Comb alcohol/drug rehab
946.4	Drug rehabilitation	946.9	Comb alcohol/drug rehab/detox

523 Alcohol/Drug Abuse or Dependence w/o Rehabilitation Therapy w/o cc

Principal Diagnosis

291.0	Delirium tremens	304.61	Drug dependence NEC - continuous
291.1	Alcohol amnestic syndrome	304.62	Drug dependence NEC - episodic
291.2	Alcoholic dementia NEC	304.63	Drug dependence NEC - remission
291.3	Alcohol hallucinosis	304.70	Opioid/other dependence - unspecified
291.4	Pathologic alcohol intoxication	304.71	Opioid/other dependence - continuous
291.5	Alcoholic jealousy	304.72	Opioid/other dependence - episodic
291.81	Alcohol withdrawal	304.73	Opioid/other dependence - remission
291.89	Alcoholic psychosis NEC	304.80	Comb drug dependence NEC - unspecified
291.9	Alcoholic psychosis NOS	304.81	Comb drug dependence NEC - continuous
292.0	Drug withdrawal syndrome	304.82	Comb drug dependence NEC - episodic
292.11	Drug paranoid state	304.83	Comb drug dependence NEC - remission
292.12	Drug hallucinosis	304.90	Drug dependence NOS - unspecified
292.2	Pathologic drug intoxication	304.91	Drug dependence NOS - continuous
292.81	Drug-induced delirium	304.92	Drug dependence NOS - episodic
292.82	Drug-induced dementia	304.93	Drug dependence NOS - remission
292.83	Drug amnestic syndrome	305.00	Alcohol abuse - unspecified
292.84	Drug depressive syndrome	305.01	Alcohol abuse - continuous
292.89	Drug mental disorder NEC	305.02	Alcohol abuse - episodic
292.9	Drug mental disorder NOS	305.03	Alcohol abuse - remission
303.00	Acute alcoholic intoxication - unspecified	305.20	Cannabis abuse - unspecified
303.01	Acute alcoholic intoxication - continuous	305.21	Cannabis abuse - continuous
303.02	Acute alcoholic intoxication - episodic	305.22	Cannabis abuse - episodic
303.03	Acute alcoholic intoxication - remission	305.23	Cannabis abuse - remission
303.90	Alcohol dependence NEC/NOS - unsp	305.30	Hallucinogen abuse - unspecified
303.91	Alcohol dependence NEC/NOS - contin	305.31	Hallucinogen abuse - continuous
303.92	Alcohol dependence NEC/NOS - episodic	305.32	Hallucinogen abuse - episodic
303.93	Alcohol dependence NEC/NOS - remiss	305.33	Hallucinogen abuse - remission
304.00	Opioid dependence - unspecified	305.40	Barbiturate abuse - unspecified
304.01	Opioid dependence - continuous	305.41	Barbiturate abuse - continuous
304.02	Opioid dependence - episodic	305.42	Barbiturate abuse - episodic
304.03	Opioid dependence - remission	305.43	Barbiturate abuse - remission
304.10	Barbiturate dependence - unspecified	305.50	Opioid abuse - unspecified
304.11	Barbiturate dependence - continuous	305.51	Opioid abuse - continuous
304.12	Barbiturate dependence - episodic	305.52	Opioid abuse - episodic
304.13	Barbiturate dependence - remission	305.53	Opioid abuse - remission
304.20	Cocaine dependence - unspecified	305.60	Cocaine abuse - unspecified
304.21	Cocaine dependence - continuous	305.61	Cocaine abuse - continuous
304.22	Cocaine dependence - episodic	305.62	Cocaine abuse - episodic
304.23	Cocaine dependence - remission	305.63	Cocaine abuse - remission
304.30	Cannabis dependence - unspecified	305.70	Amphetamine abuse - unspecified

- | | |
|--|---|
| 304.31 Cannabis dependence - continuous | 305.71 Amphetamine abuse - continuous |
| 304.32 Cannabis dependence - episodic | 305.72 Amphetamine abuse - episodic |
| 304.33 Cannabis dependence - remission | 305.73 Amphetamine abuse - remission |
| 304.40 Amphetamine dependence - unspecified | 305.80 Antidepressant abuse - unspecified |
| 304.41 Amphetamine dependence -continuous | 305.81 Antidepressant abuse - continuous |
| 304.42 Amphetamine dependence - episodic | 305.82 Antidepressant abuse - episodic |
| 304.43 Amphetamine dependence - remission | 305.83 Antidepressant abuse - remission |
| 304.50 Hallucinogen dependence - unspecified | 305.90 Drug abuse NEC - unspecified |
| 304.51 Hallucinogen dependence - continuous | 305.91 Drug abuse NEC - continuous |
| 304.52 Hallucinogen dependence - episodic | 305.92 Drug abuse NEC - episodic |
| 304.53 Hallucinogen dependence - remission | 305.93 Drug abuse NEC - remission |
| 304.60 Drug dependence NEC - unspecified | 790.3 Excess blood-alcohol level |

Refer to Items 1, 4, and 6

International Classification of Disease			
9 th Revision, Clinical Modification - (ICD-9-CM)			
*	290	Dementias	
		290.0	Senile dementia, uncomplicated
*		290.1	Presenile dementia
		290.10	Presenile dementia, uncomplicated
		290.11	Presenile dementia with delirium
		290.12	Presenile dementia with delusional features
		290.13	Presenile dementia with depressive features
*		290.2	Senile dementia with delusional or depressive features
		290.20	Senile dementia with delusional features
		290.21	Senile dementia with depressive features
		290.3	Senile dementia with delirium
*		290.4	Vascular dementia
		290.40	Vascular dementia, uncomplicated
		290.41	Vascular dementia with delirium
		290.42	Vascular dementia with delusions
		290.43	Vascular dementia with depressed mood
		290.8	Other specified senile psychotic conditions
		290.9	Unspecified senile psychotic condition
*	291	Alcohol-induced mental disorders	
		291.0	Alcohol withdrawal delirium
		291.1	Alcohol-induced persisting amnestic disorder
		291.2	Alcohol-induced persisting dementia
		291.3	Alcohol-induced psychotic disorder with hallucinations
		291.4	Idiosyncratic alcohol intoxication
		291.5	Alcohol-induced psychotic disorder with delusions
*		291.8	Other specified alcohol-induced mental disorders
		291.81	Alcohol withdrawal
		291.82	Alcohol induced sleep disorders
		291.89	Other
		291.9	Unspecified alcohol-induced mental disorders
*	292	Drug-induced mental disorders	
		292.0	Drug withdrawal
*		292.1	Drug-induced psychotic disorders
		292.11	Drug-induced psychotic disorder with delusions
		292.12	Drug-induced psychotic disorder with hallucinations
		292.2	Pathological drug intoxication
*		292.8	Other specified drug-induced mental disorders
		292.81	Drug-induced delirium
		292.82	Drug-induced persisting dementia
		292.83	Drug-induced persisting amnestic disorder
		292.84	Drug-induced mood disorder
		292.85	Drug-induced sleep disorders
		292.89	Other
		292.9	Unspecified drug-induced mental disorder
*	293	Transient mental disorders due to conditions classified elsewhere	
		293.0	Delirium due to conditions classified elsewhere
		293.1	Subacute delirium
*		293.8	Other specified transient mental disorders due to conditions classified elsewhere
		293.81	Psychotic disorder with delusions in conditions classified elsewhere
		293.82	Psychotic disorder with hallucinations in conditions classified elsewhere
		293.83	Mood disorder in conditions classified elsewhere
		293.84	Anxiety disorder in conditions classified elsewhere

		293.89	Other
		293.9	Unspecified transient mental disorder in conditions classified elsewhere
*	294		Persistent mental disorders due to conditions classified elsewhere
		294.0	Amnestic disorder in conditions classified elsewhere
*		294.1	Dementia in conditions classified elsewhere
		294.10	Dementia in conditions classified elsewhere without behavioral disturbance
		294.11	Dementia in conditions classified elsewhere with behavioral disturbance
		294.8	Other persistent mental disorders due to conditions classified elsewhere
		294.9	Unspecified persistent mental disorders due to conditions classified elsewhere
*	295		Schizophrenic disorders
			The following fifth-digit subclassification is for use with category 295:
			0 - Unspecified
			1 - Subchronic
			2 - Chronic
			3 - Subchronic with acute exacerbation
			4 - Chronic with acute exacerbation
			5 - In remission
*		295.0	Simple type
*		295.1	Disorganized type
*		295.2	Catatonic type
*		295.3	Paranoid type
*		295.4	Schizophreniform disorder
*		295.5	Latent schizophrenia
*		295.6	Residual type
*		295.7	Schizoaffective disorder
*		295.8	Other specified types of schizophrenia
*		295.9	Unspecified schizophrenia
*	296		Episodic mood disorders
			The following fifth-digit subclassification is for use with categories 296.0 - 296.6:
			0 - Unspecified
			1 - Mild
			2 - Moderate
			3 - Severe, without mention of psychotic behavior
			4 - Severe, specified as with psychotic behavior
			5 - In partial or unspecified remission
			6 - In full remission
*		296.0	Bipolar I disorder, single manic episode
*		296.1	Manic disorder, recurrent episode
*		296.2	Major depressive disorder, single episode
*		296.3	Major depressive disorder, recurrent episode
*		296.4	Bipolar I disorder, most recent episode (or current) manic
*		296.5	Bipolar I disorder, most recent episode (or current) depressed
*		296.6	Bipolar I disorder, most recent episode (or current) mixed
		296.7	Bipolar I disorder, most recent episode (or current) unspecified
*		296.8	Other and unspecified bipolar disorders
		296.80	Bipolar disorder, unspecified
		296.81	Atypical manic disorder
		296.82	Atypical depressive disorder
		296.89	Other
*		296.9	Other and unspecified episodic mood disorder
		296.90	Unspecified episodic mood disorder
		296.99	Other specified episodic mood disorder
*	297		Delusional disorders
		297.0	Paranoid state, simple

	297.1	Delusional disorder
	297.2	Paraphrenia
	297.3	Shared psychotic disorder
	297.8	Other specified paranoid states
	297.9	Unspecified paranoid state
*	298	Other nonorganic psychoses
	298.0	Depressive type psychosis
	298.1	Excitatory type psychosis
	298.2	Reactive confusion
	298.3	Acute paranoid reaction
	298.4	Psychogenic paranoid psychosis
	298.8	Other and unspecified reactive psychosis
	298.9	Unspecified psychosis
*	299	Pervasive developmental disorders
		The following fifth-digit subclassification is for use with category 299:
		0 - Current or active state
		1 - Residual state
*	299.0	Autistic disorder
*	299.1	Childhood disintegrative disorder
*	299.8	Other specified pervasive developmental disorders
*	299.9	Unspecified pervasive developmental disorder
*	300	Anxiety, dissociative and somatoform disorders
*	300.0	Anxiety states
	300.00	Anxiety state, unspecified
	300.01	Panic disorder without agoraphobia
	300.02	Generalized anxiety disorder
	300.09	Other
*	300.1	Dissociative, conversion and factitious disorders
	300.10	Hysteria, unspecified
	300.11	Conversion disorder
	300.12	Dissociative amnesia
	300.13	Dissociative fugue
	300.14	Dissociative identity disorder
	300.15	Dissociative disorder or reaction, unspecified
	300.16	Factitious disorder with predominantly psychological signs and symptoms
	300.19	Other and unspecified factitious illness
*	300.2	Phobic disorders
	300.20	Phobia, unspecified
	300.21	Agoraphobia with panic disorder
	300.22	Agoraphobia without mention of panic attacks
	300.23	Social phobia
	300.29	Other isolated or specific phobias
	300.3	Obsessive-compulsive disorders
	300.4	Dysthymic disorder
	300.5	Neurasthenia
	300.6	Depersonalization disorder
	300.7	Hypochondriasis
*	300.8	Somatoform disorders
	300.81	Somatization disorder
	300.82	Undifferentiated somatoform disorder
	300.89	Other somatoform disorders
	300.9	Unspecified nonpsychotic mental disorder
*	301	Personality disorders
	301.0	Paranoid personality disorder

*		301.1	Affective personality disorder
		301.10	Affective personality disorder, unspecified
		301.11	Chronic hypomanic personality disorder
		301.12	Chronic depressive personality disorder
		301.13	Cyclothymic disorder
*		301.2	Schizoid personality disorder
		301.20	Schizoid personality disorder, unspecified
		301.21	Introverted personality
		301.22	Schizotypal personality disorder
		301.3	Explosive personality disorder
		301.4	Obsessive-compulsive personality disorder
*		301.5	Histrionic personality disorder
		301.50	Histrionic personality disorder, unspecified
		301.51	Chronic factitious illness with physical symptoms
		301.59	Other histrionic personality disorder
		301.6	Dependent personality disorder
		301.7	Antisocial personality disorder
*		301.8	Other personality disorders
		301.81	Narcissistic personality disorder
		301.82	Avoidant personality disorder
		301.83	Borderline personality disorder
		301.84	Passive-aggressive personality
		301.89	Other
		301.9	Unspecified personality disorder
*	302		Sexual and gender identity disorders
		302.0	Ego-dystonic sexual orientation
		302.1	Zoophilia
		302.2	Pedophilia
		302.3	Transvestic fetishism
		302.4	Exhibitionism
*		302.5	Trans-sexualism
		302.50	With unspecified sexual history
		302.51	With asexual history
		302.52	With homosexual history
		302.53	With heterosexual history
		302.6	Gender identity disorder in children
*		302.7	Psychosexual dysfunction
		302.70	Psychosexual dysfunction, unspecified
		302.71	Hypoactive sexual desire disorder
		302.72	With inhibited sexual excitement
		302.73	Female orgasmic disorder
		302.74	Male orgasmic disorder
		302.75	Premature ejaculation
		302.76	Dyspareunia, psychogenic
		302.79	With other specified psychosexual dysfunctions
*		302.8	Other specified psychosexual disorders
		302.81	Fetishism
		302.82	Voyeurism
		302.83	Sexual masochism
		302.84	Sexual sadism
		302.85	Gender identity disorder in adolescents or adult
		302.89	Other
		302.9	Unspecified psychosexual disorder
*	303		Alcohol dependence syndrome

			The following fifth-digit subclassification is for use with category 303:
			0 - Unspecified
			1 - Continuous
			2 - Episodic
			3 - In remission
*		303.0	Acute alcoholic intoxication
*		303.9	Other and unspecified alcohol dependence
*	304	Drug dependence	
			The following fifth-digit subclassification is for use with category 304:
			0 - Unspecified
			1 - Continuous
			2 - Episodic
			3 - In remission
*		304.0	Opioid type dependence
*		304.1	Sedative, hypnotic or anxiolytic dependence
*		304.2	Cocaine dependence
*		304.3	Cannabis dependence
*		304.4	Amphetamine and other psychostimulant dependence
*		304.5	Hallucinogen dependence
*		304.6	Other specified drug dependence
*		304.7	Combinations of opioid type drug with any other
*		304.8	Combinations of drug dependence excluding opioid type drug
*		304.9	Unspecified drug dependence
*	305	Nondependent abuse of drugs	
			The following fifth-digit subclassification is for use with codes 305.0, 305.2 - 305.9
			0 - Unspecified
			1 - Continuous
			2 - Episodic
			3 - In remission
*		305.0	Alcohol abuse
		305.1	Tobacco use disorder
*		305.2	Cannabis abuse
*		305.3	Hallucinogen abuse
*		305.4	Sedative, hypnotic or anxiolytic abuse
*		305.5	Opioid abuse
*		305.6	Cocaine abuse
*		305.7	Amphetamine or related acting sympathomimetic abuse
*		305.8	Antidepressant type abuse
*		305.9	Other, mixed, or unspecified drug abuse
*	306	Physiological malfunction arising from mental factors	
		306.0	Musculoskeletal
		306.1	Respiratory
		306.2	Cardiovascular
		306.3	Skin
		306.4	Gastrointestinal
*		306.5	Genitourinary
		306.50	Psychogenic genitourinary malfunction, unspecified
		306.51	Psychogenic vaginismus
		306.52	Psychogenic dysmenorrhea
		306.53	Psychogenic dysuria
		306.59	Other
		306.6	Endocrine
		306.7	Organs of special sense

	306.8	Other specified psychophysiological malfunction	
	306.9	Unspecified psychophysiological malfunction	
*	307	Special symptoms or syndromes, not elsewhere classified	
	307.0	Stuttering	
	307.1	Anorexia nervosa	
*	307.2	Tics	
		307.20	Tic disorder, unspecified
		307.21	Transient tic disorder
		307.22	Chronic motor or vocal tic disorder
		307.23	Tourette's disorder
	307.3	Stereotypic movement disorder	
*	307.4	Specific disorders of sleep of nonorganic origin	
		307.40	Nonorganic sleep disorder, unspecified
		307.41	Transient disorder of initiating or maintaining sleep
		307.42	Persistent disorder of initiating or maintaining sleep
		307.43	Transient disorder of initiating or maintaining wakefulness
		307.44	Persistent disorder of initiating or maintaining wakefulness
		307.45	Circadian rhythm sleep disorder of nonorganic origin
		307.46	Sleep arousal disorder
		307.47	Other dysfunctions of sleep stages or arousal from sleep
		307.48	Repetitive intrusions of sleep
		307.49	Other
*	307.5	Other and unspecified disorders of eating	
		307.50	Eating disorder, unspecified
		307.51	Bulimia nervosa
		307.52	Pica
		307.53	Rumination disorder
		307.54	Psychogenic vomiting
		307.59	Other
	307.6	Enuresis	
	307.7	Encopresis	
*	307.8	Pain disorders related to psychological factors	
		307.80	Psychogenic pain, site unspecified
		307.81	Tension headache
		307.89	Other
	307.9	Other and unspecified special symptoms or syndromes, not elsewhere classified	
*	308	Acute reaction to stress	
	308.0	Predominant disturbance of emotions	
	308.1	Predominant disturbance of consciousness	
	308.2	Predominant psychomotor disturbance	
	308.3	Other acute reactions to stress	
	308.4	Mixed disorders as reaction to stress	
	308.9	Unspecified acute reaction to stress	
*	309	Adjustment reaction	
	309.0	Adjustment disorder with depressed mood	
	309.1	Prolonged depressive reaction	
*	309.2	With predominant disturbance of other emotions	
		309.21	Separation anxiety disorder
		309.22	Emancipation disorder of adolescence and early adult life
		309.23	Specific academic or work inhibition
		309.24	Adjustment disorder with anxiety
		309.28	Adjustment disorder with mixed anxiety and depressed mood
		309.29	Other
	309.3	Adjustment disorder with disturbance of conduct	

	309.4	Adjustment disorder with mixed disturbance of emotions and conduct
*	309.8	Other specified adjustment reactions
	309.81	Posttraumatic stress disorder
	309.82	Adjustment reaction with physical symptoms
	309.83	Adjustment reaction with withdrawal
	309.89	Other
	309.9	Unspecified adjustment reaction
*	310	Specific nonpsychotic mental disorders due to brain damage
	310.0	Frontal lobe syndrome
	310.1	Personality change due to conditions classified elsewhere
	310.2	Postconcussion syndrome
	310.8	Other specified nonpsychotic mental disorders following organic brain damage
	310.9	Unspecified nonpsychotic mental disorder following organic brain damage
	311	Depressive disorder, not elsewhere classified
*	312	Disturbance of conduct, not elsewhere classified
		The following fifth-digit subclassification is for use with categories 312.0 - 312.2
		0 - Unspecified
		1 - Mild
		2 - Moderate
		3 - Severe
*	312.0	Undersocialized conduct disorder, aggressive type
*	312.1	Undersocialized conduct disorder, unaggressive type
*	312.2	Socialized conduct disorder
*	312.3	Disorders of impulse control, not elsewhere classified
	312.30	Impulse control disorder, unspecified
	312.31	Pathological gambling
	312.32	Kleptomania
	312.33	Pyromania
	312.34	Intermittent explosive disorder
	312.35	Isolated explosive disorder
	312.39	Other
	312.4	Mixed disturbance of conduct and emotions
*	312.8	Other specified disturbances of conduct, not elsewhere classified
	312.81	Conduct disorder, childhood onset type
	312.82	Conduct disorder, adolescent onset type
	312.89	Other conduct disorder
	312.9	Unspecified disturbance of conduct
*	313	Disturbance of emotions specific to childhood and adolescence
	313.0	Overanxious disorder
	313.1	Misery and unhappiness disorder
*	313.2	Sensitivity, shyness, and social withdrawal disorder
	313.21	Shyness disorder of childhood
	313.22	Introverted disorder of childhood
	313.23	Selective mutism
	313.3	Relationship problems
*	313.8	Other or mixed emotional disturbances of childhood or adolescence
	313.81	Oppositional defiant disorder
	313.82	Identity disorder
	313.83	Academic underachievement disorder
	313.89	Other
	313.9	Unspecified emotional disturbance of childhood or adolescence
*	314	Hyperkinetic syndrome of childhood
*	314.0	Attention deficit disorder
	314.00	Without mention of hyperactivity

		314.01	With hyperactivity
		314.1	Hyperkinesis with developmental delay
		314.2	Hyperkinetic conduct disorder
		314.8	Other specified manifestations of hyperkinetic syndrome
		314.9	Unspecified hyperkinetic syndrome
*	315	Specific delays in development	
*		315.0	Specific reading disorder
		315.00	Reading disorder, unspecified
		315.01	Alexia
		315.02	Developmental dyslexia
		315.09	Other
		315.1	Mathematics disorder
		315.2	Other specific learning difficulties
*		315.3	Developmental speech or language disorder
		315.31	Expressive language disorder
		315.32	Mixed receptive-expressive language disorder
		315.34	Speech and language developmental delay due to hearing loss
		315.39	Other
		315.4	Developmental coordination disorder
		315.5	Mixed development disorder
		315.8	Other specified delays in development
		315.9	Unspecified delay in development
	316	Psychic factors associated with diseases classified elsewhere	
	317	Mild mental retardation	
*	318	Other specified mental retardation	
		318.0	Moderate mental retardation
		318.1	Severe mental retardation
		318.2	Profound mental retardation
	319	Unspecified mental retardation	
		799.9	Other unknown and unspecified cause
Refer to items #13 & #14			
* - The diagnostic code requires additional digit(s) to be acceptable.			
Please Note: When the information on the attachment is in conflict with the medical assistance reference file, the attachment takes precedent.			

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
100001584	0057	Path Inc - Drug and Alcohol Clinic	01/25/08
100001996	0004	Penndel Mental Health Center	05/01/08
100001996	0008	Penndel Mental Health Center PC	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
100727874	0005	Aldie Counseling Center	02/05/08
100727874	0006	Aldie Foundation Inc	02/05/08
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
100772252	0022	Lenape Valley Foundation	01/02/08
100777929	0005	Eagleville Hospital	12/07/07

REVENUE CODE DESCRIPTIONS FOR BEHAVIORAL HEALTH COVERED SERVICES

<u>CODE</u>	<u>DESCRIPTION</u>
Room and Board (Detox)	
0116	Detox in private room
0126	Detox in semi-private room
0136	Detox in three or four bed room
0156	Detox in room for five+

Refer to Items 4 and 5

Rehabilitation

0118	Rehab in private room
0128	Rehab in semi-private room
0138	Rehab in three or four bed room
0158	Rehab in room for five+
0944	Drug Rehabilitation
0945	Alcohol Rehabilitation

Refer to Items 6 and 7

Psychiatric/Psychological Services:

Charges for providing nursing care and employee, professional services for emotionally disturbed patients, including patients admitted for diagnosis and those admitted for treatment.

0114	Room & Board - Private
0124	Room & Board - Semi-Private
0134	Room & Board - Three or four beds
0154	Room & Board - Five+ beds
0204	Intensive Care

Refer to Items 1, 2, 3, and 15

Treatment/Observation Room

Charges for the use of a treatment room, or for the room charge associated with outpatient observation services.

0760	General Classification
0761	Treatment Room
0762	Observation Room
0769	Other Treatment/Observation Room

Refer to Items 1, 2, 3, 4, 5, 6, and 7

Psychiatric/Psychological Treatments

0900	General Classification
0901	Electroshock Treatment
0902	Milieu Therapy
0903	Play Therapy
0904	Activity Therapy
0909	Other

Refer to Items 1, 2, 3, and 15

Psychiatric/Psychological Services

0910	General Classification
0911	Rehabilitation
0914	Individual Therapy
0915	Group Therapy
0916	Family Therapy
0917	Bio-Feedback
0918	Testing
0919	Other

Refer to Items 1, 2, 3, and 15

Other Diagnostic Services

0920	General Classification w/ BH Diagnosis
0929	Other Diagnostic Service w/ BH Diagnosis

Refer to Items 1, 2, 3, and 15

Other Therapeutic Services

0949	Other Therapeutic Services w/ BH Diagnosis
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Refer to Items 1, 2, 3, 4, 5, 6, 7, and 15

Leave of Absence

0185	Nursing Home (for Hospitalization) (used as Reserve Bed Days for RTF)
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Refer to Item 15

At least one Behavioral Health revenue code must be used when billing for these services.

PT, PC w/ DESCRIPTIONS, MODIFIER, UOS, AND POS

Attachment G

Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
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
CLINIC - FAMILY PLANNING								
08	370	S9075			Smoking Cessation Treatment	15 min	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
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	S9075			Smoking Cessation Treatment	15 min	12, 31, 32, 49	40

PT, PC w/ DESCRIPTIONS, MODIFIER, UOS, AND POS

Attachment G

Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
CLINIC - INDEPENDENT MEDICAL/SURGICAL CLINIC								
08	082	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
08	370	S9075			Smoking Cessation Treatment	15 min	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
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

PT, PC w/ DESCRIPTIONS, MODIFIER, UOS, AND POS

Attachment G

Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
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	96101		HB	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
08	074	96101	TF	HB	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	15	43
08	074	96101	TG	HB	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
08	074	96101	UB	HB	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
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
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

PT, PC w/ DESCRIPTIONS, MODIFIER, UOS, AND POS

Attachment G

Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
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	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
08	184	96101	TG		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	12, 57	17
08	184	96101	UB		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	12, 57	17

PT, PC w/ DESCRIPTIONS, MODIFIER, UOS, AND POS

Attachment G

Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
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	S9075			Smoking Cessation Treatment	15 min	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
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
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

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
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	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, 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	12, 49	9
08	110	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, 49	9
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	S9075			Smoking Cessation Treatment	15 min	49	40

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
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	S9075			Smoking Cessation Treatment	15 min	11, 12, 31, 32	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
09	548	H2014	UB	HA	Skills Training & Development (Less than 6 months)	15 min	12, 99	13, 14
09	548	H2021	UB		Community-based Wraparound Svcs (TSS)	15 min	12, 23, 99	13, 14
DENTIST								
27	370	S9075			Smoking Cessation Treatment	15 min	11, 12, 22, 31, 32, 49	40
HOME HEALTH								
05	370	S9075			Smoking Cessation Treatment	15 min	12, 99	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	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	010	N/A			Clozapine	N/A	N/A	21
01	010	90870			ECT Therapy (includes necessary monitoring)	1 treatment	22	9
01	370	S9075			Smoking Cessation Treatment	15 min	22	40
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

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
01	019 or 441	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	370	S9075			Smoking Cessation Treatment	15 min	22	40
INPATIENT FACILITY - EXTENDED ACUTE PSYCHIATRIC CARE								
01	018	N/A			Inpatient Psych Svcs	N/A	N/A	3
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
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

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
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
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
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

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
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		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	110	H2015		HW	Comprehensive Community Support Svcs (Family Support Svc)	15 min	99	32
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	129	H2035		HF	Alcohol and/or Drug Treatment Program (Intensive Partial Hosp D&A)	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
PHARMACY								
24	370	S9075			Smoking Cessation Treatment	15 min	11, 12	40
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
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

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
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	96101		U1	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 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, 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	11, 21	12
31	339	96101	TG	U1	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	11, 21	12

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
31	339	96101	UB	U1	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	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	339	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	339	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	339	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	339	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
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	339	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	339	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	339	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	339	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

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
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	339	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	339	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
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

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
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
34	339	99271			Confirmatory Consult for New or Established Patient, Problem Self Ltd or Minor -- End-date 06/30/09	Occurrence	11, 12, 21, 23, 31, 32, 54, 65	12
34	339	99272			Confirmatory Consult for New or Established Patient, Problem Low -- End-date 06/30/09	Occurrence	11, 12, 21, 23, 31, 32, 54, 65	12
34	339	99273			Confirmatory Consult for New or Established Patient, Problem Moderate -- End-date 06/30/09	Occurrence	11, 12, 21, 23, 31, 32, 54, 65	12
34	339	99274			Confirmatory Consult for New or Established Patient, Problem Moderate to High -- End-date 06/30/09	Occurrence	11, 12, 21, 23, 31, 32, 54, 65	12
34	339	99275			Confirmatory Consult for New or Established Patient, Problem Moderate to High -- End-date 06/30/09	Occurrence	11, 12, 21, 23, 31, 32, 54, 65	12
31	315, 316, 322, 339, 345	99281			ER Visit for Eval & Mgmt of Patient, Problem Self Ltd or Minor	Visit	23	12
31	315, 316, 322, 339, 345	99282			ER Visit for Eval & Mgmt of Patient, Problem Low to Moderate	Visit	23	12

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
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
34	339	99301			Eval & Mgmt of New or Established Patient, Stable, Recovering, or Improving, at bedside- End-date 6/30/09	30 min	31, 32	12
34	339	99302			Eval & Mgmt of New or Established Patient, Unstable or Significant Complication, at bedside-End-date 6/30/09	40 min	31, 32	12
34	339	99303			Eval & Mgmt of New or Established Patient, Moderate to High Complexity, at bedside-End-date 6/30/09	50 min	31, 32	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

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
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
34	339	99311			Subsequent Nursing Facility Care, per Day, for Eval & Mgmt of New or Established Patient, Stable, Recovering, or Improving, at bedside End-date 6/30/09	15 min	31, 32	12
34	339	99312			Subsequent Nursing Facility Care, per Day, for Eval & Mgmt of New or Established Patient, Response Inadequate or Minor Complications, at bedside End-date 6/30/09	25 min	31, 32	12
34	339	99313			Subsequent Nursing Facility Care, per Day, for Eval & Mgmt of New or Established Patient, Significant Complication or New Problem, at bedside End-date 6/30/09	35 min	31, 32	12
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	S9075			Smoking Cessation Treatment	15 min	11, 12, 22 , 31, 32, 49 , 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

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
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
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	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

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
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
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	S9075			Smoking Cessation Treatment	15 min	11, 12, 31, 32	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, 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
19	190	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 (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, 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
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

Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
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
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
OTHER SERVICES (MA DEFINED - NON-BEHAVIORAL HEALTH)								
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
OTHER SERVICES (NON-MA BEHAVIORAL HEALTH)								
21	212*	T1016	U8		Case Management (CM)	15 min	11, 12, 21	38
THERAPIST								
17	171	97150		GO	Therapeutic procedure(s), group (2 or more individuals) (Collage Program)	15 min	11	39
TOBACCO CESSATION								
37	370	S9075			Smoking Cessation Treatment	15 min	11, 12, 22 , 31, 32, 49 , 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

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
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
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

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
08	110	96101		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 (Generally Accepted Individual Measurements or Generally Accepted Graphic Technique)	per occurrence	11, 12	13, 14
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

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
11	113, 114, 548, 549, or 559	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, 99	13, 14
11	115	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	12, 99	13, 14
08	110	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, 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, 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, 99	13, 14
11	115	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	12, 99	13, 14
08	110	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, 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, 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, 99	13, 14
11	115	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	12, 99	13, 14

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Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
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
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 <i>(Generally Accepted Projective Technique)</i>	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 <i>(Generally Accepted Projective Technique)</i>	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 <i>(Any Combination of Four or More Intellectual or Personality Evals Listed)</i>	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 <i>(Any Combination of Four or More Intellectual or Personality Evals Listed)</i>	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 <i>(Any Combination of Four or More Intellectual or Personality Evals Listed)</i>	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 <i>(Comprehensive Neuropsychological Eval w/ Personality Assessment)</i>	per hour	11, 12, 99	13, 14

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Attachment G

Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
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
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

PT, PC w/ DESCRIPTIONS, MODIFIER, UOS, AND POS

Attachment G

Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
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
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

PT, PC w/ DESCRIPTIONS, MODIFIER, UOS, AND POS

Attachment G

Pvr Type	Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	Place of Service	Refer to Line Item
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
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 Medical Crossover. Please refer to the Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) Manual for more information for all clients.								

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
		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
		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

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
		452	Family Based MH Behavioral Specialist Consultant
		453	Family Based MH Summer Therapeutic Activity Program
		548	Therapeutic Staff Support
		549	Mobile Therapy
559	Behavioral Specialist Consultant		
16	Nurse	162	Psychiatric Nurse
17	Therapist	171	Occupational Therapist
		174	Art Therapist
		175	Music Therapist
19	Psychologist	190	General Psychologist
		370	Tobacco Cessation
		548	Therapeutic Staff Support
		549	Mobile Therapy
		559	Behavioral Specialist Consultant
21	Case Manager	076	Peer Specialist
		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
24	Pharmacy	370	Tobacco Cessation
27	Dentist	370	Tobacco Cessation
28	Laboratory	280	Independent Laboratory

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
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
49	Independent Clinic		

**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 month of each contract year; the Beginning Balance for the 2nd and subsequent months should be the Ending Balance of the previous month.
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 month of the contract year; the Beginning Balance for the 2nd and subsequent months should be the Ending Balance of the previous month.
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 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 - MCO Assessment	2	9d)	Primary Contractor Administrative Expenses - MCO Assessment	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 - MCO Assessment			
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 Month \$ Amounts	N/A	Y	Totals only.

HEALTHCHOICES BEHAVIORAL HEALTH FINANCIAL REPORTING

Beaver, Fayette and Greene Counties, Lehigh Capital: Cumberland, Dauphin, Lancaster, Lebanon and Perry,
NBHCC AND North Central State Option

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 month of each contract year; the Beginning Balance for the 2nd and subsequent months should be the Ending Balance of the previous month.
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

Beaver, Fayette and Greene Counties, Lehigh Capital: Cumberland, Dauphin, Lancaster, Lebanon and Perry,
NBHCC AND North Central State Option

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 - MCO Assessment	2	9d)	Primary Contractor Administrative Expenses MCO Assessment	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 Month \$ Amounts	N/A	Y	Totals only.

HEALTHCHOICES BEHAVIORAL HEALTH FINANCIAL REPORTING

Southwest: Armstrong, Butler, Indiana, Lawrence, Washington, and Westmoreland
NC County Option: NWBHP and Blair 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 month of each contract year; the Beginning Balance for the 2nd and subsequent months should be the Ending Balance of the previous month.
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.
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 month of the contract year; the Beginning Balance for the 2nd and subsequent months should be the Ending Balance of the previous month.
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	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: Armstrong, Butler, Indiana, Lawrence, Washington, and Westmoreland
 NC County Option: NWBHP and Blair 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 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 - MCO Assessment	2	9d)	Primary Contractor Administrative Expenses MCO Assessment	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 - MCO Assessment			
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 Month \$ Amounts	N/A	Y	Totals only.

HEALTHCHOICES BEHAVIORAL HEALTH FINANCIAL REPORTING

Southeast: Bucks and Montgomery
 Southwest: Allegheny
 Lehigh Capital: Adams, Berks, Lehigh, Northampton and York
 North Central County Option: BHSSBC and CMP

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 month of each contract year; the Beginning Balance for the 2nd and subsequent months should be the Ending Balance of the previous month.
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 Medicare 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 month of the contract year; the Beginning Balance for the 2nd and subsequent months should be the Ending Balance of the previous month.
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 or Northampton County. 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

Southeast: Bucks and Montgomery
 Southwest: Allegheny
 Lehigh Capital: Adams, Berks, Lehigh, Northampton and York
 North Central County Option: BHSSBC and CMP

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 - MCO Assessment	2	9d)	Primary Contractor Administrative Expenses - MCO Assessment	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 - MCO Assessment			
9A	16e)	Administration - Distributions to Management Corporation/ASO	2	9e)	Primary Contractor Administrative Expenses - Dist. to Mgmt. Corp./ASO	Y	Y	Should be \$0 EXCEPT for Allegheny County.
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 Month \$ Amounts	N/A	Y	Totals only.

HEALTHCHOICES BEHAVIORAL HEALTH FINANCIAL REPORTING

Southeast Counties: Chester and Delaware
 North Central County Option: Cambria, Erie, Lycoming Clinton Joinder Board, and Tuscorara 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 month of each contract year; the Beginning Balance for the 2nd and subsequent months should be the Ending Balance of the previous month.
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 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 month of the contract year; the Beginning Balance for the 2nd and subsequent months should be the Ending Balance of the previous month.
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 (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, Erie, Lycoming Clinton Joinder Board, and Tuscorara 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 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 - MCO Assessment	2	9d)	Primary Contractor Administrative Expenses MCO Assessment	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 - MCO Assessment			
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 Month \$ 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

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