North Carolina

Prepaid Inpatient Health Plans

Financial Reporting Manual

Issued September 2012 (Updated December 2015)

Contents

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Introduction and General Instructions

1.01 Introduction

The provisions and requirements of the Financial Reporting Manual (Manual) are effective April 2012. The purpose of this Manual is to set forth reporting requirements for the Prepaid Inpatient Health Plans (PIHPs) contracted with the State of North Carolina (State). The Manual and financial reporting template (template) are supplementary to any other reporting requirements of the State. The template does not replace any State electronic data submission requirements or quality compliance-oriented reporting requirements from the PIHPs.

All reports shall be submitted as outlined in the general and report-specific instructions. **The financial reports submitted based on the Manual will be used to monitor the operations of the PIHPs and may be used as a potential data source in capitation rate setting.** There must be a segregation of reporting between revenue, expenditures and balance sheet-related items associated with the Medicaid PIHPs funding sources, and other State-only or other non-Medicaid funding sources.

All terms and conditions of the State's PIHP contract apply to the template. The Manual and template may be revised as deemed necessary by the State. Sanctions may be enforced for the untimely or inaccurate filing of the financial reports.

The reporting periods contained within the template relate to the PIHP's contract/rate year and may not correspond to the PIHPs fiscal year end. For example, if the PIHP started the Medicaid at-risk contract on December 1, 2012, its first quarter would end on February 28, 2013 and its year end for this template would be November 30, 2013. This would be the situation even if the PIHP has a fiscal year end of June 30, 2013.

1.02 Reporting Time Frames

Amendments and/or updates to this Manual may be issued by the State as deemed necessary. The following table depicts reporting requirements and scheduling. Due dates are based on calendar days. Schedules submitted earlier than the due dates may be accepted.

Schedule	Report name	Frequency	Due date[1]	Format
A	Balance sheet	Monthly	20 days after month end	Predetermined
B	Medicaid risk reserve balance	Monthly	20 days after month end	Predetermined
C	Medicaid income statement	Monthly	20 days after month end	Predetermined
D	Total profitability	Monthly	20 days after month end	Predetermined
D1	Medicaid profitability	Monthly	20 days after month end	Predetermined
D2	Non-Medicaid profitability	Monthly	20 days after month end	Predetermined
E	Medicaid-only medical services lag	Monthly	20 days after month end	Predetermined
E1	Medicaid cash summary	Monthly	20 days after month end	Predetermined
F	Medicaid statistics current year	Monthly	20 days after month end	Predetermined
F1	Medicaid statistics prior year	Monthly	20 days after month end	Predetermined
F2	Non-Medicaid statistics	Monthly	20 days after month end	Predetermined
G	Medicaid claim aging	Monthly	20 days after month end	Predetermined
H	Medicaid claim processing	Monthly	20 days after month end	Predetermined
I	B3 services current year	Quarterly	45 days after quarter end	Predetermined
I1	B3 services prior year	Quarterly	45 days after quarter end	Predetermined
J	Medicaid third party liability and coordination of benefits	Quarterly	60 days after quarter end	Predetermined
K	Medicaid fraud and abuse tracking	Quarterly	60 days after quarter end	Predetermined
L	Supplemental working area	As needed	As needed	Narrative
M	Alternative payment arrangements	Monthly	20 days after month end	Predetermined
N	Fund Balance	Monthly	20 days after month end	Predetermined

Schedule	Report name	Frequency	Due date[1]	Format
AA	Cost allocation plan	Annually	60 days prior to start of fiscal year	Narrative
BB	Audited financial statements	Annually	120 days after fiscal year end	Narrative
CC	OMB circular A-133 audit	Annually	120 days after fiscal year end	Narrative
DD	Related party transactions and obligations	Annually	60 days after year end	Narrative
EE	Physician incentive arrangements	Annually	60 days after year end	Narrative

[1]If a due date falls on a weekend or State recognized holiday, reports will be due the next business day.

1.03 General Instructions

All revenues and expenses must be reported using the full accrual basis method of accounting.

All monthly, quarterly and annual reports must be completed and submitted to the State by the due dates outlined above. The State may extend a report deadline if a request for an extension is communicated in writing and is received at least five business days prior to the report due date. Any request for extension must include the reason for delay and the date by which the report will be filed.

Most line and column descriptions within each report are self-explanatory and, therefore, do not constitute instructions. However, specific instructions are provided in instances when interpretation may vary. Any entry for which no specific instruction is provided should be made in accordance with sound accounting principles and in a manner consistent with related items for which instruction is provided.

Categories of service descriptions are included in Appendix A for consistency with the Data Book summary. Codes included by category of service may vary by PIHP. Always utilize predefined categories or classifications before reporting an amount as “Other.” For any material amount included as “Other”, the PIHP is required to provide **a detailed explanation on Schedule L — Supplemental Working Area**. For this purpose, material is defined as comprising an amount greater than or equal to 5% of the total for each section. For example, if “Other Income” reported is less than 5% of Total Revenue, no disclosure is necessary. However, if “Other Income” were reported with a value that is greater than or equal to 5% of Total Revenue, a disclosure would be necessary. Such disclosure is to be documented on Schedule L — Supplemental Working Area.

Unanswered questions and blank lines or schedules will not be considered properly completed and may result in a resubmission request. Any resubmission must be clearly identified as such. If no answers or entries are to be made, write “None”, not applicable (N/A) or “-0-”, in the space provided.

Only input dollar amounts rounded to the whole dollar. Do not report cents. For example, an item should be entered as $5, not $4.50.

Input areas for the spreadsheet are shaded in red.

1.04 Format and Delivery

The PIHPs will submit these reports using Excel spreadsheets in the format and in the template specified in this Manual without alteration. **Please submit the completed reports and required supplemental materials, such as narrative support for "Other" categories that are considered material in nature, to the PIHP's DMA financial analyst.**

1.05 Certification Statement

The purpose of the certification statement is to attest that the information submitted in the reports is current, complete and accurate. The statement should include the PIHP's name, period ended, preparer information and signatures. In addition, the PIHP must enter the appropriate reporting month of the contract/rate year. The input values for reporting month are 1 through 12. For example, if the PIHP at-risk business started on December 1 and the report is for April, a value of 5 would be input. If the PIHP at-risk business started on January 1 and the report is for August, a value of 8 would be input. **PLEASE NOTE: The months correspond to the contract/rate year and not to the PIHP's fiscal year. This value is critical to ensure that the calculations on the "Medicaid Monitoring" tab are calculated accurately.**

The certification statement must be signed by the PIHP's CFO or CEO and sent electronically via email or mailed to the PIHP's DMA financial analyst.

1.06 Financial Statement Check Figures and Instructions

In addition to the schedules that must be completed by the PIHPs, the template includes an "Instructions and Check Figures" worksheet that evaluates the consistency of the values entered by the PIHPs. The financial statement reporting template instructions and check figures tab lists the instructions for completing the spreadsheet, as well as check figures that identify any differences within specific schedules. The check figures must match prior to the submission of the monthly and annual financial statements. If the check figures do not match, the cells will highlight in red. If the audit check figures do not match, data should be corrected or an explanation should be provided in writing and submitted with the financial statement reporting package.

1.07 Medicaid Monitoring

In addition, the template includes a "Medicaid Monitoring" worksheet that evaluates information contained within the reports. Many of the data fields are automatically calculated within this tab.

However, there are input sections on this tab. The PIHP is required to input the service revenue capitation rate paid to the PIHP by category of service on a per member per month (PMPM) basis. This is compared to the calculated year to date accrued service expenses as a check to compare PIHP operations to the capitation rate. If "Total Capitation Rate PMPM" is less than "Total Year To Date PMPM with Incurred But Not Reported (IBNR)", the PIHP must explain

within Schedule L — Supplemental Working Area the reasons for such variance. In addition, the PIHP is required to input the member months for each month of the current contract/rate year.

1.08 Maintenance of Records

The PIHPs must maintain and make available to the State, and others determined necessary by the State, upon request, the data used to complete any reports contained within this Manual.

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Monthly and Quarterly Reporting Requirements

2.01 Schedule A: Balance Sheet

Current assets are assets that are expected to be converted into cash, used or consumed within one year from the date of the balance sheet. Restricted assets for the general risk reserves, etc., are not to be included as current assets.

The PIHP is required to segregate Medicaid, State, Federal and local assets and liabilities. The methodology for such segregation must be submitted to the State for approval.

Specification	Inclusion	Exclusion
Cash and cash equivalents	Cash and cash equivalents available for current use. Cash equivalents are investments maturing 90 days or less from the date of purchase.	Restricted cash (and equivalents) and any investments pledged by the PIHP to satisfy minimum net worth requirements.
Short-term investments	Investments that are readily marketable and are expected to be redeemed or sold within one year of the balance sheet date.	Investments maturing 90 days or less than one year from the date of purchase and restricted securities.
Medicaid capitation receivable	Capitation payments earned, but not yet received from the State.	Other receivables from the State.
Investment income receivable	Income earned, but not yet received from cash equivalents, investments, performance bonds or short- and long-term investments.	
Receivable from State	Other receivables from the State.	Medicaid capitation receivables.
Other current assets	The total current portion of other assets, which will include all other assets not accounted for elsewhere on the balance sheet. Any receivables from providers due to overpayments should be accounted for in this line item.	

Other assets are assets that are expected to be held for greater than one year of the balance sheet date.

Specification	Inclusion	Exclusion
Risk reserve account	Amounts deposited that require the PIHP to maintain the risk reserve funds in a separate account.	
Long-term investments	Investments maturing 90 days or less than one year from the date of purchase and restricted securities.	Investments that are readily marketable and that are expected to be redeemed or sold within one year of the balance sheet date.
Other non-current assets	Include all other non-current assets not accounted for elsewhere on the balance sheet. Any receivables from providers should be accounted for in this line item.	

Property and equipment consists of fixed assets, including land, buildings, leasehold improvements, furniture, equipment, etc.

Specification	Inclusion	Exclusion
Land	Real estate owned by the PIHP.	
Buildings	Buildings owned by the PIHP, including buildings under a capital lease and improvements to buildings owned by the PIHP.	Improvements made to leased or rented buildings or offices.
Leasehold improvements	Capitalized improvements to facilities not owned by the PIHP.	
Furniture and equipment	Medical equipment, office equipment, data processing hardware, software (where permitted),and furniture owned by the PIHP, as well as similar assets held under capital leases.	
Other — Property and equipment	All other fixed assets not falling under one of the other specific asset categories.	
Accumulated depreciation/amortization	The total of all depreciation and amortization accounts relating to the various fixed asset accounts.	

Current liabilities are obligations whose liquidation is reasonably expected to occur within one year from the balance sheet date.

Specification	Inclusion	Exclusion
Accounts payable	Amounts due to creditors for the acquisition of goods and services on a credit basis.	

Specification	Inclusion	Exclusion
Accrued administrative expenses	Accrued expenses, management fees and any other amounts estimated as of the balance sheet date (e.g.,,payroll, taxes). Also, include accrued interest payable on debts.	
IBNR claims payable	The respective IBNR amounts calculated on an accrual basis estimating the remaining liability of IBNR claims.	
Other services payable	Medical services payable that are not part of the IBNR claims payable amount.	
Current portion — Long-term debt	The total current portion of long-term debt, which will include the principal amount on loans, notes and capital lease obligations due within one year of the balance sheet date.	Long-term portion of and accrued interest on loans, notes and capital lease obligations.
Payable to State	Capitation amounts and non-risk amounts payable to the State as a result of overpayment.	
Other current liabilities	The total current portion of other liabilities, which will include those current liabilities not specifically identified elsewhere.	

Other liabilities are those obligations whose liquidation is not reasonably expected to occur within one year of the date of the balance sheet.

Specification	Inclusion	Exclusion
Non-current portion — Long-term debt	The total non-current portion of long-term debt, which will include the long-term portion of principal on loans, notes and capital lease obligations.	Current portion of and accrued interest on loans, notes and capital lease obligations.
Other non-current liabilities	The total non-current portion of liabilities not specifically identified elsewhere.	

Equity includes reserved, restricted, unreserved fund balances and retained earnings/fund balance. These amounts will populate automatically from the balances described in Schedule N (Fund Balance). See section 2.17 for fund definitions.

Specification	Inclusion	Exclusion
Investment in fixed assets	Fund balance set aside for investment in fixed assets.	
Restricted — Statutes and prepaid	State statute and prepaid reserved fund balance amounts.	

Specification	Inclusion	Exclusion
Restricted — Risk reserve	Risk reserve fund balance amounts set aside and restricted in use until approval by State.	
Restricted — Other	Other restricted fund balance amounts.	
Unreserved — Medicaid earnings prior years	Excess of revenues over expenses from prior years. Excess of expenses over revenues from prior years would be shown as a negative amount. Any amounts redirected to other funds should be described in detail in Schedule L.	Current year earnings/loss amounts.
Unreserved — Medicaid earnings current year	Excess of revenues over expenses from current year. Excess of expenses over revenues from current year would be shown as a negative amount. Any amounts redirected to other funds should be described in detail in Schedule L.	Prior year earnings/loss amounts.
Unreserved — Committed	Funds used for specific purposes pursuant to constraints imposed by formal action of the government's highest level of decision-making authority	
Unreserved — Assigned	Funds constrained by the government's intent to be used for specific purposes, but are neither restricted nor committed.	
Unreserved — Unassigned Other	Other unreserved fund balance amounts.	Other earnings from prior or current contract/rate year(s) that are neither committed nor assigned.

2.02 Schedule B: Medicaid Risk Reserve Balance

This report indicates the activity taking place in the risk reserve account. The information contained within this report should be consistent with the balance sheet (ending risk reserve balance) and income statement (deposits to risk reserve account). Note: An estimate of how close the balance of the account is to 15% of annual revenue is provided; however, as membership and annual estimates of revenue fluctuate, any amounts included in the monthly capitation rate explicitly for increasing the risk reserve balance should be deposited into the risk reserve account.

Specification	Inclusion	Considerations
Balance at beginning of reporting period	This is the beginning balance of the risk reserve account at the start of the current reporting period.	
Interest earned in risk reserve account	This is the interest earned within the risk reserve account during the current reporting period.	

Specification	Inclusion	Considerations
Deposits to risk reserve account	This is the cumulative deposits to the account based upon the percentage included within the capitation payment during the current reporting period.	This amount should equal the balance of risk reserve revenue from the Medicaid profitability statement.
Adjustment to bring to 15% of last year's revenue	Once the risk reserve balance equals 15% of last year's revenue, an adjustment will be reported in this line item.	After the balance reaches 15%, the capitation rate will not include the risk reserve add-on percentage.
Ending risk reserve balance	This is an automatic calculation of the activity in the risk reserve account throughout the reporting period.	This amount should equal the balance of the risk reserve account on the balance sheet.

2.03 Schedule C: Medicaid Income Statement

The PIHP shall report revenues and expenses using the full accrual method. The Medicaid Income Statement is a cumulative quarterly summarization and year-to-date (YTD) report on Medicaid revenues and expenses only. The report is completed in total across all rating groups. In addition, the report includes a YTD total for the prior year. This will be input based upon prior year's data. For example, if this report is being completed for the first six months YTD of the current contract/rate year, the PIHP should include the prior year's first six months YTD information in the prior year to date column. Please note that all quarters relate to the contract/rate year. For example, if the PIHP at-risk Medicaid business started on December 1, the quarter ends would be February 28, May 31, August 31 and November 30. In addition, the contract/rate year end would be November 30. The date field for the appropriate quarters must be updated with each monthly report submission.

NOTE: First year rates may not be in effect a full year.

Specification	Inclusion	Exclusion
Total member months	A member month is equivalent to one member for whom the PIHP has received and/or accrued at-risk capitation-based revenue.	
Service revenue	Revenue received and/or accrued on a prepaid basis for the provision of services on an at-risk basis.	
Administrative revenue	Revenue received and/or accrued on a prepaid basis for the provision of administrative services on an at-risk basis.	
Risk reserve revenue	Revenue received and/or accrued for the risk reserve set aside for Medicaid.	
Other income/revenue	Revenue from sources not identified in the other revenue categories, including investment income.	

Medical expenses and recoveries — Medical expenses must be reported net of third party reimbursement and coordination of benefits (e.g., Medicare and other commercial insurance) and in correspondence to the identified categories of service as identified in the Data Book. Expenses should be reported as **paid claims** only and include the IBNR current and prior period adjustments in lines 22 and 23. Line 22 should include the net effect of changes in IBNR for the current quarter. Line 23 should include changes to prior quarters, including claims run-out and changes in prior period estimates.

Expenses should align with categories of service descriptions included in Appendix A for consistency with the Data Book. The Data Book breaks out service expenses in the following categories (as should be reported within this schedule):

Specification
Inpatient
Community Support
Behavioral Health (BH) Long-term Residential
Psychiatric Residential Treatment Facilities (PRTF)
Case Management
Outpatient
Assertive Community Treatment Team (ACTT)
Multisystemic Therapy (MST)
Intensive In-home Service (IIHS)
Partial Hosp/Day Tx
Psych Rehab
Crisis Services
Innovations
Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR)
1915(b)(3) services

Recoveries are input as adjustments to calculate the net medical costs of the PIHPs. The categories and descriptions for recoveries are listed in the table below. These items should be used only in instances that the recovery is not reported in the claim system. Recoveries that are reported in the claim system should be netted against the claim payment and be reported in the appropriate category of service as identified above.

Specification	Inclusion	Exclusion
Third party liability and coordination of benefits recoveries	Cost recoveries subsequent to the payment of a claim that has not been adjusted to the original claim for recoveries associated with third-party resources.	Do not include coordination of benefit payments that are deducted from payments to providers in the normal course of claims processing.
Fraud and abuse recoveries	Payments to the PIHP as a result of State, PIHP or Provider-sponsored recovery efforts.	
Other recoveries	Other recoveries of medical claims previously paid not included in a category above.	

This schedule should report all administrative expenses and should use the following guidance for reporting administrative activities. These expenses should only include expenses associated with the administration of the Medicaid program.

Specification	Inclusion	Exclusion
Salary and wages	Salaries and wages paid to staff persons of the PIHP.	Professional services and other consulting fees.
Payroll benefits and expenses	Payroll taxes and benefits related to the staff persons of the PIHP.	
Professional services	Fees paid to professional services companies and consulting companies, including information technology (IT) and claim processing functions, for the assistance and management of PIHP operations.	
Supplies and materials	Supplies and materials of the PIHP.	
Travel and vehicles	Travel and vehicles expense of the PIHP.	
Utilities and postage	Utilities and postage of the PIHP.	
Capital expenses	Capital expenses of the PIHP that are not capitalized as an asset, excluding IT expenses	Capitalized assets purchased during the reporting period.
IT	Non-capitalized IT expenses such as minor upgrades or consulting fees.	Capitalized IT costs.
One-time investments/Discontinued operations	Non-ongoing expenses and costs associated with discontinued operations including consulting fees and costs associated with area expansion, contraction or mergers.	Capitalized assets and recurring expenses expected for growth, contraction or mergers.
Lobbying costs	Expenses paid for lobbying activities and political contributions.	
Sanctions	Expense incurred resulting from federal or state sanctions.	
Interest expense	Interest incurred for the late payment of claims.	

Specification	Inclusion	Exclusion
Other expenses	Those administrative expenses not specifically identified elsewhere.	Other administrative expenses indicated elsewhere.
Developmentally Disabled (DD) treatment planning	Expenses associated with the planning of treatment for DD recipients.	
Mental Health and Substance Abuse (MH/SA) treatment planning	Expenses associated with the planning of treatment for MH/SA services.	
Property expenses	Expenses and depreciation/amortization associated with the property and or lease of the PIHP.	Capitalized assets purchased during the reporting period.

Additional non-operating items are required to be reported. These items are described below:

Specification	Inclusion	Exclusion
Risk reserve set asides	The amount placed into the risk reserve account.	
Other income/(loss)	Any other income/loss not included elsewhere in the income statement.	

2.04 Schedule D: Total Profitability

This report is meant to provide detailed information on revenues and expenses for all funding sources. The columns of Schedule D are automatically calculated from the Medicaid Profitability (Schedule D1) and the Non-Medicaid Profitability (Schedule D2) reports. This schedule is a cumulative summarization of the profit/loss for the current contract/rate year.

2.05 Schedule D1: Medicaid Profitability

Schedule D1 reports the results of operations by Medicaid eligibility category and is a cumulative summarization of the profit/loss for the current contract/rate year. The table below lists the population categories and procedure codes that help define each group for reporting purposes.

Category of Aid
AFDC Ages 3+
Foster Children, Ages 3+
Aged, Ages 65+
Blind/Disabled < 21, Ages 3-20
Blind/Disabled > 21, Ages 21+
Innovations, all Ages
Open

The definitions associated with the specific revenue and expense lines detailed in Schedule C (Medicaid Income Statement) and in Appendix A are applicable for this schedule as well. Data included in the Open column should be documented on Schedule L — Supplemental Working Area.

2.06 Schedule D2: Non-Medicaid Profitability

Schedule D2 reports the results of operations by non-Medicaid funding source on a YTD basis that corresponds to the Medicaid contract/rate year. The table below lists the groups that help define each category for reporting purposes.

Population category	Other Identification Method
Federal	Funding sources received from the federal government for the provision of services and administration.
State and Fund Balances	Funding sources received from the State for the provision of services and administration. Include in this column on line 3 the portion of fund balance utilized to reduce single stream funding for the 2015–2016 fiscal year and for the 2016–2017 fiscal year.[1]
Local	Funding sources received from counties or from a local management entity (LME) fund balance for provision of services and administration.
Other lines of business	Revenue associated with other lines of business.
Other	Other funding sources not identified above.
Division of Prisons YTD # Receiving Services	The unique unduplicated count of recipients receiving services based on date of payment, fiscal YTD, for each expenditure category with an expenditure amount.

The definitions associated with the specific revenue and administrative expense lines detailed in Schedule C (Medicaid Income Statement) are applicable for this schedule as well. Data included in the Open column should be documented on Schedule L — Supplemental Working Area. The crosswalk from Procedure Code to Service Category listed in the Service Expenditure section can be found in Appendix B. Non-unit cost reimbursement (Non-UCR) expenditures are split between disabilities based on the purpose of the program under contract. For example, Non-UCR dollars that purchased a van for a DD Day Program would be recorded under Intellectual and Developmental Disabilities (IDD). If the program serves multiple disabilities, then the dollars should be prorated based on the prior year's shadow claims (when available) or other documentation (when shadow claims are not available).

2.07 Schedule E: Medicaid-only Medical Services Lag

Schedule E lists the payments by month of service and the remaining estimated IBNR by service month. The table is arranged with the month of service horizontally and the 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 C, while payments made during

[1] Session Law 2015-241 Sections 12F.2(c).

the current month for services rendered in prior months would be reported on line 1, columns D through AM. Lines 1 through 3 contain data for payments made in the current quarter. Earlier data on lines 4 through 37 shall match data on appropriate lines on the prior period's submission. If lines 4 through 37 change from the prior period's submission, include an explanation. The current month is the last month of the period that is being reported.

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

Service costs must be reported net of third party liability and coordination of benefits. 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 in a footnote.

Line 39 — **Subcapitation and other non-claim payments:** Global/subcapitation payments should be reported on this line by month of payment, and should not be included in any lines above line 39. Also, include other payment for medical expenses not paid through the claims system. **All amounts reported on line 39 should be documented on Schedule L — Supplemental Working Area.** Global/Subcapitation payments include:

- Global capitation payments: Payments made to fully delegated risk entities contracted with the PIHP. These types of payments are expected to be broken out between the appropriate categories of service.
- Subcapitation payments: Those services paid through a normal provider capitation agreement. Examples would include PMPM payments for a specified list of services.

Line 40 — **Settlements:** The PIHP should report payments/recoupment on lines 1 through 37 to the extent possible. If the PIHP makes a settlement or other payment that cannot be reported on lines 1 through 37 due to lack of data, the amount must be reported on line 40 with the payment month used as a substitute for the service month. The PIHP may use an alternative method of reporting settlements that restates prior period amounts to reflect an actual settlement for that month. **For all amounts reported on line 40, include a footnote explanation on Schedule L — Supplemental Working Area.** Do not include adjustments to IBNR amounts on this line.

Settlements should include payments to or refunds from providers that cannot be linked to a specific claim adjudicated through the payment system. For instance, fraud abuse recoupments, incentive payments and inaccurate payment settlement agreements with a provider that have not been captured through the claims payment system should be included.

Line 41 — **Claims paid outside the claims system:** The PIHP should report payments/recoupment on lines 1 through 37 to the extent possible. If the PIHP makes a claim payment outside the claim system that is not a result of a settlement, the amount must be reported in this line with the payment month used as a substitute for the service month. **All amounts reported on line 41 should be documented on Schedule L — Supplemental Working Area.** Do not include adjustments to IBNR amounts on this line.

Line 42 — This line is the total amount paid to date (including subcapitation) for services rendered and should equal the sum of lines 38 through 41. This line will calculate automatically.

Line 43 — Current estimate of remaining medical expense liability (IBNR): Amounts on this line represent the current estimates for unpaid claims by month of service for the past 36 months, and the aggregate amount for all prior months. The PIHP must determine a new IBNR amount for each service month and include this amount on line 43. The development of each IBNR should be based on the most recent paid claims data. The remaining estimate of IBNR includes services incurred for which PIHP has not yet received the claim; claims that the PIHP has received, but that have not yet processed; and claims that the PIHP has received and processed, but for which the PIHP has not mailed the check.

Line 44 — Total incurred claims: Total incurred claims is the sum of line 42 (amounts paid to date) and line 43 (IBNR). These amounts represent current estimated amounts ultimately to be paid for medical services by month of service for the past 36 months, and for all months prior to the 36th month. Each amount represents the medical expense for a particular month, not including adjustments to prior month IBNR claims estimates. This amount is comprised of claims for the incurred month known to be paid by the end of the reporting period, plus claims for the incurred month estimated to be unpaid at the end of the reporting period.

Line 45 — Prior period IBNR adjustments recorded in general ledger: At any point in time, the PIHP may review its prior period IBNR estimates and determine that it has over/under-accrued medical expenses for a prior period. To the extent that an adjustment is recorded in the general ledger during the current reporting period, that amount must be entered in this column. This is needed to ensure that the total services per the general ledger agree to this report for a given reporting period. This adjustment is only applicable for the current reporting period.

Line 46 — Total service expense per the general ledger: This column calculates automatically and is only applicable for the current reporting period.

Line 47 — Original estimate of total incurred claims for service month: This column provides the original estimate of total medical service expense for a service month. It is used to evaluate how well the PIHP estimates its liabilities and medical expenses. This amount will not change over time as adjustments to IBNR expenses are made. To evaluate how well the PIHP is estimating its total incurred medical expenses, compare this line to line 44 over time. If line 44 is greater than line 47 on a consistent basis, the PIHP is underestimating IBNR; if line 44 is less than line 47 it is overestimating IBNR. For example, in the illustration below, if line 44 for the service month of November as of November is $1 million, then line 47 for the service month of November is $1 million. If, in December, the plan determines that line 44 for November should only have been $900 thousand, line 43 will reflect the change in remaining IBNR and line 44 will show $900 thousand, but line 47 will remain at $1 million for the month of November.

Example as of November
Schedule E
Medicaid only medical services lag report
12/31/2013

Line	Month of payment	Dec-13	Nov-13
2	November-13		$ 450,000
3	October-13		
4	September-13		
37	Months Before 35th Prior Month		
38	Total Claim Payments (Total lines 1 through 37)	$ -	$ 450,000
42	Sum of Claim Payments, Capitation Payments and Settlements (lines 38+39+40+41)	$ -	$ 450,000
43	Current Estimate of Remaining Medical Expense Liability by Service Month (Claims Incurred But Not Reported)	$ -	$ 550,000
44	Total Incurred Claims by Service Month (lines 42+ 43)	$ -	$ 1,000,000
45	Prior Period IBNR Estimate Adjustments Recorded in General Ledger	$ -	$ -
46	Total Service Expenses Per General Ledger (lines 44 + 45)	$ -	$ 1,000,000
47	Original Estimate of Total Incurred Claims for Service Month	$ -	$ 1,000,000

Ties to line 44

Example As of December
Schedule E
Medicaid only medical services lag report
12/31/2013

Line	Month of payment	Dec-13	Nov-13
1	December-13	$ 475,000	$ 300,000
2	November-13		$ 450,000
3	October-13		
4	September-13		
37	Months Before 35th Prior Month		
38	Total Claim Payments (Total lines 1 through 37)	$ 475,000	$ 750,000
42	Sum of Claim Payments, Capitation Payments and Settlements (lines 38+39+40+41)	$ 475,000	$ 750,000
43	Current Estimate of Remaining Medical Expense Liability by Service Month (Claims Incurred But Not Reported)	$ 500,000	$ 150,000
44	Total Incurred Claims by Service Month (lines 42+ 43)	$ 975,000	$ 900,000
45	Prior Period IBNR Estimate Adjustments Recorded in General Ledger	$(100,000)	$ -
46	Total Service Expenses Per General Ledger (lines 44 + 45)	$ 875,000	$ 900,000
47	Original Estimate of Total Incurred Claims for Service Month	$ 975,000	$1,000,000

Adjusted in Dec

Does not

Schedule E must provide data for the period beginning with the first month the PIHP is responsible for providing medical benefits to recipients and ending with the current month.

2.08 Schedule E1: Medicaid Cash Summary

Schedule E1 lists the payments by month of service (service and administration) and revenue by month. The end result of the Schedule is a cash flow summary for the Medicaid operations of the PIHP.

Lines 1–37 — Total claim payments: These lines represent claims payments and follow the same format as Schedule E (Medicaid-only Medical Services Lag).

Lines 38 — All non-claim medical payments: This line represents all non-claim medical payments made during the month on a cash basis. It can include all settlements, non-claim payments, capitation payments, etc.

Lines 39 — Sum of cash payments for service expenses: This line represents all cash payments for service expenses and is a summation of lines 37 and 38.

Lines 40 — Total service revenue received for month: This line represents the cash capitation payments made by the State to the PIHP on a cash basis for medical services.

Lines 41 — Total cash remaining for services: This line represents the positive or negative cash flow for service revenue and expenses and is line 40 less line 39.

Lines 42 — Total administrative expenses: This line represents all administrative expenses paid during the month.

Lines 43 — Total administrative revenue received for month: This line represents the cash capitation payments made by the State to the PIHP on a cash basis for administration.

Lines 44 — Total cash remaining for administration: This line represents the positive or negative cash flow for administrative revenue and expenses and is line 43 less line 42.

Lines 45 — Total cash from Medicaid: This line represents the positive or negative cash flow for the Medicaid line of business and is a summation of line 41 and line 44.

2.09 Schedules F and F1: Medicaid Statistics

The PIHP shall submit a summary of utilization and unit cost information. The information is reported by **DATE OF SERVICE** and should correspond with the data reported in Schedule E**.** The PIHP should report the data for the two most recent contract/rate years (F — current contract/rate year and F1 — previous contract/rate year). The current contract/rate year table should continue to be updated by month. The previous contract/rate year table should include all data as reported at the end of the prior contract/rate year. Input areas are highlighted in red where data should be entered and calculations are automatically made to show cost per user, utilization per user and cost per service. The categories of service are consistent with the previous income and profitability statements and match the information contained within the Data Book.

The following table provides guidance on the inputs within this schedule.

Category	Description
Paid claims	The total dollar value of paid claims for a given month by category of service.

Category	Description
Unique members receiving services	The unique unduplicated count of recipients receiving a service for a month by category of service.
Units of service	The number of units paid by category of service.

2.10 Schedule F2: Non-Medicaid Statistics

The LME/managed care organization (MCO) shall submit a summary of utilization and unit cost information. The information is reported by **DATE OF SERVICE.** The LME/MCO should report the data for the two most recent state fiscal years. The current contract/rate year table should continue to be updated by month. The previous fiscal year table should include all data as reported at the end of the prior state fiscal year. Input areas are highlighted in red where data should be entered and calculations are automatically made to show cost per user, utilization per user and cost per service.

The following table provides guidance on the inputs within this schedule.

Category	Description
Paid claims	The total dollar value of paid claims for a given month by Disability. Disability is determined based on the primary diagnosis on the claim, utilizing the Diagnosis to Disability crosswalk in the "LME-MCO Performance Measurement and Reporting Guide".
Unique members receiving services	The unique unduplicated count of recipients receiving a service for a month by disability.
Units of service	The number of units paid by disability.
YTD # receiving services	The unique unduplicated count of recipients receiving a service YTD by disability.

2.11 Schedule G: Medicaid Claim Aging

This report provides information on outstanding claims at the end of a reporting period and the total claims processed during the reporting period. The claim inventory counts are to be reported by the appropriate expense (i.e., inpatient, emergency room and other) and aging (i.e., 1–30 days, 31–60 days, 61–90 days, 91–120 days and greater than 120 days). Note the aging of a claim starts the day it is received by the PIHP. The PIHP is encouraged to run reports close to reporting deadline to determine a more accurate estimate of outstanding and adjudicated claims that were in process as of the end of the reporting period. Claims should be counted at the header level, not the line item level. **Explanations for aging that is over 90 days should be documented on Schedule L — Supplemental Working Area.**

In addition, include a count of total claims adjudicated during the reporting period by appropriate claim category.

2.12 Schedule H: Medicaid Claim Processing

This report provides statistics on the count (header level) and dollar amount of claims processing statistics. This information must be completed by **claims processing dates — NOT** by service month. Prior Month and Second Prior Month amounts should tie to the preceding amounts reported on Schedule H for the previous month. The information is reported by month of the contract/rate quarter. Lines 1 through 7 relate to claim counts and lines 8 through 11 relate to dollar amounts. A description of each category is provided in the table below. Note: A partially paid claim should be considered a paid claim. Examples are listed in Appendix C.

Line	Category	Description
1	Total number of claims received	The total number of claims received during the month.
2	Claims approved and paid	Claims that have processed through the system and a check/explanation of benefits (EOB) has been SENT to the provider.
3	Claims denied	Claims that have processed through the system and have been denied.
4	Claims approved not paid	Claims that have processed through the system and a check/EOB has NOT been sent to the provider.
5	Claims pended	Claims that have processed but have pended for additional review.
6	Claims in process or no status	Claims that are in process or that have no status within the claim system. This can include claims received but not input and claims awaiting processing.
7	Total claims	Summarization of lines 2 through 6.
8	Claims approved and paid	The dollar amounts of claims that have processed through the system and a check/EOB has been SENT to the provider. The dollar amount reported should be the PIHP paid amount.
9	Claims denied	The dollar amounts of claims that have processed through the system and been denied. The dollar amount reported should be the provider billed amount.
10	Claims approved not paid	The dollar amounts of claims that have processed through the system and a check/EOB has NOT been sent to the provider. The dollar amount reported should be the PIHP paid amount.
11	Claims pended	The dollar amounts of claims that have processed but have pended for additional review. The dollar amount reported should be the PIHP allowed amount.

2.13 Schedules I and I1: B3 Services

The PIHP shall submit summary cost information for 1915(b)(3) services. The information is reported by **DATE OF SERVICE.** The PIHP should report the data for the two most recent contract/rate years (I — current contract/rate year and I1 — previous contract/rate year). The current contract/rate year table should continue to be updated by quarter. The previous contract/rate year table should include all four quarters of data as reported at the end of the

prior contract/rate year. Input areas are highlighted in red where total cost of claim payments by category of service should be input. The category of 1915(b)(3) services is as follows:

- Respite
- Psychological Rehab (Peer Support)
- Community Guide
- Supported Employment/Employment Specialist
- Personal Care (Individual Support)
- One-time Transitional Costs
- NC Innovations Waiver Services
- Physician Consultation
- Other 1915(b)(3) services not included above

In addition, the report is completed by population category as defined in Schedule D1 (Medicaid Profitability).

2.14 Schedule J: Medicaid Third Party Liability and Coordination of Benefits

List all third party liability resource payments made for members with active commercial or Medicare coverage on the date of claim service during the quarter. Provide the count of claims, count of claims cost avoided, amount billed, amount paid and the total resource payments paid by other insurance for commercial and Medicare recipients. All claim counts and amounts should be reflected even if no coordination of benefits took place when adjudicating the claim. Claims cost avoided are those denied in the period for lack of evidence of coordination of benefits by the provider for a member with a known third party liability resource on the date of service. For claims cost avoided, the amount billed should be reported. For claims that are adjusted in the period or for prior periods in the reporting quarter, each re-adjudication should be counted along with amounts reported. Report the count of members with active third party liability resources at the end of the quarter on lines 8 and 9. Do not include counts or amounts for members where third party liability subrogation is being pursued.

2.15 Schedule K: Medicaid Fraud and Abuse Tracking

List all new, active and closed fraud and abuse cases for the quarter. Include the count of related claims for each case by the provider name and/or case identification number. Indicate with a “Y” if the case is new, active or closed. Do not include member-specific names or identification numbers on the schedule. Include cases and recoveries regardless of whether or not they are processed through the claims system.

2.16 Schedule L: Supplemental Working Area

This schedule should be used by the PIHP for working purposes or as a supplemental reference area for financial statement disclosures.

2.17 Schedule M: Alternative Payment Arrangements

List all alternative payment arrangements with activity during the plan year by provider. Add a new line for each location where pricing may be different. If the contract is no longer active, enter the last date the arrangement was in effect in the "Active" column. Summarize the number of cases for each arrangement. Do not create a separate line for each case.

2.18 Schedule N: Fund Balances

List the detailed fund balances for the following funds:

- **Non-spendable**: Amounts that cannot be spent because they are either (a) not in spendable form or (b) legally or contractually required to be maintained intact. Examples include inventories, prepaid amounts (expenses), long-term receivables, endowment funds.
- **Restricted:** Amounts that cannot be spent because of constraints limiting their use due to creditor obligations or due to state, federal or local statutes.
- **Committed:** Amounts designated for use for specific purposes by government or the Board of Directors.
- **Assigned:** Funds designated by the government or Board of Directors intended to be used for specific purposes, but are neither restricted nor committed.
  Assignment ability can be delegated by the Board of Directors (e.g., Manager, Finance Officer. Budget Officer).
- **Unassigned:** Fund balance that has not been reported in any other classification.

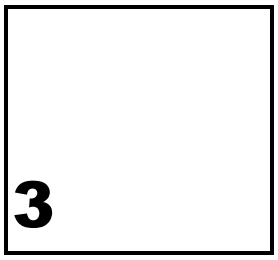
Schedule N balance flows through to Schedule A (Balance Sheet) automatically for state funds. Provide descriptions or explanations for variances in Schedule L (Supplemental Working Area).

Additional information may be found here: https://www.nctreasurer.com/slg/lfm/sample-financial/Pages/default.aspx under Other Financial Statements and Related Resources Calculation of Restricted by State Statute (RSS).

RSS is defined by N.C.G.S. § 159-8. Annual balanced budget ordinance.

(a) Each local government and public authority shall operate under an annual balanced budget ordinance adopted and administered in accordance with this Article. A budget ordinance is balanced when the sum of estimated net revenues and appropriated fund balances is equal to appropriations. Appropriated fund balance in any fund shall not exceed the sum of cash and investments minus the sum of liabilities, encumbrances, and deferred revenues arising from cash receipts, as those figures stand at the close of the fiscal year next preceding the budget year. It is the intent of this Article that, except for moneys expended pursuant to a project ordinance or accounted for in an intragovernmental service fund or a trust and agency fund excluded from the budget ordinance under G.S. 159-13(a), all moneys received and expended by a local government or public authority should be included in the budget ordinance. Therefore, notwithstanding any other provision of law, no local government or public authority may expend any moneys, regardless of their source (including moneys derived from bond proceeds, federal, state, or private grants or loans, or special assessments), except in accordance with a budget ordinance or project ordinance

adopted under this Article or through an intragovernmental service fund or trust and agency fund properly excluded from the budget ordinance.



Annual Reporting Requirements

3.01 Schedule AA: Cost Allocation Plan

Provide a copy of the annual cost allocation plan 60 days prior to the start of the upcoming fiscal year.

3.02 Schedule BB: Audited Financial Statements

Provide a copy of the annual audited financial statements within 120 days after fiscal year end. This must include the following reports:

- Annual Disclosure Statement
- Income Statement
- Independent audit – financial audit and supplemental schedules
- Retained earnings (deficit)/fund balance (Balance Sheet)
- Statement of activities and changes in net assets (Balance Sheet)
- Statement of cash flows
- Statement of financial positions reconciliation

3.03 Schedule CC: OMB Circular A-133 Audit

The PIHP must submit an OMB Circular A-133 audit within 120 days after fiscal year end.

3.04 Schedule DD: Related Party Transactions and Obligations

Provide any related party transactions and obligations for the past year within 60 days after year end. Provide the list in a narrative format. If the PIHP does not have related party transactions, it must submit on an annual certification that these transactions do not exist.

3.05 Schedule EE: Physician Incentive Arrangements

Provide any physician incentive arrangements for the past year within 60 days after year end. Provide in a narrative format with all arrangements.

Appendix A: Category of Service Definitions

Encounter Data Summarization Logic

This table reflects the logic used to capture and categorize the codes in the encounter data for Medicaid eligibles; it is not intended to be a comprehensive listing of all codes for which the LME/MCO is responsible. In addition to the code logic below, the State has chosen to (1) not split claims that have at least one covered service, and (2) include non-Pharmacy claims with a BH diagnosis. Please refer to the Division of Medical Assistance (DMA) contract for a comprehensive listing of the contractually required services.

COS	Code	Type of Utilization
Inpatient	Revenue Code 101–182, 184–219	Days
Community Support	H0036, [H2015 AND COAs other than Innovations]	Services
BH Long-term Residential	H0019, H0046, H2020, S5145	Days
PRTF	Revenue Code 911	Days
Case Management	H0032, T1017	Services
Outpatient	90785, 90791, 90792, 90801–90899, 96100, 96101, 96110, 96111, 96115–96118, G0431, G0434, H0001, H0002, H0004, H0005, H0010, H0012–H0015, H0020, H0031, H2035, Q3014, S9485, T1023, covered E/M codes (99xxx) or Revenue Codes 450–459, 900–919	Services
ACT	H0040	Services
MST	H2033	Services
IIHS	H2022	Services
Partial Hospitalization/Day Treatment	H0035, H2012	Services
Psych Rehab	H2017	Services
Crisis Services	S9484, [H2011 AND COAs other than Innovations]	Services
Innovations	All services must also have an Innovations COA	Services
• Day Support	T2021, T2027	
• Home Supports	H2015, T1015, T2013	
• Personal Care	S5125, T1019	
• Residential Supports	H2016, T2014, T2016, T2020	
• Respite	H0045, S5150, T1005	
• Supported Employment	H2023, H2025, H2026	

• Other	H2011, S5110, S5111, S5165, T1999, T2025, T2029, T2034, T2038, T2039, T2041 or [B4100–B4162 AND [age_group] = 21+]	
ICF-MR	Revenue Code 100 or 183	Days
1915(b)(3)	H0038, H0045, H2016, H2023, H2025, H2026, S5110, S5111, S5125, S5150, S5151, S5165, T1005, T1015, T1019, T2013, T2014, T2020, T2021, T2025, T2027, T2029, T2034, T2038, T2039, T2041, [(99241, 99242 OR 99244) for 1915(b)(3) funding source]	Services
Excluded Services	Blank procedure codes, prescription drugs NOT on a visit to an emergency department or Inpatient stay, procedure code and/or revenue code not listed above WITHOUT a BH diagnosis	N/A

Appendix B: DMH Service Code to Service Category Crosswalk

Svc Code	Service_Description	Rptg Category
H0040	Assertive Community Treatment Program	ACT
H2015HT	Community Support Team	Community Support Team
S9484	Facility Based Crisis Service	Crisis
S9484HA	Facility Based Crisis Service - Child	Crisis
YP485	Facility Based Crisis Program-Non-Medicaid	Crisis
H2011	Mobile Crisis Management	Crisis
YP118	Disaster/Emergency Services	Crisis
YP620	ADVP	IDD Hourly/Day Services
YP650	Community Rehabilitation Program	IDD Hourly/Day Services
YM580	Day Supports	IDD Hourly/Day Services
YP660	Day Activity	IDD Hourly/Day Services
YP610	Developmental Day	IDD Hourly/Day Services
H2014	Developmental Therapy Service Professional	IDD Hourly/Day Services
H2014HM	Developmental Therapy Service Paraprofessional	IDD Hourly/Day Services
H2014HQ	Developmental Therapy Service Professional — Group	IDD Hourly/Day Services
H2014U1	Developmental Therapy Service Paraprofessional — Group	IDD Hourly/Day Services
YM600	Financial Support Services	IDD Hourly/Day Services
YM716	Individual Supports	IDD Hourly/Day Services
YM050	Personal Care	IDD Hourly/Day Services
YP020	Per Asst — Individ	IDD Hourly/Day Services
YM850	Residential Supports	IDD Hourly/Day Services
YA389	Long Term Vocational Support IDD	IDD Hourly/Day Services
YA390	Supported Employment IDD	IDD Hourly/Day Services
H2022	Intensive In-Home Services	IIHS
YP820	Inpat Hosp	Inpatient
YP821	3-Way Contract — IPU Bed	Inpatient
YP822	3-Way Contract — Enhanced	Inpatient
99221	Initial Hospital Care Low Severity	Inpatient
99222	Initial Hospital Care Mod Severity	Inpatient
99223	Initial Hospital Care High Severity	Inpatient
99231	Subsequent Hospital Care per Day	Inpatient
99232	Subsequent Hospital Care per Day	Inpatient
99233	Subsequent Hospital Care per Day	Inpatient

Svc Code	Service_Description	Rptg Category
99234	Observation or Inpatient Hospital Care, Low Complexity	Inpatient
99235	Observation or Inpatient Hospital Care, Moderate Complexity	Inpatient
99236	Observation or Inpatient Hospital Care, High Complexity	Inpatient
99238	Hospital Discharge Day 30 min or less	Inpatient
99239	Hospital Discharge Day more than 30 min	Inpatient
H0019	Behavorial Health — Long-term Residential	Residential Services
H2020	Residential Treatment — Level II — Program Type (Therapeutic Behavioral Service)	Residential Services
S5145	Residential Treatment — Level II — Family Type	Residential Services
YA232	Room and Board — Level III (1–4 Beds)	Residential Services
YA233	Room and Board — Level III (5+ Beds)	Residential Services
YA234	Room and Board — Level II (Age 5 or less)	Residential Services
YA235	Room and Board — Level II (Age 6–12)	Residential Services
YA236	Room and Board — Level II (Age 13+)	Residential Services
YA237	Room and Board — Level IV (1–4 Beds)	Residential Services
YA238	Room and Board — Level IV (5+ Beds)	Residential Services
YA241	Wilderness Camp	Residential Services
YA254	Therapeutic Leave — Resid Level II — Therapeutic Foster Care	Residential Services
YA255	Therapeutic Leave — Residential Level II/Program Type	Residential Services
YA256	Therapeutic Leave — Residential Level III (1–4 Beds)	Residential Services
YA257	Therapeutic Leave — Residential Level III (5+ Beds)	Residential Services
YA258	Therapeutic Leave — Residential Level IV (1–4 Beds)	Residential Services
YA259	Therapeutic Leave — Residential Level IV (5+ Beds)	Residential Services
YA263	Therapeutic Leave Room and Board — Level III (1–4 Beds)	Residential Services
YA264	Therapeutic Leave Room and Board — Level III (5+ Beds)	Residential Services
YA265	Therapeutic Leave Room and Board — Level II (Age 5 or less)	Residential Services
YA266	Therapeutic Leave Room and Board — Level II (Age 6–12)	Residential Services
YA267	Therapeutic Leave Room and Board — Level II (Age 13+)	Residential Services
YA268	Therapeutic Leave Room and Board — Level IV (1–4 Beds)	Residential Services
YA269	Therapeutic Leave Room and Board — Level IV (5+ Beds)	Residential Services
YM700	Independent Living — MR/MI	Residential Services

Svc Code	Service_Description	Rptg Category
YM725	Sup Liv — High	Residential Services
YM755	Family Living — High	Residential Services
YM811	Supervised Living — 1 Resident	Residential Services
YM812	Supervised Living — 2 Resident	Residential Services
YM813	Supervised Living — 3 Resident	Residential Services
YM814	Supervised Living — 4 Resident	Residential Services
YM815	Supervised Living — 5 Resident	Residential Services
YM816	Supervised Living — 6 Resident	Residential Services
YP710	Sup Liv — Low	Residential Services
YP720	Sup Liv — Mod	Residential Services
YP740	Family Living — Low	Residential Services
YP750	Family Living — Mod	Residential Services
YP760	GP Liv — Low	Residential Services
YP770	GP Liv — Mod	Residential Services
YP780	GP Liv — Hi	Residential Services
H2033	Multisystemic Therapy	MST
90785	Interactive Evaluation with Complexity	Outpatient
90791	Clinical Evaluation/Intake	Outpatient
90792	Interactive Evaluation	Outpatient
90832	Individual Therapy (20–30 min.)	Outpatient
90833	Individual Therapy (20–30 min.) — MD	Outpatient
90834	Individual Therapy (45–50 min.)	Outpatient
90836	Individual Therapy (45–50 min.) — MD	Outpatient
90837	Individual Therapy (60 min.)	Outpatient
90838	Individual Therapy (60 min.) — MD	Outpatient
90839	Psychotherapy for Crisis (60 min.)	Outpatient
90840	Psychotherapy for Crisis (add-on)	Outpatient
90846	Family Therapy without Patient	Outpatient
90847	Family Therapy with Patient	Outpatient
90849	Group Therapy (Multiple Family Group)	Outpatient
90853	Group Therapy (Non-Multiple Family Group)	Outpatient
96101	Psychological Testing	Outpatient
96105	Aphasia Assessment	Outpatient
96110	Developmental Testing (Limited)	Outpatient
96111	Developmental Testing (Extended)	Outpatient
96116	Neurobehavioral Exam	Outpatient
96118	Neuropsychological Testing Battery	Outpatient
96372	Therapeutic, Prophylactic or Diagnostic Injection	Outpatient
97001	Physical Therapy Evaluation	Outpatient

Svc Code	Service_Description	Rptg Category
97002	Physical Therapy Re-Evaluation	Outpatient
97003	Occupational Therapy Evaluation	Outpatient
97004	Occupational Therapy Re-Evaluation	Outpatient
97110	Physcial Therapy each 15 min.	Outpatient
97112	Physical Therapy (Nueromuscular Re-Education) each 15 min.	Outpatient
97113	Aquatic Therapy	Outpatient
97116	Gait Training each 15 min.	Outpatient
97124	Massage Therapy each 15 min.	Outpatient
97140	Manual Therapy each 15 min.	Outpatient
97530	PT and OT Therapy	Outpatient
97750	Physical Performance Testing	Outpatient
97761	Prosthetic Training each 15 min.	Outpatient
97762	Checkout for Orthotic/Prosthetic Use	Outpatient
99201	Evaluation and Management — Straight Forward — Problem Focused — New Patient	Outpatient
99202	Evaluation and Management — Expanded —New Patient	Outpatient
99203	Evaluation and Management — Detailed — New Patient	Outpatient
99204	Evaluation and Management — Moderate — New Patient	Outpatient
99205	Evaluation and Management — High — New Patient	Outpatient
99211	Evaluation and Management — Problem Focused — Established Patient	Outpatient
99212	Evaluation and Management — Expanded — Established Patient	Outpatient
99213	Evaluation and Management — Detailed — Established Patient	Outpatient
99214	Evaluation and Management — Moderate — Established Patient	Outpatient
99215	Evaluation and Management — High — Established Patient	Outpatient
99241	Office Consultation	Outpatient
99242	Office Consultation	Outpatient
99243	Office Consultation	Outpatient
99244	Office Consultation	Outpatient
99245	Office Consultation	Outpatient
99251	Initial Inpatient Consultation	Outpatient
99252	Initial Inpatient Consultation	Outpatient
99253	Initial Inpatient Consultation	Outpatient
99254	Initial Inpatient Consultation	Outpatient

Svc Code	Service_Description	Rptg Category
99255	Initial Inpatient Consultation	Outpatient
99304	E&M Initial Nursing Facility Initial Visit, Typically 25 Min.	Outpatient
99305	E&M Initial Nursing Facility Visit, Typically 35 Min. per Day	Outpatient
99306	E&M Initial Nursing Facility Visit, Typically 45 Min. per Day	Outpatient
99307	E&M Subsequent Nursing Facility Visit, Typically 10 Min. per Day	Outpatient
99308	E&M Subsequent Nursing Facility Visit, Typically 15 Min. per Day	Outpatient
99309	E&M Subsequent Nursing Facility Visit, Typically 25 Min. per Day	Outpatient
99310	E&M Subsequent Nursing Facility Visit, Typically 35 Min. per Day	Outpatient
99315	E&M Nursing Facility Discharge Day Management; 30 Min. Or Less	Outpatient
99316	E&M Nursing Facility Discharge Day Management; More Than 30 Min.	Outpatient
99318	E&M Patient involving an annual nursing facility	Outpatient
99324	E&M New Patient Assisted Living Visit, Typically 20 Min.	Outpatient
99325	E&M New Patient Assisted Living Visit, Typically 30 Min.	Outpatient
99326	E&M New Patient Assisted Living Visit, Typically 45 Min.	Outpatient
99327	E&M New Patient Assisted Living Visit, Typically 60 Min.	Outpatient
99328	E&M New Patient Assisted Living Visit, Typically 75 Min.	Outpatient
99334	E&M Established Patient Assisted Living Visit, Typically 15 Min.	Outpatient
99335	E&M Established Patient Assisted Living Visit, Typically 25 Min.	Outpatient
99336	E&M Established Patient Assisted Living Visit, Typically 40 Min.	Outpatient
99337	E&M Established Patient Assisted Living Visit, Typically 60 Min.	Outpatient
99341	E&M New Patient Home Visit, Typically 20 Min.	Outpatient
99342	E&M New Patient Home Visit, Typically 30 Min.	Outpatient
99343	E&M New Patient Home Visit, Typically 45 Min.	Outpatient
99344	E&M New Patient Home Visit, Typically 60 Min.	Outpatient
99345	E&M New Patient Home Visit, Typically 75 Min.	Outpatient

Svc Code	Service_Description	Rptg Category
99347	E&M Established Patient Home Visit, Typically 15 Min.	Outpatient
99348	E&M Established Patient Home Visit, Typically 25 Min.	Outpatient
99349	E&M Established Patient Home Visit, Typically 40 Min.	Outpatient
99350	E&M Established Patient Home Visit, Typically 60 Min.	Outpatient
90785GT	Interactive Evaluation with Complexity — Telemedicine	Outpatient
90791GT	Clinical Evaluation/Intake — Telemedicine	Outpatient
90792GT	Interactive Evaluation	Outpatient
90832GT	Individual Therapy (20–30 min.) — Telemedicine	Outpatient
90833GT	Individual Therapy (20–30 min.) — MD — Telemedicine	Outpatient
90834GT	Individual Therapy (45–50 min.) — Telemedicine	Outpatient
90836GT	Individual Therapy (45–50 min.) — MD — Telemedicine	Outpatient
90837GT	Individual Therapy (60 min.) — Telemedicine	Outpatient
90838GT	Individual Therapy (60 min.) — MD — Telemedicine	Outpatient
99201GT	Evaluation and Management — Straight Forward — Problem Focused — New Patient — Telemedicine	Outpatient
99202GT	Evaluation and Management — Expanded — New Patient — Telemedicine	Outpatient
99203GT	Evaluation and Management — Detailed — New Patient — Telemedicine	Outpatient
99204GT	Evaluation and Management — Moderate — New Patient — Telemedicine	Outpatient
99205GT	Evaluation and Management — High — New Patient — Telemedicine	Outpatient
99211GT	Evaluation and Management — Problem Focused — Established Patient — Telemedicine	Outpatient
99212GT	Evaluation and Management — Expanded — Established Patient — Telemedicine	Outpatient
99213GT	Evaluation and Management — Detailed — Established Patient — Telemedicine	Outpatient
99214GT	Evaluation and Management — Moderate — Established Patient — Telemedicine	Outpatient
99215GT	Evaluation and Management — High — Established Patient — Telemedicine	Outpatient
99241GT	Office Consultation — Telemedicine	Outpatient
99242GT	Office Consultation — Telemedicine	Outpatient
99243GT	Office Consultation — Telemedicine	Outpatient
99244GT	Office Consultation — Telemedicine	Outpatient

Svc Code	Service_Description	Rptg Category
99245GT	Office Consultation — Telemedicine	Outpatient
99251GT	Initial Inpatient Consultation — Telemedicine	Outpatient
99252GT	Initial Inpatient Consultation — Telemedicine	Outpatient
99253GT	Initial Inpatient Consultation — Telemedicine	Outpatient
99254GT	Initial Inpatient Consultation — Telemedicine	Outpatient
99255GT	Initial Inpatient Consultation — Telemedicine	Outpatient
H0001	Alcohol and/or Drug Assessment	Outpatient
H0004	Behavioral Health Counseling	Outpatient
H0004HQ	Behavioral Health Counseling — Group Therapy	Outpatient
H0004HR	Behavioral Health Counseling — Family Therapy with Client	Outpatient
H0004HS	Behavioral Health Counseling — Family Therapy without Client	Outpatient
H0005	Alcohol and/or Drug Group Counseling	Outpatient
H0031	Mental Health Assessment	Outpatient
Q3014GT	Telehealth Originating Site Facility Fee	Outpatient
T1023	Diagnostic Assessment	Outpatient
T1023GT	Diagnostic Assessment — Telemedicine	Outpatient
YP830	Alcohol and/or Drug Assessment — Non-Licensed Provider	Outpatient
YP831	Behavioral Health Counseling — Non-Licensed Provider	Outpatient
YP832	Behavioral Health Counseling — Group Therapy — Non-Licensed Provider	Outpatient
YP833	Behavioral Health Counseling — Family Therapy w/Client — Non-Licensed Provider	Outpatient
YP834	Behavioral Health Counseling — Family Therapy without Client — Non-Licensed Provider	Outpatient
YP835	Alcohol and/or Drug Group Counseling — Non-Licensed Provider	Outpatient
YP836	Mental Health Assessment — Non-Licensed Provider	Outpatient
YP851	Public Psychiatry — Administrative Functions	Outpatient
YP852	Public Psychiatry — Consultation and Service Functions	Outpatient
YP690	Drop In — Attend	Partial Hosp/Day Treatment
YP692	Drop In — Cover	Partial Hosp/Day Treatment
H0035	Mental Health — Partial Hospitalization	Partial Hosp/Day Treatment
H2012HA	Mental Health — Day Treatment — Child	Partial Hosp/Day Treatment
YA230	Psychiatric Residential Treatment Facility	PRTF
H2017	Psychosocial Rehab Services	Psychosocial Rehab Services
YA125	Hourly Respite	Respite

Svc Code	Service_Description	Rptg Category
YA213	Community Respite	Respite
YP010	Hourly Respite — Individ	Respite
YP011	Hourly Respite — Group	Respite
YP730	Comm Respite	Respite
H0014	Ambulatory Detox	Substance Use Disorder Services
YP790	Detox — Soc Set	Substance Use Disorder Services
H2036	Medically Supervised or ADATC Detox	Substance Use Disorder Services
H0010	Non-Hospital Medical Detox	Substance Use Disorder Services
H0020	Opioid Treatment	Substance Use Disorder Services
H2035	SA Comprehensive Outpatient Treatment Program	Substance Use Disorder Services
H2034	SA Halfway House	Substance Use Disorder Services
H0015	SA Intensive Outpatient Program	Substance Use Disorder Services
H0013	SA Medically Monitored Community Residential Treatment	Substance Use Disorder Services
H0012HB	SA Non-Medical Community Residential Treatment — Adult	Substance Use Disorder Services
YM645	Long Term Vocational Support MH	Supported Employment
YP630	Sup Emp — Ind	Supported Employment
YP640	Sup Emp — Group	Supported Employment

Note: Alternative Services should be grouped in the appropriate Reporting Category based on the service definition.

Appendix C: J137 Scenarios for updating Schedule H (Medicaid Claims Processing)

As a result of DMA communication J137, we need to update our Medicaid claims reporting to reflect Claim Header counts instead of the current Claim Detail counts. DMA has provided some guidance around this change. Seven scenarios over a two month period are included to outline how the Schedule H should be completed.

For PIHPs to program, use the hierarchical logic:

1. If any line on a claim is pended, the whole claim is pended.
2. For claims that have not cleared the check cycle that fully adjudicated, the claim is Approved Not Paid.
3. For fully adjudicated claims after the check cycle, if any line is paid, the claim is Approved and paid.
4. For fully adjudicated claims, if all lines are denied, the claim is Denied.

Scenarios

The following seven scenarios represent reporting in the Current Month column. Each Scenario is one Claim Header that includes 10 claim detail lines with the summary of all seven at the bottom. Each claim detail line has a Claim Amount and Approved Amount of $10 (Claim Amount and Approved amount will be the same value for these scenarios). For each Scenario, we have included the Schedule H table to show the values in the current month based on the new DMA guidance.

Current Month, 7 Claims (Headers), 10 Claim Detail Lines for $10 each

1. All claim lines Approved and Paid

	Count of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
1	**Total Number of Claims Received**	**1**		
2	Claims approved and paid	1		
3	Claims denied	0		
4	Claims approved not paid	0		
5	Claims pended	0		
6	Claims in process or no status	0		
7	**Total claims**	1	0	0

	Dollar amount of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
8	Claims approved and paid	$100		
9	Claims denied	$0		
10	Claims approved not paid	$0		
11	Claims pended	$0		

2. All claim lines Denied

	Count of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
1	**Total Number of Claims Received**	1		
2	Claims approved and paid	0		
3	Claims denied	1		
4	Claims approved not paid	0		
5	Claims pended	0		
6	Claims in process or no status	0		
7	**Total claims**	1	0	0

	Dollar amount of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
8	Claims approved and paid	$0		
9	Claims denied	$100		
10	Claims approved not paid	$0		
11	Claims pended	$0		

3. 10 claim lines Approved not Paid

	Count of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
1	**Total Number of Claims Received**	1		
2	Claims approved and paid	0		
3	Claims denied	0		
4	Claims approved not paid	1		
5	Claims pended	0		
6	Claims in process or no status	0		
7	**Total claims**	1	0	0

	Dollar amount of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
8	Claims approved and paid	$0		
9	Claims denied	$0		
10	Claims approved not paid	$100		
11	Claims pended	$0		

4. 5 claim lines Approved and Paid, 5 lines Denied

	Count of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
1	**Total Number of Claims Received**	1		
2	Claims approved and paid	1		
3	Claims denied	0		
4	Claims approved not paid	0		
5	Claims pended	0		
6	Claims in process or no status	0		
7	**Total claims**	1	0	0

	Dollar amount of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
8	Claims approved and paid	$50		
9	Claims denied	$0		
10	Claims approved not paid	$0		
11	Claims pended	$0		

5. 6 claim lines Approved not Paid, 4 Lines Pended

	Count of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
1	**Total Number of Claims Received**	1		
2	Claims approved and paid	0		
3	Claims denied	0		
4	Claims approved not paid	0		
5	Claims pended	1		
6	Claims in process or no status	0		
7	**Total claims**	1	0	0

	Dollar amount of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
8	Claims approved and paid	$0		
9	Claims denied	$0		
10	Claims approved not paid	$0		
11	Claims pended	$100		

6. 5 claim lines Denied, 5 lines Pended

	Count of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
1	**Total Number of Claims Received**	1		
2	Claims approved and paid	0		
3	Claims denied	0		
4	Claims approved not paid	0		
5	Claims pended	1		
6	Claims in process or no status	0		
7	**Total claims**	1	0	0

	Dollar amount of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
8	Claims approved and paid	$0		
9	Claims denied	$0		
10	Claims approved not paid	$0		
11	Claims pended	$50		

7. 6 claim lines Approved not Paid, 2 lines Denied, 2 lines Pended

	Count of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
1	**Total Number of Claims Received**	1		
2	Claims approved and paid	0		
3	Claims denied	0		
4	Claims approved not paid	0		
5	Claims pended	1		
6	Claims in process or no status	0		
7	**Total claims**	1	0	0

	Dollar amount of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
8	Claims approved and paid	$0		
9	Claims denied	$0		
10	Claims approved not paid	$0		
11	Claims pended	$80		

All 7 Scenarios shown together:

	Count of claims processing statistics			
Line #	Category	Current Month	Prior Month	Second Prior Month
1	**Total Number of Claims Received**	7		
2	Claims approved and paid	2		
3	Claims denied	1		
4	Claims approved not paid	1		
5	Claims pended	3		
6	Claims in process or no status	0		
7	**Total claims**	7	0	0

	Dollar amount of claims processing statistics			
Line #	Category	Current Month	Prior Month	Second Prior Month
8	Claims approved and paid	$150		
9	Claims denied	$100		
10	Claims approved not paid	$100		
11	Claims pended	$230		

Historical Reporting

Historical Reporting represent the report values reported the month following the initial report. Data from the current month column does not change when moved to the prior month column. Changes to the status of claims are included in the current month value even though the claims received value is zero.

1. Claim 4 above: The 5 lines Denied were re-adjudicated internally and are Approved, +5 Approved and Paid lines. For reporting, the claim is considered approved and paid. The dollars reported in the current month should reflect only the additional payment amount.

	Count of claims processing statistics			
Line #	Category	Current Month	Prior Month	Second Prior Month
1	**Total Number of Claims Received**	**0**	**1**	
2	Claims approved and paid	1	1	
3	Claims denied	0	0	
4	Claims approved not paid	0	0	
5	Claims pended	0	0	
6	Claims in process or no status	0	0	
7	**Total claims**	1	1	0

	Dollar amount of claims processing statistics			
Line #	Category	Current Month	Prior Month	Second Prior Month
8	Claims approved and paid	$50	$50	
9	Claims denied	$0	$0	
10	Claims approved not paid	$0	$0	
11	Claims pended	$0	$0	

2. Claim 5 Above: The 4 pended claim lines have received a new status and the previously Approved claims lines are now paid, with the final claim having +8 Approved and Paid line,

+2 Denied lines. For reporting, the claim is considered approved and paid. The dollars reported in the current month should reflect only the additional payment amount.

	Count of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
1	**Total Number of Claims Received**	**0**	**1**	
2	Claims approved and paid	1	0	
3	Claims denied	0	0	
4	Claims approved not paid	0	0	
5	Claims pended	0	1	
6	Claims in process or no status	0	0	
7	**Total claims**	1	1	0

	Dollar amount of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
8	Claims approved and paid	$80	$0	
9	Claims denied	$0	$0	
10	Claims approved not paid	$0	$0	
11	Claims pended	$0	$100	

3. Claim 6 above: The 5 pended claim lines have received a new status, +4 Approved and Paid lines, +1 Denied line. For reporting, the claim is considered approved and paid. The dollars reported in the current month should reflect only the additional payment amount.

	Count of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
1	**Total Number of Claims Received**	**0**	**1**	
2	Claims approved and paid	1	0	
3	Claims denied	0	0	
4	Claims approved not paid	0	0	
5	Claims pended	0	1	
6	Claims in process or no status	0	0	
7	**Total claims**	1	1	0

	Dollar amount of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
8	Claims approved and paid	$40	$0	
9	Claims denied	$0	$0	
10	Claims approved not paid	$0	$0	
11	Claims pended	$0	$50	

4. Claim 7 above: The 2 pended claim lines have received a new status and all previously Approved claim lines are now paid, +8 Approved and Paid lines. For reporting, the claim is

considered approved and paid. The dollars reported in the current month should reflect only the additional payment amount.

	Count of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
1	**Total Number of Claims Received**	**0**	**1**	
2	Claims approved and paid	1	0	
3	Claims denied	0	0	
4	Claims approved not paid	0	0	
5	Claims pended	0	1	
6	Claims in process or no status	0	0	
7	**Total claims**	1	1	0

	Dollar amount of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
8	Claims approved and paid	$80	$0	
9	Claims denied	$0	$0	
10	Claims approved not paid	$0	$0	
11	Claims pended	$0	$100	

Prior Month Summary of 4 adjusted Scenarios:

	Count of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
1	**Total Number of Claims Received**	**0**	**7**	
2	Claims approved and paid	4	2	
3	Claims denied	0	1	
4	Claims approved not paid	0	1	
5	Claims pended	0	3	
6	Claims in process or no status	0	0	
7	**Total claims**	4	7	0

	Dollar amount of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
8	Claims approved and paid	$250	$150	
9	Claims denied	$0	$100	
10	Claims approved not paid	$0	$100	
11	Claims pended	$0	$230	

Zero Dollar Claims

A Zero Dollar Claim represents a situation where a claim is approved, but no dollar amount is paid to the provider. For example, a zero dollar claim would happen in a situation where a COB amount is equal to or more than the contract rate. These claims are still recorded even if they do not have a dollar amount recorded in line 8–11.

1. Claim with primary COB amount more than the Medicaid contract rate - All Approved and Paid (at $0)

	Count of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
1	**Total Number of Claims Received**	1		
2	Claims approved and paid	1		
3	Claims denied	0		
4	Claims approved not paid	0		
5	Claims pended	0		
6	Claims in process or no status	0		
7	**Total claims**	1	0	0

	Dollar amount of claims processing statistics			
Line #	**Category**	**Current Month**	**Prior Month**	**Second Prior Month**
8	Claims approved and paid	$0		
9	Claims denied	$0		
10	Claims approved not paid	$0		
11	Claims pended	$0		