PROPRIETARY & CONFIDENTIAL

Due within thirty (30) days after the month end for services provided by contracted hospitals during the reporting month.

Item 1. Health Plan Name. Enter the full name of the health plan that has contracted with the State of Missouri to provide MHD Managed Care services.

Item 2. Reporting Month/Year. Enter the month and year of the report corresponding with the payments covered in this schedule.

Column Number	Column Header	Description
(1)	Payment Calendar Year and Month	The year and month in which services were paid and reported as "YYYYMM." The payment year and month should be consistent with the reporting month and year of the report.
(2)	Service Calendar Year and Month	The year and month in which services were provided corresponding to the Service Calendar Year and reported as "YYYYMM." All service months associated with the payment month should be reported.
(3)	Hospital NPI Number	Enter the hospital's ten-digit National Provider Identifier (NPI) Number. The Hospital NPI Number should be consistent with the MO HealthNet Fee-For-Service (FFS) Hospital Rate list when applicable. The MO HealthNet online FFS Hospital Rate list is available electronically at the state agency's website: http://www.dss.mo.gov/mhd/providers/pages/cptagree.htm
(4)	Hospital Facility Name	Enter the full name of the hospital that has contracted with the health plan to provide MHD Managed Care services.
(5)	Hospital Facility State	Enter the State location of the Hospital Facility and report as a two-letter abbreviation. For example, Missouri would be reported as "MO."
(6)	COS ID	Enter the Category of Service (COS) ID. See the COS Tab for definitions of each COS.
(7)	Amount of Billed Charges Allowed by Plan	Enter the dollar amount of all claims billed by the hospital and processed by the health plan less any charges denied or rejected by the health plan.
(8)	FFS Paid	Fee-for-Service expenses reported and paid for all services, incurred during the reporting period. See the table[(1)] below for definitions of utilization by COS.
(9)	FFS Quantity	Fee-for-Service utilization reported and paid for all services, incurred during the reporting period. See the table[(1)] below for definitions of utilization by COS.
(10)	FFS Discharges	The total number of inpatient hospital discharges by the hospital and processed by the health plan for the period.
(11)	Capitation Paid	Enter the dollar amount of all claims processed and approved by the subcontractor reported and paid during the reporting time period. If payment detail is not available, please estimate the hospital reimbursement based on contract terms for members that are not under the subcontractor arrangement or some other reimbursement proxy. These dollar amounts should be reflective of the services provided and not the capitation
(12)	Capitation Quantity	COS utilization (not number of payments) reported and paid by the subcontractor during the reporting time period. See the table[(1)] below for definitions of utilization by COS.
(13)	Capitation Discharges	The total number of inpatient hospital discharges by the subcontractor and processed by the subcontractor for the period.

[(1)] Utilization should be reported using the following units of measure:

Utilization	Category of Service
Days	Inpatient - PH, Inpatient - MH

Visits	Emergency Room, Outpatient - PH, Outpatient - MH

ID	CATEGORY OF SERVICE	DESCRIPTION
01	Inpatient Hospital - PH	* Inpatient hospital - physical health costs include **routine** and **ancillary** services for a MO HealthNet managed care enrolled recipient while confined to an acute care hospital. * **Routine** hospital services include room and board, dietary and nursing services, medical surgical supplies, medical social services, and the use of certain equipment and facilities for which the provider does not normally make a separate charge. * **Ancillary** hospital services include laboratory, radiology, drugs, physical therapy, etc. Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge. * An "inpatient" service, which requires the submission of an inpatient claim, is one in which the hospital expects to provide service to the patient in the hospital for a 24 hour period or longer. The service is still considered inpatient if the intent is to stay 24 hours or longer even though the patient dies, is discharged or is transferred to another institution and does not actually stay in the hospital 24 hours. Services in an observation room, regardless of the length of time, without a formal admission are not considered inpatient services. * Inpatient Hospital - PH must **NOT** include: > Professional charges for hospital based physicians. Physician expenses related to hospitalizations must be excluded from this report. > Hospitalizations with a diagnosis that meets the criteria for Inpatient Hospital - Mental Health. Inpatient hospitalizations meeting the Mental Health criteria must be reported in COS 02. > Emergency Room services with a Place of Service 23 resulting in an IP stay, should be reported as IP. All services provided in the Emergency Room are reported in COS 03, Emergency Room. However, any Emergency Room services resulting in an Inpatient Stay should be reported under COS 01.
02	Inpatient Hospital - MH	* Same services as Inpatient Hospital - PH except services are for Mental Health * Mental Health services are defined by the following ICD-9 Codes (primary diagnosis): > 290 - 316, V11.0 - V11.9, V15.4, V17.0, V40.0 - V40.3, V40.9, V61.0, V61.10 - V61.12, V61.20 - V61.22, V61.29, V62.4, V62.81 - V62.83, V62.89, V62.9, V67.3, V70.1 - V70.2, V71.01 - V71.02, V71.09, V79.0 - V79.1, V79.8 - V79.9. Providers must use the appropriate 4th and 5th digits when applicable or * Mental Health services are defined by the following ICD-10 Codes (primary diagnosis): > F01 - F69, F80 - F99, G44.209, H93.25, R37, R41.83, R45.1 - R45.2, R45.5 - R45.851, R46.81, R46.89, R48.0, Z00.8, Z03.89, Z04.6, Z09, Z13.4, Z13.89, Z60.0, Z60.3 - Z60.9, Z62.0, Z62.1, Z62.22 - Z62.890, Z62.898, Z62.9, Z63.32 - Z63.5, Z63.8, Z64.4, Z65.4, Z65.8 - Z65.9, Z69.010 - Z69.12, Z69.82, Z71.89, Z72.810 - Z72.811, Z73.4 - Z73.6, Z81.8, Z86.51, Z86.59, Z87.890, Z91.410 - Z91.49, Z91.83 * Inpatient Hospital - MH must **not** include: > Professional charges for hospital based physicians for mental health services. Physician expenses related to hospitalizations for mental health services must be excluded from this report. > Emergency Room services with a Place of Service 23. All services provided in the Emergency Room are reported in COS 03, Emergency Room.
03	Emergency Room	* All services provided in the Emergency Room. These services include: > Services with a Place of Service value equal to 23 or > Services with a Revenue Code in the range of 450-459. * Please note that claims that have both an ER Revenue Code and a hospital admission Revenue Code (100-219) should not be counted as an ER service.
04	Outpatient Hospital - PH	* Expenses related to physical health services rendered in an outpatient hospital setting. * The outpatient hospital is defined as the portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. * Outpatient Hospital - PH must **not** include: > Professional charges for hospital based physicians. Physician expenses related to outpatient hospitalizations must be excluded from this report. > Outpatient hospitalizations with a diagnosis that meets the criteria for Outpatient Hospital - Mental Health. Outpatient hospitalizations meeting the Mental Health criteria must be reported in COS 05, Outpatient Hospital - MH. > Emergency Room services with a Place of Service 23. All services provided in the Emergency Room are reported in COS 03, Emergency Room.
05	Outpatient Hospital - MH	* Same services as Outpatient Hospital - PH except services are for Mental Health * Mental Health services are defined by the following ICD-9 Codes (primary diagnosis): > 290 - 316, V11.0 - V11.9, V15.4, V17.0, V40.0 - V40.3, V40.9, V61.0, V61.10 - V61.12, V61.20 - V61.22, V61.29, V62.4, V62.81 - V62.83, V62.89, V62.9, V67.3, V70.1 - V70.2, V71.01 - V71.02, V71.09, V79.0 - V79.1, V79.8 - V79.9. Providers must use the appropriate 4th and 5th digits when applicable or * Mental Health services are defined by the following ICD-10 Codes (primary diagnosis): > F01 - F69, F80 - F99, G44.209, H93.25, R37, R41.83, R45.1 - R45.2, R45.5 - R45.851, R46.81, R46.89, R48.0, Z00.8, Z03.89, Z04.6, Z09, Z13.4, Z13.89, Z60.0, Z60.3 - Z60.9, Z62.0, Z62.1, Z62.22 - Z62.890, Z62.898, Z62.9, Z63.32 - Z63.5, Z63.8, Z64.4, Z65.4, Z65.8 - Z65.9, Z69.010 - Z69.12, Z69.82, Z71.89, Z72.810 - Z72.811, Z73.4 - Z73.6, Z81.8, Z86.51, Z86.59, Z87.890, Z91.410 - Z91.49, Z91.83 * Outpatient Hospital - MH must **not** include: > Professional charges for hospital based physicians. Physician expenses related to outpatient mental health hospitalizations must be excluded from this report. > Emergency Room services with a Place of Service 23. All services provided in the Emergency Room are reported in COS 03, Emergency Room.

PROPRIETARY & CONFIDENTIAL

HOSPITAL SERVICES REPORTING FORM - MONTHLY PAYMENT SCHEDULE FOR MO HEALTHNET MANAGED CARE HOSPITAL SERVICES

1. Health Plan Nai EXAMPLE PLAN

2. Reporting Month/Year: 7/1/2016

(1) Payment Calendar Year and Month	(2) Service Calendar Year and Month	(3) Hospital NPI Number	(4) Hospital Facility Name	(5) Hospital Facility State	(6) COS ID	(7) Amount of Billed Charges Allowed by Plan	(8) FFS Paid	(9) FFS Quantity	(10) FFS Discharges	(11) Capitation Paid	(12) Capitation Quantity	(13) Capitation Discharges
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PROPRIETARY & CONFIDENTIAL

Hospital Services Reporting Form

Certification of the Monthly Hospital Services Reporting Form
EXAMPLE PLAN
7/1/2016

I hereby certify, to the best of my knowledge, information and belief, to the accuracy, completeness, and truthfulness of the Hospital Services Report data submitted on **"Insert submission date here"**.

Signature	
Name (please print)	
Title	
Company/Health Plan Name	
Signature Date	