Pennsylvania's Office of Mental Health and Substance Abuse Services

2022 Encounter Data Validation Study

Beacon Health Options of Pennsylvania

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IPRO
Better healthcare, realized.

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Introduction

The Pennsylvania Department of Human Services (DHS), Office of Mental Health and Substance Abuse Services (OMHSAS) has partnered with its external quality review organization (EQRO), IPRO, to conduct a behavioral health (BH) managed care organization (MCO) encounter data validation (EDV) study.

The Centers for Medicare & Medicaid Services (CMS) encourages states to implement the voluntary EDV protocol due to the need for overall valid and reliable encounter data as part of any state quality improvement efforts. As federal programs transition toward payment reform for demonstrated quality of care, validation of encounter data in the use of performance data will become increasingly important. Transparency of payment and delivery of care is an integral part of health reform. EDV can help states reach the goals of transparency and payment reform to support their efforts in quality measurement and improvement.

EDV is an ongoing process, involving the MCOs, state encounter data unit, and the EQRO. Improving encounter data reporting is an ongoing project across federal and state healthcare agencies. Encounter data that are accurate and reliable can lead agencies to drive healthcare improvements that can positively affect the overall population and those who have high-risk health issues. EDV activities conducted by state agencies or EQROs can help to identify incomplete data, perform missing-or incorrect data quality checks, and assess frequency and impact of late encounter data submissions.

BH MCOs are required to submit the encounter data files to the Provider Reimbursement and Operations Management Information System (PROMISe). IPRO receives weekly PROMISe professional and institutional inpatient encounter data extracts from Gainwell Technologies and IPRO loads the data to a SAS® data warehouse.

During 2022, an EDV study was carried out by IPRO on behalf of OMHSAS to assess the completeness and accuracy of the BH MCOs encounter data submitted to PROMISe.

Methodology

IPRO requested BH MCO claims data residing in their claims system for the period of services October 1, 2021, to December 31, 2021, for all encounter types and fields included in **Tables 1–3**. The state fiscal year (SFY) 2022 EDV study was conducted for the following participating Medicaid BH MCOs:

- Beacon Health Options of Pennsylvania (BHO),
- Community Behavioral Health (CBH),
- Community Care Behavioral Health Organization (CCBH),
- Magellan Behavioral Health of Pennsylvania (Magellan), and
- PerformCare for Pennsylvania (PerformCare).

IPRO requested that the BH MCOs provide all encounters with dates of service from October 1 to December 31, 2021, and submitted to the state between October 1, 2021, and March 31, 2022. The BH MCOs were requested to select all claims adjudicated by the BH MCO's vendors. The claims provided to IPRO included encounter submissions that were all paid (original, corrected, adjusted/voided, or paid at $0) encounter data and partial payments denied at the line level and paid at the header level. IPRO provided the BH MCOs documentation identifying the logic to be utilized in the identification of the claims to be selected. The BH MCOs submitted the claims by claim type to IPRO. IPRO provided the BH MCOs the identifying data elements that IPRO used to compare to the claims IPRO receives and stores on the weekly vendor extracts.

The BH MCOs are required to submit professional (837P) and institutional inpatient (837I) encounters to PROMISe; any institutional outpatient encounters received and processed by the BH MCO are converted, cross walked, and submitted to PROMISe as professional encounters. For the 2022 EDV study, IPRO requested the BH MCOs submit the institutional outpatient data as received from their providers.

Encounter Data Validation Study Methodology

IPRO utilized the following methodology for the EDV study:

1. The BH MCOs submitted all data elements in **Tables 1–3** by claim type obtained from their adjudicated source claims that corresponded to the audit period. To verify the source claims data, IPRO requested the BH MCOs include the internal control number (ICN), if available, obtained by the BH MCOs when the encounter was submitted and accepted by PROMISe.
2. IPRO imported the BH MCO files into SAS and stored the different encounter types separately.
3. IPRO compared the BH MCO source data (claims and encounters) to the encounter data received by PROMISe.
4. IPRO identified the discrepancies by comparing the source data for each data element. IPRO identified differences between the data element (**Tables 1–3**) values from the source data and the data element values included in IPRO's data warehouse (DW). Discrepancies were identified by data element.
5. Data elements with less than a 90% match rate were reviewed. IPRO reviewed discrepancies and categorized them for each encounter type (**Tables 5–6**).
6. IPRO selected a sample of up to 1,000 records for each encounter type and data element discrepancy category identified for each BH MCO. IPRO provided counts of all discrepancies by discrepancy category to OMHSAS and the BH MCOs.

Interviews with BH MCOs

IPRO scheduled teleconferences with OMHSAS and the BH MCOs for the following:

- a review of discrepant records comparing IPRO DW results to BH MCO claims screen and the 837-file string;
- a walkthrough by BH MCOs of the processes for receipt of claims, reconciliation, translation, and submission of claims data to OMHSAS, as well as a walkthrough of any recent system changes, since December 31, 2021, that have been implemented during the past year; review of any questions related to the information systems capability assessment (ISCA).
- a presentation by BH MCOs to IPRO and OMHSAS using the sampled discrepant records and how the claim was adjudicated; and
- a demonstration of all the steps identified by BH MCOs involved in the transfer and processing of source claims data and identification process steps where data could possibly be changed or altered.
- a review of discrepant records comparing IPRO DW results to BH MCO claims screen and the 837-file string.

The BH MCOs provided details on how several sample ICNs were adjudicated and displayed on their claim adjudication system and how each ICN's data elements appeared on the professional (837P) and institutional (837I) encounters submitted to PROMISe.

Data File Layout Request

The BH MCOs were provided the file layouts for each of the following file types:

- professional claims file,
- institutional inpatient claims file, and
- institutional outpatient claims file.

Professional Claims File

Table 1 defines the fields for the professional claims to be submitted by the BH MCOs.

Table 1: Professional Claims File

Professional Claims Field Name	Type	Description
BH_MCO_NAME	Char	BH MCO Name
PLAN CODE	Char	2-digit alpha code
RECIP_ID	Char	Unique number assigned to the recipient (9-digit PA member identification number)
PROMISe ICN	Char	PROMISe Internal Control Number If available, if submitted and accepted by PROMISe.

Professional Claims Field Name	Type	Description
MCO ICN	Char	Unique control number assigned by the MCO
NUM_ADJ_ICN	Char	The PROMISe ICN of the original claim if the claim is an adjustment
LINE_NUMBER	Num	The detail number for the specific detail on the claim (Number (4)) Include any leading zeros
DTE_FIRST_SVC_DTL	Date	Date on which the statement period on the claim began for the detailed line item (mm/dd/yyyy)
DTE_LAST_SVC_DTL	Date	Date on which the statement period on the claim ended for the detailed line item (mm/dd/yyyy)
PLACESVC	Char	A code to indicate where the service was provided (Place of service)
ICD-10 diagnosis – based on the header level diagnosis DO NOT INCLUDE DECIMALS		
DIAGCD1	Char	Primary Diagnosis
DIAGCD2	Char	Second diagnosis
DIAGCD3	Char	Third diagnosis
DIAGCD4	Char	Fourth diagnosis
DIAGCD5	Char	Fifth diagnosis
DIAGCD6	Char	Sixth diagnosis
DIAGCD7	Char	Seventh diagnosis
DIAGCD8	Char	Eighth diagnosis
DIAGCD9	Char	Ninth diagnosis
DIAGCD10	Char	Tenth diagnosis
DIAGCD11	Char	Eleventh diagnosis
DIAGCD12	Char	Twelfth diagnosis
Payment information		
PTMT_ADJ_DATE	Date	MCO Adjudication date (mm/dd/yyyy)
AMT_BH MCO_PAID_HDR	Num	The BH MCO paid amount from the header for header paid claims. Total paid amount of the claim (Number (12,2))
AMT_OTH_INS_PD_HDR	Num	The total TPL paid amount at the claim level (Number (12,2))
AMT_BH MCO_PAID_DTL	Num	The BH MCO paid amount from the detail for detail paid claims. Total paid amount of the line item (Number (12,2))
AMT_OTH_INS_PD_DTL	Num	The TPL paid amount from the detail (Number (12,2)
Procedure code information		
PROCCODE1	Char	Procedure/supplies/service code (i.e., CPT-4, CDT, and/or HCPCS)
QTY_UNITS_BILLED	Num	The units of service billed at the detail (Number (9,2))
MODIFIER1	Char	The first of up to 4 procedure/service/supplies modifier (if applicable)
MODIFIER2	Char	The second of up to 4 procedure/service/supplies modifier (if applicable)
MODIFIER3	Char	The third of up to 4 procedure/service/supplies modifier (if applicable)
MODIFIER4	Char	The fourth of up to 4 procedure/service/supplies modifier (if applicable)
Provider information		
BILLING_PROV_ID	Char	The billing provider PROMISe ID (MPI) 13-digit code including the service location
BILLING_PROV_NPI	Char	The billing provider NPI
RENDERING_PROV_ID	Char	The Rendering Provider PROMISe ID 13-digit code including the service location
RENDERING_PROV_NPI	Char	The Rendering Provider NPI
REFERRING _PROV_ID	Char	The Referring Provider PROMISe ID

Professional Claims Field Name	Type	Description
		9-digit code
REFERRING _PROV_NPI	Char	The Referring Provider NPI

BH: behavioral health; MCO: managed care organization; PA: Pennsylvania; PROMISe: Provider Reimbursement and Operations Management Information System; ICN: internal control number; ICD-10: International Classification of Diseases, Tenth Revision; TPL: third-party liability; CPT-4: Current Procedural Terminology, 4th Edition; CDT: Current Dental Terminology; HCPCS: Healthcare Common Procedure Coding System; ID: identification; MPI: master provider index; NPI: National Provider Identifier.

Institutional Claims File-Inpatient

Table 2 defines the fields for the institutional claims to be submitted by the BH MCOs.

Table 2: Institutional Inpatient Claims File – Inpatient Fields

Institutional Inpatient Field Name	Type	Description
BH_MCO_NAME	Char	BH MCO Name
PLAN CODE	Char	2-digit alpha code
RECIP_ID	Char	Unique number assigned to the recipient (9-digit PA member identification number)
PROMISe ICN	Char	PROMISe Internal Control Number If available, if submitted and accepted by PROMISe
MCO ICN	Char	Unique control number assigned by the MCO
NUM_ADJ_ICN	Char	The PROMISe ICN of the original claim if the claim is an adjustment
LINE_NUMBER	Num	The detail number for the specific detail on the claim (Number (4)) Include any leading zeros
DTE_ADMISSION	Date	Date that the recipient was admitted by the provider for inpatient care (mm/dd/yyyy)
DTE_DISCHARGE	Date	Date that the recipient was discharged by the provider for inpatient care (mm/dd/yyyy)
DTE_FIRST_SVC_HDR	Date	Date on which the statement period on the claim began from the header paid claims (mm/dd/yyyy)
DTE_LAST_SVC_HDR	Date	Date on which the statement period on the claim ended from the header paid claims (mm/dd/yyyy)
DTE_FIRST_SVC_DTL	Date	Date on which the statement period on the claim began for the detailed line item (mm/dd/yyyy)
DTE_LAST_SVC_DTL	Date	Date on which the statement period on the claim ended for the detailed line item (mm/dd/yyyy)
ADMITTYP	Char	Admission type
DIS_STAT	Char	Patient discharge status code
TYPEBILL	Char	Type of bill 3-digit code
DRG	Char	DRG code (3-digit field; please submit value in this field only if it is an inpatient claim paid on a DRG rate as reported on the encounter)
ICD-10 diagnosis – based on the header level diagnosis DO NOT INCLUDE DECIMALS		
DIAGCD1	Char	Principal diagnosis
DIAGCD2	Char	Second diagnosis
DIAGCD3	Char	Third diagnosis
DIAGCD4	Char	Fourth diagnosis

Institutional Inpatient Field Name	Type	Description
DIAGCD5	Char	Fifth diagnosis
DIAGCD6	Char	Sixth diagnosis
DIAGCD7	Char	Seventh diagnosis
DIAGCD8	Char	Eighth diagnosis
DIAGCD9	Char	Ninth diagnosis
DIAGCD10	Char	Tenth diagnosis
DIAGCD11	Char	Eleventh diagnosis
DIAGCD12	Char	Twelfth diagnosis
DIAGCD13	Char	Thirteenth diagnosis
DIAGCD14	Char	Fourteenth diagnosis
DIAGCD15	Char	Fifteenth diagnosis
DIAGCD16	Char	Sixteenth diagnosis
DIAGCD17	Char	Seventieth diagnosis
DIAGCD18	Char	Eighteenth diagnosis
DIAGCD19	Char	Nineteenth diagnosis
DIAGCD20	Char	Twentieth diagnosis
DIAGCD21	Char	Twenty First diagnosis
DIAGCD22	Char	Twenty Second diagnosis
DIAGCD23	Char	Twenty Third diagnosis
DIAGCD24	Char	Twenty Fourth diagnosis
DIAGCD25	Char	Twenty Fifth diagnosis
Procedure codes DO NOT INCLUDE DECIMALS		
SURG1	Char	Surgical code 1
SURG2	Char	Surgical code 2
SURG3	Char	Surgical code 3
SURG4	Char	Surgical code 4
SURG5	Char	Surgical code 5
SURG6	Char	Surgical code 6
SURGDTE1	Date	Surgical date 1 (mm/dd/yyyy)
SURGDTE2	Date	Surgical date 2 (mm/dd/yyyy)
SURGDTE3	Date	Surgical date 3 (mm/dd/yyyy)
SURGDTE4	Date	Surgical date 4 (mm/dd/yyyy)
SURGDTE5	Date	Surgical date 5 (mm/dd/yyyy)
SURGDTE6	Date	Surgical date 6 (mm/dd/yyyy)
Payment information – inpatient claims are paid at the header.		
PTMT_ADJ_DATE	Date	MCO Adjudication date (mm/dd/yyyy)
AMT_BH MCO_PAID_HDR	Num	The BH MCO paid amount from the header for header paid claims. Total paid amount of the claim (Number (12,2))
AMT_OTH_INS_PD_HDR	Num	The total TPL paid amount at the claim level (Number (12,2))
AMT_BH MCO_PAID_DTL	Num	The BH MCO paid amount from the detail for detail paid claims. Total paid amount of the line item (Number (12,2))
Revenue code		
REVENUE_CODE	Char	Revenue center code Include any leading zeros
Provider information		
BILLING_PROV_ID	Char	The billing provider PROMISe ID (MPI)

Institutional Inpatient Field Name	Type	Description
		13-digit code including the service location
BILLING_PROV_NPI	Char	The billing provider NPI
RENDERING_PROV_ID	Char	The Rendering Provider PROMISe ID 13-digit code including the service location
RENDERING_PROV_NPI	Char	The Rendering Provider NPI
REFERRING _PROV_ID	Char	The Referring Provider PROMISe ID 9-digit code
REFERRING _PROV_NPI	Char	The Referring Provider NPI

BH: behavioral health; MCO: managed care organization; PA: Pennsylvania; PROMISe: Provider Reimbursement and Operations Management Information System; ICN: internal control number; DRG: diagnosis-related group; ICD-10: International Classification of Diseases, Tenth Revision; TPL: third-party liability; ID: identification; MPI: master provider index; NPI: National Provider Identifier.

Institutional Claims File-Outpatient

Table 3 defines the fields for the institutional outpatient claims to be submitted by the BH MCOs.

Table 3: Institutional Outpatient Claims File – Outpatient Fields

Institutional Outpatient Field Name	Type	Description
BH_MCO_NAME	Char	BH MCO Name
PLAN CODE	Char	2-digit alpha code
RECIP_ID	Char	Unique number assigned to the recipient (9-digit PA member identification number)
PROMISe ICN	Char	PROMISe Internal Control Number If available, if submitted and accepted by PROMISe
MCO ICN	Char	Unique control number assigned by the MCO
NUM_ADJ_ICN	Char	The PROMISe ICN of the original claim if the claim is an adjustment.
LINE_NUMBER	Num	The detail number for the specific detail on the claim (Number (4)) Include any leading zeros
DTE_FIRST_SVC_HDR	Date	Date on which the statement period on the claim began from the header paid claims (mm/dd/yyyy)
DTE_LAST_SVC_HDR	Date	Date on which the statement period on the claim ended from the header paid claims (mm/dd/yyyy)
DTE_FIRST_SVC_DTL	Date	Date on which the statement period on the claim began for the detailed line item (mm/dd/yyyy)
DTE_LAST_SVC_DTL	Date	Date on which the statement period on the claim ended for the detailed line item (mm/dd/yyyy)
TYPEBILL	Char	Type of bill 3-digit code
ICD-10 diagnosis – based on the header level diagnosis DO NOT INCLUDE DECIMALS		
DIAGCD1	Char	Principal Diagnosis
DIAGCD2	Char	Second diagnosis
DIAGCD3	Char	Third diagnosis
DIAGCD4	Char	Fourth diagnosis
DIAGCD5	Char	Fifth diagnosis

Institutional Outpatient Field Name	Type	Description
DIAGCD6	Char	Sixth diagnosis
DIAGCD7	Char	Seventh diagnosis
DIAGCD8	Char	Eighth diagnosis
DIAGCD9	Char	Ninth diagnosis
DIAGCD10	Char	Tenth diagnosis
DIAGCD11	Char	Eleventh diagnosis
DIAGCD12	Char	Twelfth diagnosis
DIAGCD13	Char	Thirteenth diagnosis
DIAGCD14	Char	Fourteenth diagnosis
DIAGCD15	Char	Fifteenth diagnosis
DIAGCD16	Char	Sixteenth diagnosis
DIAGCD17	Char	Seventieth diagnosis
DIAGCD18	Char	Eighteenth diagnosis
DIAGCD19	Char	Nineteenth diagnosis
DIAGCD20	Char	Twentieth diagnosis
DIAGCD21	Char	Twenty First diagnosis
DIAGCD22	Char	Twenty Second diagnosis
DIAGCD23	Char	Twenty Third diagnosis
DIAGCD24	Char	Twenty Fourth diagnosis
DIAGCD25	Char	Twenty Fifth diagnosis
ICD-10 procedure codes DO NOT INCLUDE DECIMALS		
SURG1	Char	Surgical code 1
SURG2	Char	Surgical code 2
SURG3	Char	Surgical code 3
SURG4	Char	Surgical code 4
SURG5	Char	Surgical code 5
SURG6	Char	Surgical code 6
SURGDTE1	Date	Surgical date 1 (mm/dd/yyyy)
SURGDTE2	Date	Surgical date 2 (mm/dd/yyyy)
SURGDTE3	Date	Surgical date 3 (mm/dd/yyyy)
SURGDTE4	Date	Surgical date 4 (mm/dd/yyyy)
SURGDTE5	Date	Surgical date 5 (mm/dd/yyyy)
SURGDTE6	Date	Surgical date 6 (mm/dd/yyyy)
Payment information		
PTMT_ADJ_DATE	Date	MCO Adjudication date (mm/dd/yyyy)
AMT_BH MCO_PAID_HDR	Num	This is the BH MCO paid amount from the header for header paid claims. Total paid amount of the claim (Number (12,2))
AMT_OTH_INS_PD_HDR	Num	The total TPL paid amount at the claim level (Number (12,2))
AMT_BH MCO_PAID_DTL	Num	The BH MCO paid amount from the detail for detail paid claims. Total paid amount of the line item (Number (12,2))
AMT_OTH_INS_PD_DTL	Num	The TPL paid amount from the detail (Number (12,2))
Procedure code and revenue code		
PROCEDURE_CODE	Char	Procedure code (if applicable)
UNITS_BILLED	Num	Units of service billed for payment (Number (9,2))
MODIFIER1	Char	The first of up to four procedures/services/supplies modifiers (if applicable)
MODIFIER2	Char	The second of up to four procedures/services/supplies modifiers (if applicable)

Institutional Outpatient Field Name	Type	Description
MODIFIER3	Char	The third of up to four procedures/services/supplies modifiers (if applicable)
MODIFIER4	Char	The fourth of up to four procedures/services/supplies modifiers (if applicable)
REVENUE_CODE	Char	Revenue center code Including any leading zeros.
Provider information		
BILLING_PROV_ID	Char	The billing provider PROMISe ID (MPI) 13-digit code including the service location
BILLING_PROV_NPI	Char	The billing provider NPI
RENDERING_PROV_ID	Char	The Rendering Provider PROMISe ID 13-digit code including the service location
RENDERING_PROV_NPI	Char	The Rendering Provider NPI
REFERRING _PROV_ID	Char	The Referring Provider PROMISe ID 9-digit code
REFERRING _PROV_NPI	Char	The Referring Provider NPI

BH: behavioral health; MCO: managed care organization; PA: Pennsylvania; PROMISe: Provider Reimbursement and Operations Management Information System; ICN: internal control number; ICD-10: International Classification of Diseases, Tenth Revision; TPL: third-party liability; ID: identification; MPI: master provider index; NPI: National Provider Identifier.

Findings

Beacon Health Options of Pennsylvania (BHO) EDV study call was conducted on October 18th, 2022. BHO's system was reviewed for discrepancies of data fields present in the professional and institutional inpatient encounter types between the submitted EDV data file and the data submitted to PROMISe. The attendees of the BHO's EDV study call included OMHSAS, Behavioral HealthChoices Contractors (BHHC), Allan Collautt Associates, Inc. (ACA), IPRO and BHO. BHO only receives institutional inpatient and professional claims from their providers, and their providers do not submit institutional outpatient encounters; therefore, the standard conversion of institutional outpatient data to the professional format recommended for submission by the state did not lead to a loss of data for the institutional outpatient encounter type.

Professional and Institutional Inpatient Claims Files

IPRO receives weekly encounter data extracts from Gainwell Technologies for PROMISe encounter data that were used in comparing the MCO encounter data study files received. IPRO receives and stores the following data tables in IPRO's data warehouse which consist of the following SAS data table:

- Institutional common header: containing claim header information for the ICN, including ICD-10-CM diagnosis codes 1-12, and member identification number for the Institutional inpatient encounters.
- Institutional header: containing claim header information for the ICN, including additional ICD-10-CM diagnosis codes 13-25, DRG code, ICD-10-CM procedure code, place of service code and type of bill for the Institutional inpatient encounters.
- Institutional detail: containing service line detail information for the ICN, including procedure codes, revenue codes and modifier codes 1-4 for the institutional inpatient encounters.
- Professional common header: containing claim header information for the ICN, including ICD-10-CM diagnosis codes 1-12, and member identification number for the Professional encounters.
- Professional detail: containing claim header information for the ICN, including, ICD-10-CM procedure codes, modifier codes, place of service, and procedure codes for the Professional encounters.

IPRO matched the EDV study to IPRO's DW encounter data tables for the paid/accepted PROMISe encounters by ICN, and IPRO identified there were records submitted on the EDV study file that were not included on the IPRO DW data tables. The majority of these ICNs that were not matched were identified as being adjusted or voided records where the ICN begins with a '7.'

Table 4 outlines the number of records received by encounter type, number of records matched to ICN, and the number of records that were voided that started with 7. Each of the three encounter types received for the EDV study were compared to multiple encounter data tables in IPRO's DW.

Table 4: Number of Types of Records Received by Encounter Type

Encounter Type	Number of Records Received by Encounter Type	Number of Records Matched to ICN	Number of Records that were Voided that Started with 7
Professional (header)	452,585	445,152	7,398
Institutional inpatient (header)	4,129	4,116	13

ICN: internal control number.
Number of Records Received by Encounter Type: indicates the total number of records received on the EDV study file.
Number of Records Matched to ICN: indicates the number of records on the EDV study file that were matched to IPRO's DW tables, by ICN.
Number of Records that were Voided that Started with 7: indicates the number of records received on the EDV study file that were voided and the ICN began with a '7.'

BHO Professional Data Element Discrepancies and Findings

Table 5 details the BHO **professional** discrepant data element results.

Table 5: BHO Professional Encounter Type Discrepant Fields Match Frequencies and Findings

Professional Encounter Data Element	BHO Percent Matching (%)	Reason for Discrepancy
PLAN_CODE	100.00	
RECIP_ID	100.00	
PROMISe_ICN	100.00	
MCO_ICN	95.55	
NUM_ADJ_ICN	100.00	
PLACESVC	84.46	**BH MCO response:** BHO reviewed the discrepant records and advised that claims provided on the EDV study file were processed differently than the encounters submitted to PROMISe since encounters submitted to PROMISe are cross walked to the BHSRCC grid values and only acceptable values are submitted to PROMISe on the encounter extract file. **Remote meeting discussion:** During the remote meeting, BHO advised that place of service (POS) 02, telehealth, was not available in PROMISe during the entire audit period. Examples of discrepant records that were reviewed and discussed during the remote meeting were related to ICN's that were subsequently voided (discrepant ICN's starting with '7') and the Place of Service was missing in IPRO's DW but present in the EDV study file. This was an EDV study pull issue since SOW indicated only final encounters should be submitted.
DIAGCD1	99.90	
DIAGCD2	95.76	
DIAGCD3	97.35	
DIAGCD4	98.57	
DIAGCD5	99.98	
DIAGCD6	100.00	
DIAGCD7	100.00	
DIAGCD8	100.00	
DIAGCD9	100.00	
DIAGCD10	100.00	
DIAGCD11	100.00	
DIAGCD12	100.00	
PTMT_ADJ_DATE	99.99	
AMT_BH_MCO_PAID_HDR	97.85	
AMT_OTH_INS_PD_HDR	99.19	
BILLING_PROV_ID	0.00	**Remote meeting discussion:** EDV study pull issue, the BHO EDV study file included null values for the BILLING_PROV_ID field.

Professional Encounter Data Element	BHO Percent Matching (%)	Reason for Discrepancy
		Follow-up item: Following the remote meeting, IPRO removed the ICNs that were not found on IPRO's DW and updated the matching logic.
BILLING_PROV_NPI	0.37	**BH MCO response:** BHO reviewed the discrepant records and indicated that ACA applied logic to submit the13-digit provider number. A 13-digit ID was previously being submitted to PROMISe, and if an MPI wasn't submitted, it automatically cross walked to a valid NPI. **Remote meeting discussion:** During the remote meeting, BHO advised that providers have multiple NPIs, and if the MCO submits a wrong one, then PROMISe will deny the encounter, BHO is not submitting any values. **Follow-up item:** Following the remote meeting, IPRO removed the ICNs that were not found on IPRO's DW and updated the matching logic. Following the remote meeting discussion, OMHSAS indicated that the encounter data extracts use master provider index (MPI) not the NPI and OMHSAS has most of the NPI edits turned off. MCO provides a master provider index (MPI) number, PROMISe automatically maps it to an NPI. Providers have multiple NPIs, and if an MCO submits a wrong NPI, the encounter will deny it, BHO is not submitting any NPI values to PROMISe. An NPI is not required to be submitted to PROMISe. IPRO's DW contains an NPI which is derived from the PRV430 reference file. This is an EDV study pull issue, BHO did not submit any provider NPI on the EDV study file.
RENDERING_PROV_ID	0.00	**BH MCO response:** BHO reviewed the discrepant records. **Follow-up item:** The EDV study file RENDERING_PROV_ID did not match to the IPRO's DW. The BHO EDV study file contained a value consisting of 6 digits, the BHO encounter data study file contained fewer digits than the RENDERING_PROV_ID in IPRO's DW 13 digits. IPRO attempted to match the 6 digits on the EDV study file to the first 6 digits of IPRO's DW values.
RENDERING_PROV_NPI	49.25	**BH MCO response:** BHO reviewed the discrepant records and indicated that they applied ACA logic to the raw claims data. A 13-digit ID was previously being submitted to PROMISe, and if an MPI wasn't submitted, it automatically cross walked to a valid NPI. **Remote meeting discussion:** During the remote meeting, BHO advised that providers have multiple NPIs, and if the MCO submits a wrong one, then the encounter will be denied by PROMISe, so MCOs are not submitting any values. **Follow-up item:** Following the remote meeting, IPRO removed the ICNs that were not found on IPRO's DW and updated the matching logic. Following the remote meeting discussion, OMHSAS indicated that the encounter data extracts use master provider index (MPI) not the NPI and OMHSAS has most of the NPI edits turned off. MCO provides a master provider index (MPI) number, PROMISe automatically maps it to an NPI. Providers have multiple NPIs, and if an MCO submits a wrong NPI, the encounter will deny it, BHO is not submitting any NPI values to PROMISe. An NPI is not required to be submitted to PROMISe. IPRO's DW contains an NPI

Professional Encounter Data Element	BHO Percent Matching (%)	Reason for Discrepancy
		which is derived from the PRV430 reference file. This is an EDV study pull issue, BHO did not submit any provider NPI on the EDV study file.
LINE_NUMBER	100.00	
DTE_FIRST_SVC_DTL	99.42	
DTE_LAST_SVC_DTL	90.22	
AMT_BH_MCO_PAID_DTL	99.46	
PROCCODE1	90.80	
QTY_UNITS_BILLED	99.77	
MODIFIER1	49.98	**BH MCO response:** BHO reviewed the discrepant records and indicated that they changed to utilizing modifier values submitted by the provider on the claim. **Remote meeting discussion:** During the remote meeting BHO confirmed that the EDV study file included the modifier code submitted by the provider and IPRO's DW included the modifier code submitted to PROMISe, which contains the BHSRCC mapping logic.
MODIFIER2	82.73	**BH MCO response:** BHO reviewed the discrepant records and indicated that they changed to utilizing modifier values submitted by the provider on the claim. **Remote meeting discussion:** During the remote meeting BHO confirmed that the EDV study file included the modifier code submitted by the provider and IPRO's DW included the modifier code submitted to PROMISe, which contains the BHSRCC mapping logic. **Follow-up item:** Following the remote meeting, IPRO removed the ICNs that were not found on IPRO's DW and updated the matching logic.
MODIFIER3	98.70	
MODIFIER4	100.00	

Yellow shading indicates a percent match rate of less than 90%.
Grey shading indicates a BH MCO EDV study data extraction issue.
Light green shading indicates a difference in values attributed to the BHSRCC grid mapping.
BHO: Beacon Health Options of Pennsylvania; BH: behavioral health; MCO: managed care organization; PROMISe: Provider Reimbursement and Operations Management Information System; ICN: internal control number; EDV: encounter data validation; ACA: Allan Collautt Associates, Inc.; NPI: National Provider Identifier; BHSRCC: Behavioral Health Services Reporting Classification Chart.

BHO Institutional Inpatient Data Element Discrepancies and Findings

Table 6 details the BHO **institutional inpatient** discrepant data element results.

Table 6: BHO Institutional Inpatient Encounter Type Discrepant Fields Match Frequencies and Findings

Institutional Inpatient Data Element	BHO Percent Matching (%)	Reason for Discrepancy
PLAN_CODE	100.00	
RECIP_ID	100.00	
PROMISe_ICN	100.00	
MCO_ICN	96.45	
NUM_ADJ_ICN	100.00	

Institutional Inpatient Data Element	BHO Percent Matching (%)	Reason for Discrepancy
DTE_ADMISSION	37.83	**BH MCO response:** BHO reviewed the discrepant records and indicated that they are adjusting the EDV study file pull method of deriving DTE_ADMISSION to pull based on the first service date exclusively. **Remote meeting discussion:** During the remote meeting, BHO advised that this discrepancy is related to an EDV study pull issue. The BHO EDV study pull included an admission date based on the admit date from the authorization instead of the first service date. **Follow-up item:** Following the remote meeting, IPRO removed the ICNs that were not found on IPRO's DW and updated the matching logic.
DTE_DISCHARGE	0.00	**BH MCO response:** BHO reviewed the discrepant records and indicated that they are adjusting the EDV study file pull method of deriving DTE_DISCHARGE to pull based on the last service date exclusively. **Remote meeting discussion:** During the remote meeting, BHO advised that this discrepancy is related to an EDV study pull issue. The BHO EDV study pull included a discharge date based on the admit date from the authorization instead of the last service date.
DTE_FIRST_SVC_HDR	99.44	
DTE_LAST_SVC_HDR	99.30	
ADMITTYP	70.02	**BH MCO response:** BHO reviewed the discrepant records and indicated that the value included on the EDV study file was assigned based on the last digit of the type of bill. **Remote meeting discussion:** During the remote meeting, BHO confirmed that the discrepancy was due to an EDV study pull issue. During the remote meeting discrepant records were reviewed and compared to the claim screens and the 837 string and the values matched to IPRO's DW values. **Follow-up item:** Following the remote meeting, IPRO removed the ICNs that were not found on IPRO's DW and updated the matching logic.
DIS_STAT	0.00	**BH MCO response:** BHO included null value on the EDV study file. BHO reviewed the discrepant records and indicated that BHO updated to pull from the patient status code. **Remote meeting discussion:** During the remote meeting, BHO advised that the discrepant records were reviewed comparing IPRO's DW to the patient status and the values matched to IPRO's DW. For future EDV studies, BHO advised they will pull the patient status from the National Table.
TYPEBILL	43.10	**BH MCO response:** BHO reviewed the discrepant records and indicated that TYPEBILL on the 837I is populated with '11' for all facility claims and the third digit is the frequency code. ACA cross walks the type of bill value before it is submitted. **Remote meeting discussion:** During the remote meeting, BHO advised that ACA populates the information in 837 and all facility claims submit 11. The third digit is the claim frequency code and may not reflect the incoming claim since it really reflects the number in the claim system.

Institutional Inpatient Data Element	BHO Percent Matching (%)	Reason for Discrepancy
		The type of bill logic of cross walking 114 to 111 is that 111 indicates admit to discharge and 114 indicates an interim bill. **Follow-up item: Following the remote meeting,** BHO advised they are pulling bill code from national table, and type of bill is not submitted on the encounter file. BHO applies logic for deriving claim frequency code values on outgoing institutional 837s for submission to PROMISe is as follows: - If the Institutional claim is being sent as an original to DHS: ▪ Set the claim frequency code = 1 when the patient was discharged and the admit date equals the statement begin date. ▪ Set claim frequency code = 2 when the patient was not discharged and the admit date equals the statement begin date. ▪ Set claim frequency code = 3 when the patient was not discharged and the admit date does not equal the statement begin date. ▪ Otherwise, set claim frequency code = 4. - If the Institutional claim is being sent as a void (8) or a replacement (7) to DHS, then send claim frequency code as-is.
DRG	83.92	**BH MCO response:** BHO reviewed the discrepant records and indicated that BHO does not submit DRG code values on the 837I encounter data extract. **Remote meeting discussion:** During the remote meeting, BHO and IPRO confirmed that the IPRO DW includes the APR DRG code derived by PROMISe.
DIAGCD1	99.03	
DIAGCD2	99.37	
DIAGCD3	99.54	
DIAGCD4	99.61	
DIAGCD5	99.98	
DIAGCD6	99.98	
DIAGCD7	99.98	
DIAGCD8	99.98	
DIAGCD9	99.95	
DIAGCD10	99.98	
DIAGCD11	100.00	
DIAGCD12	100.00	
DIAGCD13	100.00	
DIAGCD14	100.00	
DIAGCD15	100.00	
DIAGCD16	100.00	
DIAGCD17	100.00	
DIAGCD18	100.00	
DIAGCD19	99.95	
DIAGCD20	99.95	
DIAGCD21	99.98	
DIAGCD22	100.00	
DIAGCD23	100.00	
DIAGCD24	100.00	

Institutional Inpatient Data Element	BHO Percent Matching (%)	Reason for Discrepancy
DIAGCD25	100.00	
SURG1	100.00	
SURG2	100.00	
SURG3	100.00	
SURG4	100.00	
SURG5	100.00	
SURG6	100.00	
SURGDTE1	100.00	
SURGDTE2	100.00	
SURGDTE3	100.00	
SURGDTE4	100.00	
SURGDTE5	100.00	
SURGDTE6	100.00	
PTMT_ADJ_DATE	99.95	
AMT_BH_MCO_PAID_HDR	95.68	
AMT_OTH_INS_PD_HDR	98.98	
LINE_NUMBER	100.00	
DTE_FIRST_SVC_DTL	98.55	
DTE_LAST_SVC_DTL	98.55	
AMT_BH_MCO_PAID_DTL	97.95	
REVENUE_CODE	100.00	
BILLING_PROV_ID	0.00	**Follow-up item:** Following the remote meeting, IPRO removed the ICNs that were not found in IPRO's DW and updated the matching logic. BILLING_PROV_ID was blank in the EDV Study file originally submitted and was matching to the populated values in the Data Warehouse.
BILLING_PROV_NPI	79.66	**BH MCO response:** BHO reviewed the discrepant records and advised that they will be adjusting the EDV study pull logic for future EDV studies. **Remote meeting discussion:** During the remote meeting, BHO advised that OMHSAS confirmed that if an NPI is not submitted any time the MCO provides a master provider index (MPI) number, PROMISe automatically maps to an NPI. Providers have multiple NPIs and if an MCO submits a wrong NPI, the encounter will deny it, so MCOs are not submitting any values.
RENDERING_PROV_ID	0.00	**BH MCO response:** BHO reviewed the discrepant records and advised that they will be adjusting the EDV study pull logic for future EDV studies.
RENDERING_PROV_NPI	0.02	**BH MCO response:** BHO reviewed the discrepant records and advised that they will be adjusting the EDV study pull logic for future EDV studies.

Yellow shading indicates a percent match rate of less than 90%.
Grey shading indicates a BH MCO EDV study data extraction issue.
Light green shading indicates a difference in values attributed to the BHSRCC grid mapping.
BHO: Beacon Health Options of Pennsylvania; PROMISe: Provider Reimbursement and Operations Management Information System; ICN: internal control number; EDV: encounter data validation; ACA: Allan Collautt Associates, Inc.; NPI: National Provider Identifier; DRG: diagnosis-related group; HI: a segment in the 837 I extract that includes DRG code; OMHSAS: Office of Mental Health and Substance Abuse Services; BHSRCC: Behavioral Health Services Reporting Classification Chart.

Summary of Findings

Based on IPRO's review of the BHO EDV study file values for the sampled records, identification and research of the discrepant values, review of the discrepant reason codes received from the BH MCO, and discussions with the BH MCO and OMHSAS during and following the teleconferences, there are no major encounter data issues. However, there are areas that require further research by encounter type by the BH MCO, OMHSAS and IPRO.

The EDV study pull issues and discrepancies identified during and following the remote meeting will be addressed by the BH MCO in future EDV studies.

Challenges identified as a result of the EDV study and review of the discrepant data elements included:

Professional Claims:

- Rendering provider information on the electronic data interchange (EDI) claim loop 2310B is not submitted for professional claims. Providers have multiple National Provider Identifiers (NPIs) and if they submit an incorrect NPI, the encounter will be denied by PROMISe, so the BH MCOs are not submitting any values for billing and rendering provider NPIs, since BH encounters are processed using provider MPI instead.

Institutional Inpatient Claims:

- Regarding date of discharge, a combination of discharge and end date was used to align with the encounter; however, it was adjusted to pull discharge dates only. A discharge date isn't submitted on an 837I. The discharge date is derived from patient discharge status code and the 'to' date of service. In future EDV studies, IPRO will remove the discharge date from the list of data element requested.
- Regarding the DRG code, BHO reviewed the discrepant records and confirmed that the DRG code is not submitted to PROMISe on the 837I. During the remote meeting, BHO and IPRO confirmed that the discrepancy is associated with PROMISe deriving the APR DRG included on IPRO's DW.
- Challenges were seen with billing type since specific logic is used for deriving claim frequency code values on outgoing institutional 837s for submission to PROMISe. If the institutional claim is being sent as a void (8) or a replacement (7) to DHS, then the claim frequency code is sent as-is. The specific logic for deriving claim frequency code values on outgoing institutional 837s for submission to PROMISe can be found as a follow-up item for billing type in **Table 6**.

The primary reason identified for the data element discrepancies is related to the utilization of OMHSAS's Behavioral Health Services Reporting Classification Chart (BHSRCC) and the cross walking of data element values for submission of encounters to PROMISe. BHO reviews the encounter data submission process related to the BHSRCC requirements and data element mapping which is tied to encounter data reporting requirements.

BHO encounter data staff and subcontractors have a good understanding of the encounter data submitted to PROMISe and the PROMISe requirements.

BHO has communicated with providers that BHO only accepts professional and institutional inpatient claims files, eliminating the BH MCO's need to convert the institutional outpatient encounters to a professional encounter for submission to PROMISe on an 837P extract.