Pennsylvania's Office of Mental Health and Substance Abuse Services

2022 Encounter Data Validation Study

Magellan Behavioral Health of Pennsylvania

July 2023

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 periods 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 6–8**).
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.
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

Professional Claims Field Name	Type	Description
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, 10th Edition; 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

Institutional Inpatient Field Name	Type	Description
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
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

Institutional Inpatient Field Name	Type	Description
		Include 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; DRG: diagnosis-related group; ICD-10: International Classification of Diseases, 10th Edition; 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		

Institutional Outpatient Field Name	Type	Description
DIAGCD1	Char	Principal 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
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))

Institutional Outpatient Field Name	Type	Description
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)
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, 10th Edition; TPL: third-party liability; ID: identification; MPI: master provider index; NPI: National Provider Identifier.

Findings

Magellan Behavioral Health of Pennsylvania (Magellan) EDV study call was conducted on October 6th, 2022. Magellan's incoming data (claims) and submitted data (encounters) was reviewed for discrepancies between the submitted EDV data file and the data submitted to PROMISe for the data fields present in the professional, institutional inpatient and institutional outpatient encounter types. The attendees of the Magellan EDV study call included OMHSAS, Behavioral HealthChoices Contractor (BHHC), IPRO and Magellan.

Professional, Institutional Inpatient, and Institutional Outpatient 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 (for Professional and Institutional Outpatient): 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.
- Institutional outpatient common header: member identification number, plan identification information, statement start and end date, diagnosis codes 1-12, payment adjudication date, amounts paid, billing and rendering provider ID and NPI

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 a '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)	727,385	727,209	0
Institutional inpatient (header)	3,277	3,277	0
Institutional outpatient (header)	14,303	14,288	0

ICN: internal control number.

Institutional Claims File – Outpatient

Magellan only submits professional (837P) and institutional inpatient (837I) encounters to PROMISe. Any institutional outpatient claims and encounters received and processed by Magellan are converted, cross walked, and submitted to PROMISe as professional encounters. For the 2022 EDV study, IPRO requested Magellan to submit the institutional outpatient data as received from their providers. IPRO identified the institutional outpatient claim diagnosis codes that would not be included in the 837P encounter extract file since the professional extract allows for a maximum of 12 International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes to be submitted to PROMISe. Magellan submitted 14,303 institutional outpatient records on the EDV study file.

Table 5 identifies how many ICNs were submitted on the institutional outpatient EDV study file with values that were not submitted to PROMISe on the 837P for these data fields and would not be available to IPRO for the EDV study comparison and for subsequent reporting activities.

Table 5: Institutional Claims File – Outpatient Fields Not in Professional Format

Data Fields	Magellan Counts of Data Values Present on EDV Study Not Submitted to PROMISe
DIAGCD13	4
DIAGCD14	10
DIAGCD15	7
DIAGCD16	5

Data Fields	Magellan Counts of Data Values Present on EDV Study Not Submitted to PROMISe
DIAGCD17	3
DIAGCD18	3
DIAGCD19	1
DIAGCD20	1
DIAGCD21	1
DIAGCD22	1
DIAGCD23	1
DIAGCD24	1
DIAGCD25	1
SURG1	0
SURG2	0
SURG3	0
SURG4	0
SURG5	0
SURG6	0
SURGDTE1	0
SURGDTE2	0
SURGDTE3	0
SURGDTE4	0
SURGDTE5	0
SURGDTE6	0
REVENUE_CODE	0
REFERRING_PROV_ID	0
REFERRING_PROV_NPI	0
TYPEBILL	14,303

EDV: encounter data validation; PROMISe: Provider Reimbursement and Operations Management Information System.

Magellan Professional Data Element Discrepancies and Findings

Table 6 details the Magellan **professional** discrepant data elements results.

Table 6: Magellan Professional Encounter Type Discrepant Fields Match Frequencies and Findings

Professional Encounter Data Element	Magellan Percent Matching (%)	Reason for Discrepancy
PLAN_CODE	100.00	
RECIP_ID	100.00	
PROMISe_ICN	100.00	
MCO_ICN	96.77	
NUM_ADJ_ICN	100.00	
PLACESVC	85.01	**BH MCO response:** Magellan reviewed the discrepant records and indicated that for 837s, Magellan submits the place of service (POS) on the claim if it matches the Behavioral Health Services Reporting Classification Chart (BHSRCC). Magellan stated that if the POS does not match the BHSRCC grid, Magellan will report an appropriate code. Based on the remote meeting discussion this means that a provider value that was not based on the BHSRCC grid, was mapped to a different code value based on the BHSRCC grid.

Professional Encounter Data Element	Magellan Percent Matching (%)	Reason for Discrepancy
		Remote meeting discussion: During the remote meeting, Magellan advised that for certain code combinations, the provider value was not acceptable nor was it based on the BHSRCC grid. These provider values needed to be mapped to a different code value based on the BHSRCC grid. Magellan used their master benefit file for place of service (POS) where an inbound code has an outbound code assigned specific to the service. The number of these records which had provider values that needed to be mapped to a different code is not the majority of all records. Provider outreach and training do not manage too many of these. Magellan is working with providers and training the providers. Magellan is working closely with providers to match the master benefit file to the BHSRCC grid. POS corresponding to a given state procedure code and modifier combination sometimes changes based on the BHSRCC grid. Providers don't always keep up with the changes, resulting in Magellan getting invalid procedure codes, modifier, and POS combinations.
DIAGCD1	100.00	
DIAGCD2	99.72	
DIAGCD3	98.76	
DIAGCD4	98.71	
DIAGCD5	97.79	
DIAGCD6	99.04	
DIAGCD7	99.46	
DIAGCD8	99.68	
DIAGCD9	99.81	
DIAGCD10	99.88	
DIAGCD11	99.92	
DIAGCD12	99.94	
PTMT_ADJ_DATE	100.00	
AMT_BH_MCO_PAID_HDR	50.15	**BH MCO response:** Magellan reviewed the discrepant records and indicated that when creating the EDV study file, Magellan rolled up the costs for amount fields by claim number. However, Magellan submits ICWC encounters and reports every claim and line separately on the 837. In PROMISe, every claim contains only one LX*1. **Remote meeting discussion:** During the remote meeting, Magellan advised that there was an EDV study pull issue for this data field. Prior to submitting the EDV study file, Magellan rolled up and summarized all claim's service line and submitted the rolled up and summarized costs.
AMT_OTH_INS_PD_HDR	96.63	
BILLING_PROV_ID	0.00	**BH MCO response:** Magellan reviewed the discrepant records and indicated that IPRO is using the Master Provider Index (MPI) for comparison. Magellan reported the tax identification number (TIN) on the EDV file and submits the TIN in the 2010AA loop on the 837. The *Companion Guide* states that when the billing provider and the rendering provider are the same entity, only the billing provider is reported (per the *CMS HIPAA Implementation Guide*) using Loop 2010AA

Professional Encounter Data Element	Magellan Percent Matching (%)	Reason for Discrepancy
		(Billing Provider Name). When the billing provider and the rendering provider are not the same entity, the billing provider is reported in Loop 2010AA (Billing Provider Name) and the rendering provider is reported in Loop 2310B (Rendering Provider). Note the *CMS HIPAA Implementation Guide* instructions regarding the use of the PRV segment in Loops 2000A and 2310B. **Remote meeting discussion:** During the remote meeting, Magellan advised that the EDV data file has the TIN. The TIN is submitted on the 837 file at the 2010 level. The PROMISe provider and service location is submitted on NM*1. This issue was identified to be associated with a BH MCO EDV study pull issue.
BILLING_PROV_NPI	73.77	**BH MCO response:** Magellan reviewed the discrepant records and indicated that Magellan does not submit a Billing National Provider Identifier (NPI). On EDV file, Magellan reported what is in the CAPS system. **Remote meeting discussion:** During the remote meeting, Magellan advised that the Billing NPI is not submitted on the 837 at all. There are several NPI for each provider, but only one is used for PROMISe. The NPI in PROMISe is the one OMHSAS gave to enroll them. OMHSAS suggests that it is a good idea to submit the NPI but submit the one on the PRV 430. The MCO would need to use the cross walk or else the encounters could be denied.
RENDERING_PROV_ID	100.00	
RENDERING_PROV_NPI	65.01	**BH MCO response:** Magellan reviewed the discrepant records and indicated that Magellan does not submit the Rendering NPI on the 837.
LINE_NUMBER	60.17	**BH MCO response:** Magellan reviewed the discrepant records and indicated that, on the 837, Magellan reports a unique claim and line for every claim. Issue related to EDV study pull issue.
DTE_FIRST_SVC_DTL	99.95	
DTE_LAST_SVC_DTL	99.95	
AMT_BH_MCO_PAID_DTL	99.95	
PROCCODE1	91.48	
QTY_UNITS_BILLED	99.96	
MODIFIER1	31.49	**BH MCO response:** Magellan reviewed the discrepant records and indicated that Magellan uses as many submitted modifier codes as possible, but sometimes the BHSRCC grid is used to cross walk codes prior to submission to PROMISe. **Remote meeting discussion:** During the remote meeting, Magellan advised that the discrepant records are strictly driven by Magellan conversion of modifiers to state modifiers based on the BHSRCC grid. The differences between the claims and the 837 encounters are attributed to the BHSRCC grid. Modifier codes may be changed by the BH MCO to align to OMHSAS's BHSRCC grid.

Professional Encounter Data Element	Magellan Percent Matching (%)	Reason for Discrepancy
MODIFIER2	48.05	**BH MCO response:** Magellan reviewed the discrepant records and indicated that Magellan uses as many submitted modifier codes as possible, but sometimes the BHSRCC grid is used to cross walk codes prior to submission to PROMISe. **Remote meeting discussion:** During the remote meeting, Magellan advised that the EDV data file demonstrated that there were codes used to depict the payment of two services on the same day. This prevents a duplicate denial in Magellan's system. BHSRCC codes specific to payment of two services on the same day (which prevent a duplicate denial in Magellan's system) are used. Modifier codes may be changed by the BH MCO to align to OMHSAS's BHSRCC grid.
MODIFIER3	93.39	
MODIFIER4	99.87	

Yellow shading indicates match percentage 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.
BH: behavioral health; MCO: managed care organization; PROMISe: Provider Reimbursement and Operations Management Information System; ICN: internal control number; EDV: encounter data validation; TIN: taxpayer identification number; CMS: Centers for Medicare and Medicaid Services; HIPAA: Health Insurance Portability and Accountability Act of 1996; OMHSAS: Office of Mental Health and Substance Abuse Services; BHSRCC: Behavioral Health Services Reporting Classification Chart.

Magellan Institutional Inpatient Data Element Discrepancies and Findings

Table 7 details the Magellan **institutional inpatient** discrepant data elements results.

Table 7: Magellan Institutional Inpatient Encounter Type Discrepant Fields Match Frequencies and Findings

Institutional Inpatient Data Element	Magellan Percent Matching (%)	Reason for Discrepancy
PLAN_CODE	100.00	
RECIP_ID	100.00	
PROMISe_ICN	100.00	
MCO_ICN	100.00	
NUM_ADJ_ICN	100.00	
DTE_ADMISSION	90.39	
DTE_DISCHARGE	2.04	**BH MCO response:** Magellan reviewed the discrepant records and indicated that on the EDV file, Magellan provided the discharge date for the complete member episode. Magellan does not submit a discharge date to PROMISe. **Remote meeting discussion:** During the remote meeting for a particular example on the EDV study, this was a derived discharge date. Magellan advised that they do not capture the discharge date in their system and that they do not submit that. The discharge date provided on the extract was a derived date. Magellan would not have provided the discharge

Institutional Inpatient Data Element	Magellan Percent Matching (%)	Reason for Discrepancy
		date on the 837s – they described that it was not a required field because they were not getting rejections for this. Discharge date is not submitted on the 837I and only discharge time, which is required when patient status code is reporting "discharged."
DTE_FIRST_SVC_HDR	99.15	
DTE_LAST_SVC_HDR	99.18	
ADMITTYP	9.61	**BH MCO response:** Magellan reviewed the discrepant records and indicated that Magellan reported the Admission Source on the EDV file, not Admission Type. On the 837, Magellan reports the value 2 for all Admission Type records. **Remote meeting discussion:** During the remote meeting, Magellan advised that the admission type source is not the admission type reported for the EDV study.
DIS_STAT	84.25	**BH MCO response:** Magellan reviewed the discrepant records and indicated that, on the 837 file, Magellan reports Discharge Status and Bill Type based on episode building logic. Provider submissions of these values have historically not always been accurate. **Remote meeting discussion:** During the remote meeting, Magellan advised that there is logic that creates an episode for the member. Magellan may need to look at a straight pass through. Magellan will review discharge and bill type. Magellan has started to review the process and volume (10–15%). The encounter would need to be corrected, reported, and resubmitted.
TYPEBILL	85.60	**BH MCO response:** Magellan reviewed the discrepant records and indicated that, on the 837 file, Magellan will cross walk the Discharge Status and Bill Type. Provider submissions of these values have historically not always been accurate. **Remote meeting discussion:** During the remote meeting, Magellan advised that Magellan will correct the logic.
DRG	69.94	**BH MCO response:** Magellan reviewed the discrepant records and indicated that Magellan did not populate this field on the EDV file. On the 837, Magellan derives the DRG from the primary diagnosis code. **Remote meeting discussion:** During the remote meeting, Magellan advised that the DRG is driven by the principal diagnosis code. PROMISe calculates the DRG using APR DRG. Magellan does not use the submitted DRG for any payment or processing; it is simply pulled and passed through the 700 series edits. All institutional claims have the DRG in the claim-level NTE segment starting at position 5. The format is a string.
DIAGCD1	100.00	
DIAGCD2	100.00	
DIAGCD3	100.00	
DIAGCD4	100.00	
DIAGCD5	100.00	
DIAGCD6	100.00	
DIAGCD7	100.00	

Institutional Inpatient Data Element	Magellan Percent Matching (%)	Reason for Discrepancy
DIAGCD8	100.00	
DIAGCD9	100.00	
DIAGCD10	100.00	
DIAGCD11	100.00	
DIAGCD12	100.00	
DIAGCD13	84.62	**BH MCO response:** Magellan reviewed the discrepant records and indicated that DIAGCD13 was identified as discrepant, but an explanation was not provided. **Remote meeting discussion:** During the remote meeting, Magellan advised that this was an EDV study pull issue. What Magellan has in PROMISe matched what was in CAPS, but it was submitted incorrectly in the data file. DIAGCD13 for institutional inpatient claims was determined to be an EDV study pull issue.
DIAGCD14	96.34	
DIAGCD15	96.86	
DIAGCD16	97.50	
DIAGCD17	97.80	
DIAGCD18	98.14	
DIAGCD19	98.72	
DIAGCD20	98.96	
DIAGCD21	99.24	
DIAGCD22	99.30	
DIAGCD23	99.51	
DIAGCD24	99.63	
DIAGCD25	99.69	
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	100.00	
AMT_BH_MCO_PAID_HDR	98.02	
AMT_OTH_INS_PD_HDR	91.64	
LINE_NUMBER	91.94	
DTE_FIRST_SVC_DTL	100.00	
DTE_LAST_SVC_DTL	100.00	
AMT_BH_MCO_PAID_DTL	100.00	
REVENUE_CODE	95.97	

Institutional Inpatient Data Element	Magellan Percent Matching (%)	Reason for Discrepancy
BILLING_PROV_ID	0.00	**BH MCO response:** Magellan reviewed the discrepant records and indicated that Magellan reported the TIN on the EDV file and submits the TIN in the 2010AA loop.
BILLING_PROV_NPI	67.53	**BH MCO response:** Magellan reviewed the discrepant records and indicated that Magellan does not report the Billing NPI on the 837 file. **Remote meeting discussion:** During the remote meeting, Magellan advised that Magellan does not submit an NPI on the 837 file or on the extract for the EDV. It is the same issue as for the professional encounter type. If an NPI is submitted, the NPI will need to match on the PRV 430. The MPI submitted on the provider cross walks with what is on PROMISe. There are NPIs that are in PROMISe for a provider; however, several providers have multiple NPIs which is an issue as Magellan discussed.
RENDERING_PROV_ID	100.00	
RENDERING_PROV_NPI	0.00	**BH MCO response:** Magellan reviewed the discrepant records and indicated that Magellan does not submit using the 2430 Rendering NPI Loop on the 837. **Remote meeting discussion:** During the remote meeting, Magellan advised that the NPI would not have been submitted and would not be matching.

Yellow shading indicates match percentage 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.
BH: behavioral health; MCO: managed care organization; PROMISe: Provider Reimbursement and Operations Management Information System; ICN: internal control number; EDV: encounter data validation; DRG: diagnosis-related group; TIN: taxpayer identification number; NPI: National Provider Identifier; MPI: master provider index; BHSRCC: Behavioral Health Services Reporting Classification Chart.

Magellan Institutional Outpatient Data Element Discrepancies and Findings

Table 8 details the Magellan **institutional outpatient** discrepant data elements results.

Table 8: Magellan Institutional Outpatient Encounter Type Discrepant Fields Match Frequencies and Findings

Institutional Outpatient Data Element	Magellan Percent Matching (%)	Reason for Discrepancy
PLAN_CODE	100.00	
RECIP_ID	100.00	
PROMISe_ICN	100.00	
MCO_ICN	96.95	
NUM_ADJ_ICN	96.95	
DIAGCD1	100.00	
DIAGCD2	100.00	
DIAGCD3	100.00	
DIAGCD4	100.00	
DIAGCD5	100.00	
DIAGCD6	100.00	
DIAGCD7	100.00	
DIAGCD8	100.00	

Institutional Outpatient Data Element	Magellan Percent Matching (%)	Reason for Discrepancy
DIAGCD9	100.00	
DIAGCD10	100.00	
DIAGCD11	100.00	
DIAGCD12	100.00	
PTMT_ADJ_DATE	100.00	
AMT_BH_MCO_PAID_HDR	45.17	**BH MCO response:** Magellan reviewed the discrepant records and indicated that in creating the EDV claim file, Magellan rolled up costs by claim number. However, Magellan reports every claim and line separately on the 837. In PROMISe, every claim has an LX*1, but in the claim system it could have several lines. **Follow-up item:** Magellan presented claims screen of examples.
AMT_OTH_INS_PD_HDR	91.45	
BILLING_PROV_ID	0.00	**BH MCO response:** Magellan reviewed the discrepant records and indicated that Magellan reported the TIN on the EDV file and submits the TIN in the 2010AA loop.
BILLING_PROV_NPI	97.77	
RENDERING_PROV_ID	100.00	
RENDERING_PROV_NPI	95.14	
LINE_NUMBER	51.76	**BH MCO response:** Magellan reviewed the discrepant records and indicated that, on the 837, Magellan reports a unique claim and line for every claim. **Follow-up item:** Magellan provided a claims screen print and 837 string.
DTE_FIRST_SVC_HDR	56.70	**BH MCO response:** Magellan reviewed the discrepant records and indicated that, on the 837, Magellan reports unique claim and line for every claim. **Follow-up item:** Magellan provided a claims screen print and 837 string.
DTE_LAST_SVC_HDR	56.79	**BH MCO response:** Magellan reviewed the discrepant records and indicated that, on the 837, Magellan reports a unique claim and line for every claim. **Follow-up item:** Magellan provided a claims screen print and 837 string.
DTE_FIRST_SVC_DTL	100.00	
DTE_LAST_SVC_DTL	100.00	
AMT_BH_MCO_PAID_DTL	100.00	
PROCEDURE_CODE	93.85	
UNITS_BILLED	100.00	
MODIFIER1	16.83	**BH MCO response:** Magellan reviewed the discrepant records and indicated that modifier codes may be changed by the BH MCO to align to OMHSAS's BHSRCC grid. **Follow-up item:** Magellan provided a claims screen print and 837 string for the ICN example.

Institutional Outpatient Data Element	Magellan Percent Matching (%)	Reason for Discrepancy
MODIFIER2	76.60	**BH MCO response:** Magellan reviewed the discrepant records and indicated that modifier codes may be changed by the BH MCO to align to OMHSAS's BHSRCC grid. **Follow-up item:** Magellan provided a claims screen print and 837 string for the ICN example.
MODIFIER3	100.00	
MODIFIER4	100.00	

Yellow shading indicates match percentage 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.
BH: behavioral health; MCO: managed care organization; PROMISe: Provider Reimbursement and Operations Management Information System; ICN: internal control number; EDV: encounter data validation; TIN: taxpayer identification number; BHSRCC: Behavioral Health Services Reporting Classification Chart.

Summary of Findings

Based on IPRO's review of the Magellan 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. Common sources of discrepancies that led to match percentages less than 90% included: rolled-up costs reported on the header level in the EDV data file as opposed to claims being reported on multiple lines with portions of the cost in PROMISe for cost data fields; the discrepancies accounted for by mapping codes that were submitted by providers to the Behavioral Health Services Reporting Classification Chart (BHSRCC) grid; EDV study pull issues with incorrectly pulled data for fields by Magellan; derived/calculated discharge date (a field which is not submitted to PROMISe); and the reporting of discharge status and bill type based on episode building logic which has been historically inaccurate.

Based on PROMISe encounter data submission requirements, BH MCOs including Magellan submit institutional outpatient claims as professional. As a result, the diagnosis codes from 13 to 25 would not be included on the PROMISe extracts, which may impact OMHSAS's reporting based on PROMISe data elements. This is noted in the report, but not identified as a weakness or opportunity for improvement for the BH MCO, since Magellan is following OMHSAS companion guidelines for submission of encounters.

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 with conducting of the EDV study and review of the discrepant data elements included:

Professional Claims:

- Procedure code and modifier codes may be changed by the BH MCO to align to OMHSAS's usually semi-annual BHSRCC.

Institutional Inpatient Claims:

- EDV study pull issue: the amount paid found on the service line was submitted to PROMISe, but the summarized amount paid was submitted for the EDV study.
- Revenue codes may be changed by the BH MCO to align to OMHSAS's usually semi-annual BHSRCC.
- Since providers have multiple National Provider Identifiers (NPIs), if Magellan submits an incorrect NPI, the encounter will be denied by PROMISe; therefore, the BH MCOs are not submitting any values for Billing Provider NPI and Rendering Provider NPI.

Institutional Outpatient Claims:

- EDV study pull issue: the amount paid found on the service line was submitted to PROMISe, but the summarized amount paid was submitted for the EDV study.

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. Magellan reviews the encounter data submission process related to the BHSRCC requirements and data element mapping which is tied to encounter data reporting requirements.

Magellan encounter data staff and subcontractors have a good understanding of the encounter data extracts and the PROMISe requirements.