Commonwealth of Pennsylvania
Department of Human Services
Office of Mental Health and Substance Abuse Services

2016 Encounter Data Onsite Validation

Community Behavioral Health

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Glossary of Terms

APA	Alternate payment arrangements (APAs) include any payment arrangement between MCO and its providers other than Fee-for-Service (FFS). Some alternative payment arrangements call for the reporting of zero monetary amounts on the 837 transaction files.
BH Eligibility Slice File	Quarterly eligibility file received by IPRO from Department of Human Services (DHS). The file contains date of birth, county, gender, race, ethnicity, recipient ID#, assistance/aid categories, effective and expiration dates.
BHSRCC	Behavioral Health Services Reporting Classification Chart. OMHSAS updates and distributes the chart to the BH-MCOs semi-annually. The chart assists the BH-MCOs with determining the appropriate coding of services for both financial and encounter data reporting for HealthChoices. The BHSRCC grid is intended to assist the BH-MCOs in establishing edits in their reporting processes. However, it is not in any way intended to limit or expand behavioral health services in the HealthChoices Program. OMHSAS advises the BH-MCOs to keep the previous charts as reference guides.
ICN	Internal Control Number. 13- Digit unique identification number assigned to each claim processed in PROMISe.
CIS	DHS's client information system (CIS) that is available to the BH-MCOs to access enrollment information.
ESC	Error Status Code. PROMISe error codes for encounters submitted by BH-MCOs. ESC dispositions are typically set to pay and list or deny, occasionally to super-suspend, which are then recycled by DXC Technology.
MAID	Medical Assistance Identification Number. Assigned to a member by DHS.
PM FUH	Follow-up After Hospitalization for Mental Illness (FUH) performance measure (PM). This 2016 BH PM assesses the percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis or who were in day/night treatment with a mental health provider on the date of discharge up to seven and 30 days after hospital discharge. BH-MCOs are required to submit data files and source code to IPRO. For this measure two separate versions are requested: HEDIS specifications and PA-specific specifications.
PM REA	Readmission Within 30 Days of Inpatient Psychiatric Discharge. This 2016 BH PM assesses the percentage of discharges for enrollees from inpatient acute psychiatric care that are subsequently followed by an inpatient acute psychiatric care readmission within 7 and 30 days of the previous discharge. BH-MCOs are required to submit data files and source code to IPRO.
PROMISe	Provider Reimbursement and Operations Management Information System (in electronic format). DHS's claim processing and management information system provided by DXC Technology stands. PROMISe accepts HIPAA 837 files for claims processing.

Introduction

HealthChoices Behavioral Health (BH) is the mandatory managed care program which provides Medical Assistance recipients with BH services in the Commonwealth of Pennsylvania (PA). The PA Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) contracted with IPRO as its external quality review organization (EQRO) to conduct the 2016 Encounter Data Validation (EDV) onsite reviews for the HealthChoices BH managed care organizations (BH-MCOs).

Encounter data validation is an ongoing process, involving the MCOs, the state encounter data unit and the EQRO. It includes both a baseline evaluation and ongoing monitoring of submission patterns. The purpose of this monitoring is to identify and resolve issues that arise in the encounter data submission process. In 2013, BH-MCO onsite reviews were conducted as a baseline evaluation of the BH-MCO encounter data units. In the third quarter of 2016 and the first and second quarters of 2017, BH-MCO's onsite visits and calls were conducted as a part of the ongoing monitoring of submission of encounter data to the DHS's claim processing and management information system, Provider Reimbursement and Operations Management Information System (PROMISe).

Since 2005, on a weekly basis, IPRO receives encounter data extracts from PROMISe and loads the files to IPRO's Statistical Analysis Software (SAS) data warehouse (DW). For physical health (PH) encounter data, IPRO loads the PROMISe paid/accepted dental, professional, institutional and pharmacy extracts (Table 1). For BH encounter data, IPRO loads the PROMISe paid/accepted professional and institutional data extracts to its DW. Since January 1, 2012, IPRO also loads the PROMISe denied BH encounter data to its DW. As the weekly PH and BH encounter data extracts are loaded into IPRO's DW, IPRO conducts checks on the data elements and volumes received (Table 1).

Table 1: Physical and Behavioral Health Encounter Data Volume

Encounter Type	Claim Volume
Physical Health[1]	
Institutional	62,622,327
Professional	208,985,522
Dental	9,586,305
Pharmacy	368,870,836
Behavioral Health[1]	
Institutional	1,593,010
Professional	183,497,799

[1] Claim header volume stored in IPRO's data warehouse as of 1/23/2017.

In addition, on a quarterly basis, IPRO receives the PH and BH eligibility slice files from DHS and loads them into IPRO's SAS DW. The BH eligibility slice file contains eligibility and limited demographic information about members, such as date of birth, county, gender, race, ethnicity, recipient ID#, assistance/aid categories, effective and expiration dates.

On a monthly basis, IPRO attends the Encounter Action Team (EAT) technical meetings with DHS, DXC Technology (formerly known as HP), which provides technical discussions on encounter data submission issues, change orders and defect statuses. On a monthly basis, IPRO also attends the technical PROMISe call with DXC Technology, Office of Medical Assistance Programs (OMAP), Mercer and the PH MCOs to discuss encounter data submission status and issues regarding the PH encounter data submissions. IPRO also participates on weekly PH calls with DHS and bi-weekly calls with OMHSAS to discuss BH encounter data validation activities.

During 2016 and 2017, as part of CMS's EDV protocol activities, IPRO reviewed and analyzed each BH-MCO's capability to produce encounter data and their electronic PROMISe submission process for accuracy and completeness. The BH-MCOs were instructed to complete an information systems capabilities assessment (ISCA) tool that IPRO developed based on CMS's ISCA tool developed on 5/1/2002. IPRO analyzed information from the ISCA tool and conducted a one-day onsite review or a four-hour webinar with each BH-MCO.

The ISCA and the EDV onsite visits/webinars focused on the following areas:

- enrollment systems,
- claims and encounter systems,
- BH performance measure (PM) development, and
- PROMISe submission and reconciliation process.

Encounter Data Validation Process

The BH-MCOs were requested to complete and return the ISCA tool to IPRO prior to the EDV onsite visit. IPRO modified the 5/1/2002 version 1.0 ISCA found in CMS's appendix section of the External Quality Review Activity Protocol. IPRO tailored the questions for the BH-MCO, DHS and PROMISe submission process. IPRO also included a section on the BH-MCOs annual performance measure development activities and processes. The purpose of the assessment was to specify the capabilities of the BH-MCO's information systems (IS) and to pose standard questions to be used to assess the strengths of the BH-MCO with respect to these capabilities. The ISCA assisted IPRO to assess the extent to which the BH-MCO's IS is capable of producing valid encounter data, PM member-level data, tracking PROMISe encounter data submissions and other data necessary to support quality assessment and improvement and PM improvement programs.

The ISCA was divided into the following sections:

1. General Information
2. Enrollment Systems
    a. Enrollment File Loads and Eligibility System(s)
    b. Enrollment Reporting System
3. Claim Systems
    a. Claims Types and Volume
    b. Claims Processing
    c. Claims Reporting System
4. Reporting
5. PROMISe Submission
    a. Encounter Data Submission
    b. Denial and Resubmission Processes

IPRO conducted a one-day onsite visit or a four-hour webinar with each BH-MCO. The purpose of the onsite visits/webinar was:

1. to be able to review the ISCA findings with the appropriate BH-MCO staff, and discuss any outstanding questions regarding the BH-MCO's ISCA responses;
2. to review the BH-MCO's production enrollment, claim/encounter, and PROMISe submission and PM development processes; and
3. to view member and claim examples selected from the 2016 BH Performance Measure HEDIS Follow-up After Hospitalization for Mental Illness (FUH) member-level data files submitted on the BH-MCO's system screens.

General Information

Community Behavioral Health (CBH) has participated in the BH HealthChoices contract since 1997. In 2016, CBH continued to service one county for the HealthChoices product line, Philadelphia. Their average enrollment in 2015 was 520,970 members (Table 2).

As of the last CBH EDV onsite visit on July 11, 2013, CBH has undergone a major system conversion. CBH was in the process of retiring BRAHMS, their claims adjudication system, and implementing a new claims processing system, XeoHealth XeoRules Solution. XeoRules is a software package offered by XeoHealth for claims processing. As of October 1, 2015, XeoRules began to process claims electronically. BRAHMS was being used to adjudicate third party liability (TPL) and paper claims (approximately 3% of the total claim volume). As of September 1, 2016, XeoRules began adjudicating TPL claims received electronically, but currently only one provider has the capability to submit TPL claims electronically. Since October 1, 2015, XeoRules has processed all CBH electronic claims. BRAHMS continues to exist in a "read only" mode to allow historical views of electronic claims. In regards to non-electronic claims, BRAHMS is processing the TPL and out-of-network provider claims that are received on paper.

The 2016 EDV onsite visit was held in CBH's offices in Philadelphia, PA on December 12, 2016. OMHSAS and IPRO attended the onsite visit. CBH and CBH contractors, Allan Collautt Associates, Inc. (ACA) and XeoHealth also attended the onsite visit.

ACA MASTRR™ Monitor application, MASTRR Sync eligibility database and XeoRules for claims processing were reviewed during the onsite visit. As of the onsite visit date, the electronic claims implementation in XeoRules was complete and the paper claims implementation was in process. The entry of TPL claims into XeoRules began in September 2016 and is expected to be completed by December 31, 2017.

Table 2 lists the PA BH counties where CBH enrolled members during 2015 and the average monthly number of HealthChoices members enrolled for the period from January 1, 2015 to December 31, 2015:

Table 2: Average Monthly HealthChoices Enrollment by County

BH-MCO County Name	Average Monthly Enrollment in 2015
Philadelphia	520,970

Enrollment Systems

CBH's primary source of enrollment information is the 834 Daily Eligibility File received from OHMSAS. These files communicate information about newly eligible members, updated demographic information, changed or terminated eligibility for existing members, and negated or deleted eligibility for members previously thought to be eligible. This information is extracted from the daily eligibility files and applied to the ACA HealthChoices eligibility system, which then generates a set of files containing eligibility and demographic information used to refresh the MASTRR Sync eligibility database at CBH. The MASTRR Sync database is then used to update eligibility data in the CBH operational systems. The 834 Daily Eligibility File also contains added, changed, or deleted TPL information for each member. Extracted TPL information is forwarded to CBH without any pre-processing for use by the operational systems.

CBH also utilizes the following two enrollment files to validate and supplement the 834 daily eligibility file:

1. 834 Monthly Eligibility File – This file provides a snapshot of all members projected to be eligible as of the first day of the month following receipt of the file. The monthly eligibility files are, therefore, used to identify and terminate open eligibility for members for whom termination information was never communicated in a daily file.
2. 820 Monthly Capitation File – This file is used as the primary source to terminate members. If a member does not appear on this file, they are terminated on CBH's eligibility system.
3. Monthly TPL File – This file contains new, changed or deleted TPL information, which is applied to the ACA HealthChoices eligibility system. The TPL file is uploaded into XeoRules and BRAHMS since both claim systems are adjudicating TPL claims.

Each daily eligibility file is uploaded upon receipt at ACA via an automated process. A set of daily eligibility sync files is generated and transferred to CBH upon completion of the DHS 834 file import. ACA eligibility information is also updated manually by authorized data analysts under the following circumstances: 1) the automated eligibility process registers an error requiring manual intervention typically less than once a week; 2) upon receipt of an inquiry from a CBH business systems analyst – several times per month; and 3) following upload of monthly 820 premium payment files which reveal discrepancies between eligibility and capitation data. All such manual changes are communicated to CBH in the next day's eligibility sync files.

CBH's primary source of enrollment data is the MASTRR Monitor application. In the course of processing the 834 eligibility files, new members, identified by their unique PA recipient medical assistance identification number (MAID) numbers and social security numbers (SSNs), are assigned unique client identification (Client ID) values in the MASTRR Monitor application. If the SSN associated with an incoming Recipient MAID number is already associated with another member in the system, the SSN will be removed from the existing members account and added for the incoming member. These unique Client ID values are maintained as eligibility data flows to the MASTRR Sync eligibility database and CBH operational systems. In the event a member is disenrolled and re-enrolled following a lapse in coverage, the active episode is closed as of the termination date and a new episode is added for the member with the new effective date. Members retain the same unique system-assigned Client ID number across episodes of eligibility

The majority of members in HealthChoices are assigned a single MAID by DHS. However, an individual can be known by multiple Recipient MAID numbers in the DHS client information system (CIS) in the event of an adoption. In these cases, each MAID is initially associated with a unique CBH Client ID and the cases can be linked by identifying the MAID with the adopted member's SSN associated with it in the past.

CBH enrolls members on the effective date provided on the daily 834 enrollment files. HealthChoices disenrollment in a given county typically occurs on the last day of the month. HealthChoices eligibility terminations that do not occur on the last day of the month are generally the result of the member being placed in some kind of facility (e.g., juvenile detention and long-term care).

CBH utilizes a relational database for enrollment data reporting. This database is refreshed daily with a feed of eligibility information from the MASTRR Monitor application. The database is validated to ensure data completeness. CBH stores and is able to report on enrollment and demographic categories.

During the onsite visit, IPRO requested and CBH demonstrated their enrollment system data entry, enrollment history and demographic screens.

As part of EDV, IPRO compared the 2016 FUH PM member-level data to data in the BH paid/accepted PROMISe DW tables maintained by IPRO. IPRO also compared the enrollment information of the members included on the 2016 FUH PM member-level file to IPRO's BH Eligibility DW.

Prior to the EDV onsite visit, IPRO compared the members included in the 2016 FUH PM member-level data file to IPRO's BH eligibility data. IPRO utilized the enrollment data to verify and flag any members that were not enrolled with CBH on the discharge date or were enrolled with a different BH-MCO on the discharge date. IPRO identified three member records with enrollment history discrepancies and reviewed the member records during the onsite visit. The following data elements were reviewed during the EDV onsite visit on CBH's enrollment system for the three members: recipient ID#, date of birth, last and first name and enrollment and disenrollment dates for 2015.

The following observations were made:

1. Member last and first name: IPRO was not able to confirm member last and first name in IPRO's DW, since the information is not available in the quarterly BH Eligibility Slice File. The name on the 2016 FUH PM member-level data file matched the name in CBH's enrollment system for all three records.
2. Date of birth: IPRO was able to confirm that the date of birth on CBH's enrollment system matched the date of birth on IPRO's BH Eligibility DW for all three members.
3. Enrollment history: The effective and expiration dates from CBH's enrollment system did not match the dates on IPRO's BH Eligibility DW. Based on IPRO's experience, the earliest enrollment date discrepancies may be related to retroactivity and timing issues with the receipt of the quarterly BH Eligibility Slice File.

Prior to the EDV onsite visit, IPRO also identified 17 members found on the 2016 FUH PM member-level data file whose recipient identification number did not match the recipient identification number received by IPRO on the PROMISe institutional encounters. IPRO selected two of the 17 member records to review and verify member enrollment data during the onsite visit. During the EDV onsite visit, it was identified that the change in recipient identification number was associated with adoption for the two members. Table 3 illustrates an example of the enrollment records for one adopted member. The two children's recipient identification number was changed by CBH in their enrollment system after the daily 834 eligibility file reflected the adoption. CBH's enrollment system retains the original recipient identification number, the historical enrollment and claims data for the member and links the two enrollment records.

Table 3 lists the enrollment data for the adopted member received by IPRO for the period from January 1, 2015 to December 31, 2015.

Table 3: Enrollment Data for Adopted Member

Member	Recipient ID#	Effective Date	Expiration Date
A	1	1/1/2015	1/4/2015
		1/5/2015	1/20/2015
	2	2/1/2015	3/31/2015
		4/1/2015	6/30/2015
		7/1/2015	9/30/2015
		10/1/2015	12/31/2015

Claims/Encounter Systems

CBH receives and processes claims[1] from providers in three different formats: 837 files from providers, direct online entry via CBH's provider accesses website, and HCFA1500 and UB04 paper claims. Approximately 6.5 million claims with a date of service in 2015 were received and processed as of the date of the onsite visit. Approximately 98% of CBH's claims are received electronically. The remaining 2% of the claims were TPL or out-of-network provider claims that were received on paper and entered manually. As of the onsite visit, only one CBH provider is able to electronically submit TPL claims. CBH indicated that the MCO is continuing to work with their providers to transition submission of TPL claims from paper to an electronic version.

CBH receives almost all claims in electronic format. Once a claim is received, CBH's first step is to perform structural validation of the electronic data interchange (EDI) 837 file to verify the data format. Failure of these validation steps cause the claim to be returned to the sender. The system processes the 837 data through a series of front-end edits. Failures from the system front-end edits are returned to the sender as a rejection. After the claim passes the EDI validation and front-end edits, it is accepted for adjudication. The claim is processed against a series of adjudication rules determining if the claim and respective services are valid. Results from the adjudication process are returned to the sender.

CBH is in the process of transitioning their entire claims adjudication from BRAHMS to XeoRules; the last phase of the transition is the conversion of TPL claim processing from BRAHMS to XeoRules, which began in September 2016 and is expected to be completed by December 31, 2017. XeoRules is processing all electronic claims and 78% of the paper claim batches (66% of paper claim lines). The other 22% of paper claim batches (34% of the paper claim lines) are being adjudicated in BRAHMS.

CBH does not allow original claims data to be changed by the claims staff. Paper claims missing required data are presented to the claims entry staff for evaluation with the appropriate error code. EDI claims with missing, incomplete or invalid fields are rejected.

CBH uses the XeoRules which applies rules to claims for adjudication to ensure that the claims are correctly adjudicated. CBH applies front-end edits prior to adjudication. Claims failing the front-end edits are rejected, requiring the provider to correct the error and resubmit the claim.

Prior to September 1, 2015, claims adjudicated in BRAHMS were pended if the member had TPL present. On or after September 1, 2015, paper claims entered and adjudicated in BRAHMS are pended if the member has a TPL indicator noted in the claims system or if TPL is noted on the paper claim received. On a daily basis, pended claims are evaluated manually and released. CBH claims entered and adjudicated in XeoRules on or after September 1, 2015 are paid or denied and not pended for medical review. Table 4 presents the number of claims paid or denied in 2015.

Table 4: Paid and Denied Claims in 2015

Type of Claim/Encounter	Claims Paid	Claims Denied
Institutional	64,193	26,621
Professional	5,770,496	724,139

CBH stores adjudicated and approved claims data in a relational database for reporting purposes. Claims that are "backed out" or "MCO denied" with an amount paid less than zero are not stored in CBH's reporting data repository. Checks on the number of claims and correct format of fields are done prior to loading to the database. The database is updated with claim approval or denial status after submission to PROMISe. Since CBH's data reporting repository includes only MCO-paid claims, CBH extracts MCO-denied claims for the development of the BH PM rates directly from XeoRules.

[1] For the purposes of this report, the word "claim" is used to represent both claim and encounter data.

Based on CBH's ISCA response, their professional services data are on an average 93% complete and institutional services are on an average 78% complete three months after the end of the month in which the service was rendered. Combined services are on an average 90% complete.

CBH stores claims and encounter data in their reporting system from the inception of their contract with DHS in 1997. Historical data is accessed through the online reporting system.

For claims with a payment date before October 1, 2015, encounter claims are pulled directly from CBH's operational system, by pay date, usually on a monthly basis. For claims with a payment date on or after October 1, 2015, the XeoRules application retrieves the list of claims that are to be considered for submission to DHS, directly from the operational database that contains the transaction log file information populated directly from the adjudication system. In addition, the application compares all processed claims that were processed prior to the current run date against a list of all the claims that have been sent to the state. Any claims that may be identified as not previously sent are added to the latest run. A weekly report is run indicating the number of claims that were identified for submission along with outstanding encounter responses from the state, as well as rejection and acceptance percentages.

As per CBH's contract with providers, a provider can submit "clean claims" no more than 90 days following the date of service for covered services. In the event a provider is pursuing coordination of benefits (COB), the provider must obtain a final determination from the primary payer dated no more than 180 days following the date of service and submit a clean claim to CBH within 90 days after receipt of a determination from the primary payer. "Unclean rejected claims" must be resubmitted as clean claims within these time requirements. CBH reserves the right to make no payments for claims received beyond these time requirements.

Prior to the EDV onsite visit, IPRO compared the PROMISe ICNs included in the denominator and numerator of the 2016 FUH PM member-level data file to IPRO's BH PROMISe accepted/paid institutional and professional DW tables.

IPRO selected three institutional PROMISe ICN records and two professional ICN records with discrepancies to review on CBH's claim system for accuracy during the EDV onsite visit. The following data elements were reviewed during the EDV onsite review on CBH's claim system: recipient ID, admission and discharge dates, dates of service, diagnosis codes, revenue codes, UB type of bill code, hospital/provider ID number, place of service (POS), patient discharge status codes and Current Procedural Terminology (CPT) codes.

The following observations were noted during the EDV onsite review of the three inpatient and two professional records:

1. Discharge date: CBH utilizes the authorization end date instead of the claim's discharge date in the source code logic used to develop the FUH member-level data file.
2. Diagnosis codes: for encounters with adjudication dates prior to September 30, 2015, CBH only submitted up to two diagnosis codes to PROMISe; therefore, IPRO's PROMISe DW did not reflect any diagnosis codes after the second. CBH confirmed that for all claims with adjudication date on or after October 1, 2015, CBH submits all secondary diagnosis codes received from the provider to PROMISe.
3. POS code: prior to submission of professional encounters to PROMISe, the POS code '03' is mapped to POS code of '99' for claims except certain alcohol and drug abuse services listed in Table 5.

Table 5: Professional Encounters Where POS '03' Not Mapped to '99'

Specialty	Proc. Code	Price Mod.	Info Modifier	Service Description	Units	POS[1]
184	H0047	--	HA	Alcohol and/or other drug abuse services, not otherwise specified (Drug and Alcohol Outpatient Treatment in an Alternative Setting)	15 min	03, 99

[1] CBH utilizes the BHSRCC grid to crosswalk all POS codes to '99', though if a professional claim with a POS of '03' is received by a provider with a specialty of '184' and a service line with a HCPCS code of 'H0074' and a modifier of 'HA' the POS is not mapped and CBH submits a POS code of '03'.
184: outpatient drug and alcohol; H0047: alcohol and/or other drug abuse services; HA: child/adolescent program; 03: school; 99: other place of service.

PROMISe Submission and Reconciliation Process

CBH creates the PROMISe submission files using a relational database. CBH submits all MCO-paid claims to PROMISe, MCO-denied claims are not submitted to PROMISe. For encounters with an adjudication date before October 1, 2015, the PROMISe submission file was extracted from BRAHMS. When a submission file was created, the claim and line number was stored for tracking purposes. A status flag was assigned to each submitted encounter. When the PROMISe response file was received, the responses were matched to CBH's submitted data and the status flag was updated accordingly. CBH compared record counts from BRAHMS to their relational database to ensure all appropriate encounters were submitted to PROMISe.

For encounters with an adjudication date on or after October 1, 2015, the PROMISe submission file is extracted from XeoRules and BRAHMS (for TPL and out-of-network provider claims). Any claims that may be identified as not previously sent are added to the latest run. When the PROMISe response file is received, the responses are matched to CBH's submitted data. CBH runs a weekly report that indicates the number of claims that were identified for submission, outstanding encounter responses from the state, rejection percentages and acceptance percentages.

For claims adjudicated in the XeoRules, CBH receives regular reports on receipt of the U277. The report highlights acceptance and rejection status of claims and contains additional claim information to aid in the investigation of rejected encounters. Encounters are resubmitted to the state after the root cause of the rejection has been rectified. The average number of business days between the initial denial and the date the encounter was accepted by PROMISe is 30 days. Encounters denied by PROMISe would never be resubmitted by CBH if there is no discernible way to fix the error and resubmit.

CBH may modify the encounter data system depending on the rejection reason, but CBH will not modify the enrollment system as a result of a PROMISe denial associated with the member's eligibility.

In its ISCA response, CBH indicated that claims with a date of service in 2015 were submitted to PROMISe on an average of 15 business days after claim adjudication by the BH-MCO.

For encounters submitted with adjudication dates on or before September 30, 2015, CBH submitted up to two diagnosis codes to PROMISe, provided that the diagnosis codes existed in a Diagnosis Code Reference Table. For encounters submitted with an adjudication date on or after October 1, 2015, CBH includes all secondary diagnosis codes that were submitted by the provider, up to the allowable limit of 25 secondary diagnosis codes.

According to CBH's ISCA response, for claims with a date of service in 2015, CBH submitted the claims presented in Table 6 to PROMISe as of August 24, 2016.

Table 6: Unique Encounters Submitted to PROMISe with 2015 Dates of Service

Type of Claim	Number of Claims with 2015 Dates of Service as of 8/24/2016
Institutional	54,263
Professional	4,693,822
Total	4,748,085

CBH indicated the status for the 4,748,085 claims that were submitted to PROMISe with date of service in 2015 (Table 7) as follows:

1. accepted by PROMISe on first submission;
2. denied by PROMISe on the first submission, and accepted on resubmission; and
3. denied by PROMISe on the first submission, and not yet accepted.

Table 7: Status of Claims Submitted to PROMISe with 2015 Dates of Service

	Accepted		Denied, Accepted on Resubmission		Denied, Not Yet Accepted		
Type of Claim[1]	#	% of Total[2]	#	% of Total[2]	#	% of Total[2]	Total
Institutional	44,692	82%	6,054	11%	3,517	6%	54,263
Professional	4,456,351	95%	107,855	2%	129,616	3%	4,693,822

[1] As of October 1, 2015 CBH transitioned to XeoRules for claims processing and submission of encounters to PROMISe.
[2] Percentages might not add up to 100% due to rounding.

A comparison of the PROMISe "denied, not yet accepted" encounters to the total encounters with date of service in 2015 submitted to PROMISe indicates a 6% PROMISe denial rate for institutional encounters and a 3% PROMISe denial rate for professional encounters (Table 7).

CBH has identified that 3,519 institutional and 155,515 professional claims were denied by PROMISe or awaiting resubmission as of August 24, 2016 (Table 8).

Table 8: Denied or Not Yet Accepted Claims as of August 24, 2016

Claim Type	Denied or Not Yet Accepted Claims
Institutional	3,519
Professional	155,515

OMHSAS updates and distributes the Behavioral Health Services Reporting Classification Chart (BHSRCC) to the BH-MCOs semi-annually. The chart assists the BH-MCOs with determining the appropriate coding of services for both financial and encounter data reporting for HealthChoices. The BHSRCC grid is intended to assist the BH-MCOs in establishing edits in their reporting processes. However, it is not in any way intended to limit or expand BH services in the HealthChoices Program. CBH distributes the BHSRCC grid to their providers as a guideline on how claims must be submitted to CBH. CBH does not crosswalk procedure codes or revenue codes prior to PROMISe submission. CBH incorporates the BHSRCC grid logic into their provider contracts and requires the providers to submit claims according to the BHSRCC grid for payment.

In 2015, CBH implemented a change as per OMHSAS's directive to submit all secondary diagnosis codes to PROMISe. Prior to October 1 2015, CBH submitted encounters with only the primary and up to one secondary diagnosis code. As of October 1, 2015, CBH is submitting to PROMISe all secondary diagnosis codes found on the claim.

Even though as of October 1, 2015 CBH is submitting all secondary diagnosis codes to PROMISe, CBH's logic references the diagnosis code pointers and is altering and dropping diagnosis codes from the 837 professional header record. For example, if the professional header record contained 12 diagnosis codes and there was only one service line with diagnosis codes 2, 3, 5 and 6 referenced on the diagnosis code pointer values, the remaining eight diagnosis codes are not submitted to PROMISe and the order of the header level diagnosis codes are reordered from the values submitted by the provider. Table 9 presents three examples of how limiting the diagnosis codes submitted to PROMISe based on the value of the diagnosis code pointer has an impact on the submission of diagnosis codes in the PROMISe encounter records.

Table 9: Impact of Diagnosis Code Pointers on Submission of Diagnosis Codes to PROMISe

Example#[1]	Diagnosis Code Pointers on Claim Service Line 1	Diagnosis Code Pointers on Claim Service Line 2	Total # of Diagnosis Codes Submitted to PROMISe	Diagnosis Codes Submitted to PROMISe
1	1,2,3,4	5,6,7,8	8	DX1, DX2, DX3, DX4, DX5, DX6, DX7, DX8
2	1,5,6,8	2,6,7,8	6	DX1, DX2, DX5, DX6, DX7, DX8
3	4,6,9		3	DX4, DX6, DX9

[1] Examples are based on a professional claim with 12 diagnosis codes on the header record.

CBH has implemented claim adjudication rules that comply with the BHSRCC grid. At present, the rules are set to "warning" or "reject" within XeoRules. CBH is in the process of validating that the claim adjudication rules are working as anticipated. CBH will change the rules to set to "reject" instead of "warning" after confirming that the claim adjudication rules are working as expected. CBH indicated that a "warning" does not prevent the claim from being approved and sent to PROMISe. A "warning" only captures the information and provides it on a report for claims personnel to investigate. A "reject" will cause a claim to not be approved or sent to PROMISe.

Findings:

Based on the 2016 EDV activities, responses provided by the MCO on the ISCA and the EDV onsite review, IPRO found the following strengths, opportunities for improvement and corrective action requests.

Strengths

- CBH has spent considerable time and effort in educating its provider network about the HealthChoices benefits and billing requirements. This has translated into receiving approximately 98% of claims in an electronic format, which allows for timely and efficient adjudication as it eliminates errors in paper claims.
- CBH distributes the BHSRCC grid to their providers as a guideline on how claims must be submitted to CBH. CBH incorporates the BHSRCC grid logic into their provider contracts and requires the providers to submit claims according to the BHSRCC grid for payment. CBH does not crosswalk procedure codes or revenue codes prior to PROMISe submission.
- CBH is able to link any member when a change in a member identification number is found on the 834 daily eligibility file. In cases of adoption, CBH is able to link the adopted member records and the multiple identification numbers associated with the adopted child.
- CBH's XeoRules applies additional quality checks on claims staff to ensure a higher claim acceptance and adjudication rates.
- CBH's XeoRules uses a multi-departmental approach to determine PROMISe denial reasons. This allows for timely decisions to implement corrective measures to fix issues and resubmit encounters to PROMISe.
- As of October 1, 2015, CBH is submitting to PROMISe all secondary diagnosis codes received on the claim.

Opportunities for Improvement

- CBH imports the MCO-paid claims into their data reporting repository. For the development of the BH PMs, CBH extracts the MCO-denied claims directly from XeoRules. CBH will benefit from incorporating the MCO-denied claims into the data repository for the development of the BH PMs and other reporting needs.

Corrective Action Needed

- CBH uses programming logic to drop diagnosis codes submitted to PROMISe on the 837 professional extract based on values of the diagnosis code pointers found on the service lines. The mapping and reordering of the diagnosis codes could lead to primary and/or secondary diagnosis codes being dropped from PROMISe submissions and not included for reporting purposes by OMHSAS. CBH needs to provide a plan of action demonstrating the volume of encounters submitted to PROMISe with the diagnosis codes altered, impact of the logic and provide a step by step plan to modify the PROMISe professional encounter submission logic.
- CBH currently only submits MCO-paid encounters to PROMISe. CBH needs to review OMHSAS's instructions on submitting MCO-denied encounters and identify which MCO-denied encounters should be submitted to PROMISe, for example: MCO-denied for no authorization on file; MCO-denied due to TPL; MCO-denied for exhausted benefit; and MCO-denied for timely filing. CBH needs to provide a plan of action demonstrating CBH's intent to submit MCO-denied encounters to PROMISe and identify the types of encounters to extract.
- As of July 2017, CBH has not completed the transition of the claim adjudication transition process from BRAHMS to XeoRules. Since the completion of the transition was anticipated in 2016, CBH needs to provide OMHSAS with a timeline describing the anticipated system completion dates for claims adjudication, and PROMISe submission. CBH should outline the remaining items to be transitioned to XeoRules and details on what volumes of claims are still adjudicated in BRAHMS.
- CBH is currently adjudicating paper TPL and out-of-network provider claims received. CBH should provide OMHSAS with a plan of action demonstrating a policy and procedure detailing the PROMISe submission process of submitting paper TPL and out-of-network provider claims adjudicated in BRAHMS. CBH should also include documentation on how the BRAHMS processed claims are incorporated into CBH's PM reports.
- CBH transitioned to XeoRules for submission and reconciliation of PROMISe encounter processing of electronic claims as of October 1, 2015. CBH should ensure that all claims processed in the BRAHMS claim system prior to October 1, 2015 have been submitted to PROMISe and all PROMISe denials have been corrected and resubmitted.

CBH should provide OMHSAS with the volumes of encounters processed in BRAHMS since October 1, 2015 that have not yet been sumitted to PROMISe or have not yet been corrected and resubmitted in PROMISe.

Appendix A: Information Systems Capabilities Assessment (ISCA)

Commonwealth of Pennsylvania
Department of Human Services
Office of Mental Health and Substance Abuse Services

2016
Information Systems Capabilities Assessment
For
Behavioral Health Managed Care Organizations

07/21/2016

IPRO Corporate Headquarters
Managed Care Department
1979 Marcus Avenue
Lake Success, NY 11042-1002
phone: (516) 326-7767
fax: (516) 326-6177
www.ipro.org

REPORT CONTENT

INTRODUCTION

PURPOSE OF THE ASSESSMENT

The Pennsylvania Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) has partnered with its External Quality Review Organization; the Island Peer Review Organization (IPRO) to conduct a second Behavioral Health (BH) Managed Care Organization (MCO) system and process review. One component of this effort is for OMHSAS and IPRO to survey the BHHC HealthChoices (BHHC) (i.e., Medicaid managed behavioral health care) BH-MCOs Information Systems (IS).

Encounter data validation is on ongoing process, involving the Managed Care Organizations (MCOs), the State encounter data unit and the External Quality Review Organization (EQRO). It includes both a baseline evaluation and ongoing monitoring of submission patterns. The purpose of this monitoring is to identify, resolve and follow-up on issues that arose in the 2013 BH-MCO onsites, identified since the 2013 BH-MCO onsites or during the 2014 and 2015 BH Performance Measure(PM) validation.

Knowledge of the capabilities of a BH-MCO's IS is essential to effectively and efficiently:
- Validate BH-MCO encounter data,
- Calculate or validate BH-MCO Performance Measures (PM), and
- Assess a BH-MCO's capacity to manage the health care of its enrollees
- Review the BH-MCOs PROMISe encounter data process

The purpose of this assessment is to specify the desired capabilities of the BH-MCO's IS, and to pose standard questions to be used to assess the strength of a BH-MCO with respect to these capabilities. This will assist an External Quality Review Organization (EQRO) to assess the extent to which a BH-MCO's information system is capable of producing valid encounter data, performance measures, tracking PROMISe encounter data submissions and other data necessary to support quality assessment and improvement, as well as managing the care delivered to its enrollees.

This assessment is divided into five sections

I. General Information
II. Enrollment Systems
III. Claim Systems
IV. Reporting
V. PROMISe Submissions

Please complete the assessment below and return to IPRO by **08/26/2016**. Please include any relevant attachments requested in the assessment. The completed assessment should be posted to IPRO's FTP site under the ED\ISCA\ sub-folder. Please send an email to Mary Dramitinos (mdramitinos@ipro.org) advising the completed assessment has been posted.

This assessment will be followed by a conference call or a one-day onsite visit. A conference call will consist of further questions and review of processes. An onsite visit will consist of a detailed review of the following:
- Completed Information Systems Capabilities Assessment
- Enrollment systems
- Claims systems
- BH-MCOs PROMISe encounter data submission process

If you have any questions regarding this assessment, please contact Mary Dramitinos (mdramitinos@ipro.org)

I. GENERAL INFORMATION

Please provide the following general information:

1. Contact Information

Please enter the identification information for the primary contact for this assessment.

BH-MCO Name:	Click here to enter text.
Contact Name and Title:	Click here to enter text.
Mailing address:	Click here to enter text.
Phone number:	Click here to enter text.
Fax number:	Click here to enter text.
E-mail address:	Click here to enter text.

2. Managed Care Model Type (Please check one, or specify other.)

☐MCO-staff model ☐MCO-group model ☐MCO-IPA model ☐MCO-mixed model

Other - specify:Click here to enter text.

3. Number of years with BHHC membership in Pennsylvania (PA): Click here to enter text.

4. Average monthly BHHC enrollment for the last three years.

BHHC Enrollment	2013	2014	2015
January	Click here to enter text.	Click here to enter text.	Click here to enter text.
February	Click here to enter text.	Click here to enter text.	Click here to enter text.
March	Click here to enter text.	Click here to enter text.	Click here to enter text.
April	Click here to enter text.	Click here to enter text.	Click here to enter text.
May	Click here to enter text.	Click here to enter text.	Click here to enter text.
June	Click here to enter text.	Click here to enter text.	Click here to enter text.
July	Click here to enter text.	Click here to enter text.	Click here to enter text.
August	Click here to enter text.	Click here to enter text.	Click here to enter text.
September	Click here to enter text.	Click here to enter text.	Click here to enter text.
October	Click here to enter text.	Click here to enter text.	Click here to enter text.
November	Click here to enter text.	Click here to enter text.	Click here to enter text.
December	Click here to enter text.	Click here to enter text.	Click here to enter text.

5. List the PA BH-Counties where your BH-MCO provided BHHC enrollment in 2015:

BH-MCO County Name	BH-MCO County Name
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.

6. Average monthly BHHC enrollment by PA BH-Counties in 2015:

BH-MCO County Name	**Average Monthly BHHC Enrollment**
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
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Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.

7. What is the name of the enrollment or eligibility system: Click here to enter text.

8. What is the name of the claim processing system: Click here to enter text.

II. ENROLLMENT SYSTEMS

Enrollment File Loads and Eligibility System(s)

1. For each enrollment file provided by OMHSAS that your BH-MCO uses to populate your eligibility system, provide the file name, how often the file is received, the contents of the file (adds, changes and or deletes), and also describe how the file is used to populate the enrollment system.

Filename: Click here to enter text.	**Frequency of receipt (daily, weekly, monthly):** Click here to enter text.	**Indicate whether file contains: Adds (A), Changes(C), Deletes (D):** Click here to enter text.
Describe how this file is used to populate eligibility system: Click here to enter text.		

Filename: Click here to enter text.	**Frequency of receipt (daily, weekly, monthly):** Click here to enter text.	**Indicate whether file contains: Adds (A), Changes(C), Deletes (D):** Click here to enter text.
Describe how this file is used to populate eligibility system: Click here to enter text.		

Filename: Click here to enter text.	**Frequency of receipt (daily, weekly, monthly):** Click here to enter text.	**Indicate whether file contains: Adds (A), Changes(C), Deletes (D):** Click here to enter text.
Describe how this file is used to populate eligibility system: Click here to enter text.		

Filename: Click here to enter text.	**Frequency of receipt (daily, weekly, monthly):** Click here to enter text.	**Indicate whether file contains: Adds (A), Changes(C), Deletes (D):** Click here to enter text.
Describe how this file is used to populate eligibility system: Click here to enter text.		

Filename: Click here to enter text.	**Frequency of receipt (daily, weekly, monthly):** Click here to enter text.	**Indicate whether file contains: Adds (A), Changes(C), Deletes (D):** Click here to enter text.
Describe how this file is used to populate eligibility system: Click here to enter text.		

Filename: Click here to	**Frequency of receipt (daily, weekly,**	**Indicate whether file**

enter text.	**monthly):** Click here to enter text.	**contains: Adds (A), Changes(C), Deletes (D):** Click here to enter text.
Describe how this file is used to populate eligibility system: Click here to enter text.		

2. Please describe the process that your BH-MCO uses to populate your enrollment system from the files listed above. Attach any applicable process diagrams, flowcharts, etc.
   Click here to enter text.

3. Please describe how BHHC eligibility is updated, how frequently and who has "change" authority.
   Click here to enter text.

4. What software/programming language is used to load the enrollment file(s) into your eligibility system?
   Click here to enter text.

5. Does the program provide reports of records unable to be loaded? ☐YES ☐NO

7. If yes, please describe the process used to determine how these records are handled. (Include attachments if necessary)
   Click here to enter text.

8. Describe the controls used to assure all BHHC enrollment data entered into the system is fully accounted for. (Include report examples, process flowcharts, etc. as necessary)
   Click here to enter text.

9. What is the process for version control when the enrollment loading program code is revised?
   Click here to enter text.

10. How does your BH-MCO uniquely identify enrollees?
    Click here to enter text.

11. How does your BH-MCO handle enrollee disenrollment and re-enrollment in the BHHC product line? Does the member retain the same ID?
    Click here to enter text.

12. Can your eligibility system track enrollees who switch from one product line (e.g., HealthChoices Behavioral Health, commercial plan, Medicare, FFS?) to another? ☐Yes ☐No

13. Can your eligibility system track enrollees who switch from one BH-County to another?
    ☐Yes ☐No

14. Can your BH-MCO track an enrollee's initial enrollment date with your BH-MCO or is a new enrollment date assigned when a member enrolls in a new product line?
    Click here to enter text.

15. Can your BH-MCO track previous claim/encounter data or are you unable to link previous claim/encounter data across product lines?
    Click here to enter text.

16. Under what circumstances, if any, can a BHHC member exist under more than one identification number within your BH-MCO's information management systems? Under what circumstances, if any, can a member's identification number change?
    Click here to enter text.

17. How does your BH-MCO enroll and track newborns born to an existing BHHC enrollee?
    Click here to enter text.

18. When a member is enrolled in HealthChoices Behavioral Health, does the enrollment always start on the same date (i.e. the first day of the month)? Describe any situations where a member would not be enrolled on that date.
    Click here to enter text.

19. When a member is disenrolled in HealthChoices Behavioral Health, does the enrollment always end on the same date (i.e. the last day of the month)? Describe any situations where a member would be disenrolled on another date.
    Click here to enter text.

20. How is your BH-MCO notified of a death or termination? Please describe.
    Click here to enter text.

21. How is your BH-MCO notified of a newborn? Please describe.
    Click here to enter text.

22. Please describe how your BH-MCO provides eligibility information to your providers?
    Click here to enter text.

Enrollment Reporting System

23. What data base management system(s) (DBMS) do/does your BH-MCO use to BHHC enrollment data for reporting purposes? Are all members stored in the BH-MCO's membership system available for reporting purposes?
    Click here to enter text.

24. How would you characterize this/these DBMSs?

A. Relational	☐	E. Network	☐
B. Hierarchical	☐	F. Flat File	☐
C. Indexed	☐	G. Proprietary	☐
D. Other	☐	H. Don't Know	☐

25. Describe the process that is used to populate your reporting DBMS(s). Include process flowcharts as needed
    Click here to enter text.

26. What software/programming language is used to load the enrollment files into your reporting system?
    Click here to enter text.

27. Describe the controls used to assure all BHHC enrollment data entered into the reporting system is fully accounted for. (Include report examples, process flowcharts, etc. as necessary)
    Click here to enter text.

28. What is the process for version control when the enrollment loading program code is revised?
    Click here to enter text.

29. How frequently is your enrollment DBMS(s) updated?
    Click here to enter text.

30. Are members with dual BHHC and Medicare eligibility able to be identified in your enrollment reporting system? If so, describe how they are identified and the process used to ensure the correct members are identified.
    Click here to enter text.

31. How does your BH-MCO identify and count BHHC member months? BHHC member years?
    Click here to enter text.

32. How does your BH-MCO identify BHHC member disabilities? Programs Status Codes? Assistance Categories? Please describe how changes are tracked.
    Click here to enter text.

33. Please indicate which Race and Ethnicity values your BH-MCO stores:

Race	Yes/No	Ethnicity	Yes/No
01-African American	Choose an item.	01-Non-Hispanic	Choose an item.
02-Hispanic	Choose an item.	02-Hispanic	Choose an item.
03-America Indian or Alaskan Native	Choose an item.	03-Missing or Not Available	Choose an item.
04-Asian	Choose an item.		
05-White	Choose an item.		
06-Other or Not Volunteered	Choose an item.		
07-Native Hawaiian or Other Pacific Islander	Choose an item.		

Section Contact: Who is responsible for completing this section:

Contact Name and Title:	Click here to enter text.
Mailing address:	Click here to enter text.
Phone number:	Click here to enter text.
Fax number:	Click here to enter text.
E-mail address:	Click here to enter text.

III. CLAIMS SYSTEMS

Claims Types and Volume

1. Does your BH-MCO use standard claims or encounter forms for the following? If yes, please specify (e.g., CMS1500, UB 92)

Data Source	Yes/No	If yes, please specify
Institutional	Choose an item.	Click here to enter text.
Professional	Choose an item.	Click here to enter text.
Other	Choose an item.	Click here to enter text.

2.Please document whether the following data elements (data fields) are required by your BH-MCO for providers, for each of the types of BHHC claims/encounters identified below. If required, check in the appropriate box.

	Claims/Encounter Types		
Data Elements	**Institutional**	**Professional**	**Other**
Patient Gender	☐	☐	☐
Patient DOB/Age	☐	☐	☐
ICD-9-CM Diagnosis	☐	☐	☐
ICD-10-CM Diagnosis	☐	☐	☐
ICD-9-CM Procedure	☐	☐	☐
ICD-10-CM Procedure	☐	☐	☐
CPT/HCPCS	☐	☐	☐
DRG	☐	☐	☐
First Date of Service	☐	☐	☐
Last Date of Service	☐	☐	☐
Revenue Code	☐	☐	☐
Provider Specialty	☐	☐	☐

3. How many diagnoses codes are captured on each claim? Note: ICD-9 should refer only to claims with a date of service prior to October 1, 2015.

	ICD-9-CM Diagnosis Codes	ICD-10-CM Diagnosis Codes
Institutional Data	Click here to enter text.	Click here to enter text.
Professional Data	Click here to enter text.	Click here to enter text.

4. Can your BH-MCO distinguish between principal and secondary diagnoses? ☐Yes ☐ No

5. If "Yes" to 4, above, how does the BH-MCO distinguish between principal and secondary diagnoses?
Click here to enter text.

6. For claims with dates of service in 2015, enter the volume of claims received by claim type.

	Claims Paid	Claims Denied
Institutional	Click here to enter text.	Click here to enter text.
Professional	Click here to enter text.	Click here to enter text.
Other	Click here to enter text.	Click here to enter text.

7. For claims with dates of service in 2015, identify the number of ICD-9 and ICD-10 secondary diagnosis codes received.

	# of Secondary ICD-9 Diagnosis Codes	# of Secondary ICD-10 Diagnosis Codes
Institutional	Click here to enter text.	Click here to enter text.
Professional	Click here to enter text.	Click here to enter text.

8. Please describe how your BH-MCO validates provider claims data?
Click here to enter text.

9. Please provide any documented process, frequency, and criteria for review (ex. Annual=standardized review, Adhoc =monitoring triggers), selection criteria (random, rotational, etc) for the validation of the provider on the claim.

Click here to enter text.

10. Please identify how provider validation findings are shared and issues addressed.
Click here to enter text.

Claims Processing

11. Please provide a process document / flowchart that describes the claim adjudication process from the time a claim is received, to the time a claim is loaded into the reporting DBMS(s). Include the descriptions and purpose of each system.

12. Please explain what happens if a BHHC claim/encounter is submitted and one or more required fields are missing, incomplete or invalid. For example, if diagnosis is not coded, is the claims examiner required by the system to use an on-line software product like AutoCoder to determine the correct ICD-9 or ICD-10 diagnosis code?

Institutional Data:
Click here to enter text.

Professional Data:
Click here to enter text.

13. What steps do your BH-MCO take to verify the accuracy of submitted information (e.g., procedure code- diagnosis edits, gender-diagnosis edits, gender-procedure code edits)?

Institutional Data:
Click here to enter text.

Professional Data:
Click here to enter text.

14. Under what circumstances can claims processors change BHHC claims/encounter information?
Click here to enter text.

15. How are BHHC claims/encounters received?

Source	Received Directly from Provider	Submitted through an Intermediary
Institutional	Choose an item.	Choose an item.
Professional	Choose an item.	Choose an item.
Other	Choose an item.	Choose an item.

16. If the data are received through an intermediary, what changes, if any, are made to the data.

Click here to enter text.

17. Please identify the BHHC claims/encounters that are coded using the following coding schemes: Check off each coding scheme that applies. Note: ICD-9 should refer only to claims with a date of service prior to October 1, 2015.

Coding Scheme	Inpatient Diagnosis	Inpatient Procedure	Outpatient Diagnosis	Outpatient Procedure
ICD-9-CM Diagnosis	☐	☐	☐	☐
ICD-10-CM Diagnosis	☐	☐	☐	☐
ICD-9-CM Procedure	☐	☐	☐	☐
ICD-10-CM Procedure	☐	☐	☐	☐
CPT-4	☐	☐	☐	☐
HCPCS	☐	☐	☐	☐
DSM-IV	☐	☐	☐	☐
MS-DRG	☐	☐	☐	☐
APR-DRG	☐	☐	☐	☐
Revenue	☐	☐	☐	☐
Internally Developed	☐	☐	☐	☐
Other (specify)	☐	☐	☐	☐
Not required	☐	☐	☐	☐

18. Identify all information systems through which service and utilization data for the BHHC population is processed.

Click here to enter text.

19. Please describe any major systems changes/updates that have taken place in the last three years in your BHHC claims or encounter system *(be sure to provide specific dates on which changes were implemented).*

- New system purchased and installed to replace old system.
- New system purchased and installed to replace most of old system; old system still used.
- Major enhancements to old system (what kinds of enhancements?).
- New product line adjudicated on old system.
- Conversion of a product line from one system to another.

Click here to enter text.

20. In your opinion, have any of these changes influenced, even temporarily, the quality and/or completeness of the BHHC data that are collected? If so, how and when?
Click here to enter text.

21. What is your BH-MCO's policy regarding BHHC claim/encounter audits? Are BHHC encounters audited regularly? Randomly? What are the standards regarding timeliness of processing?
Click here to enter text.

22. Please provide detail on claim system edits that are targeted to field content and consistency. Are diagnostic and procedure codes edited for validity?
Click here to enter text.

23. Describe the BHHC claims/encounter suspend ("pend") process including timeliness of reconciling pended services.
Click here to enter text.

24. Describe how BHHC claims are suspended/pended for medical review, for non-approval due to missing authorization code(s) or for other reasons. What triggers a processor to follow up on "pended" claims? How frequent are these triggers?
Click here to enter text.

25. If any BHHC services/providers are capitated, have you performed studies on the completeness of the information collected on capitated services? If yes, what were the results?

Click here to enter text.

26. Beginning with receipt of a BHHC claim in-house, describe the claim handling, logging, and processes that precede adjudication. When are BHHC claims assigned a document control number and logged or scanned into the system? When are BHHC claims microfilmed? If there is a delay in microfilming, how do processors access a claim that is logged into the system, but is not yet filmed?
Click here to enter text.

27. Discuss which decisions in processing a BHHC claim/encounter are automated, which are prompted by automated messages appearing on the screen, and which are manual. Document the opportunities a processor has for overriding the system manually. Is there a report documenting over-rides or "exceptions" generated on each processor and reviewed by the claim supervisor? If so, please attach a recent copy of the report
Click here to enter text.

28. Are there any outside parties or contractors used to complete adjudication, including but not limited to:

- Bill auditors (hospital claims, claims over a certain dollar amount)
Choose an item.

- Peer or medical reviewers
  Choose an item.

- Sources for additional charge data (usual & customary)
  Choose an item.

  How is this data incorporated into your BH-MCO's encounter data?
  Click here to enter text.

29. Describe the system's editing capabilities that assure that BHHC claims are correctly adjudicated. Provide a list of the specific edits that are performed on claims as they are adjudicated, and note: 1) whether the edits are performed pre or post-payment, and 2) which are manual and which are automated functions.
    Click here to enter text.

30. Discuss the routine and non-routine (ad hoc or special) audits that are performed on claims/encounters to assure the quality and accuracy and timeliness of processing. Note which audits are performed per processor, which rely on targeted samples and which use random sampling techniques. What is the total percentage of claims on-hand that are audited through these QA processes? How frequently?
    Click here to enter text.

31. Describe all performance monitoring standards for BHHC claims/encounters processing and recent actual performance results.
    Click here to enter text.

32. If applicable, describe your BH-MCO's process(es) used for claim adjudication when there is a physical health component to the service.

- A claim is received for a behavioral health professional service performed during a physical health inpatient stay.
  Click here to enter text.

- A member is transferred to a physical health facility from a behavioral health facility.
  Click here to enter text.

- An outpatient claim is received from a physical health provider (i.e. a PCP) with a behavioral health primary diagnosis.
  Click here to enter text.

Claims Reporting System

33. What data base management system(s) (DBMS) do/does your organization use to store BHHC encounter data for reporting purposes?
    Click here to enter text.

34. How would you characterize this/these DBMSs?

A. Relational	☐	E. Network	☐
B. Hierarchical	☐	F. Flat File	☐
C. Indexed	☐	G. Proprietary	☐
D. Other	☐	H. Don't Know	☐

35. Describe the process that is used to populate your reporting DBMS(s)
Click here to enter text.

36. What software/programming language is used to load the enrollment files into your BH-MCO's reporting system?
Click here to enter text.

37. Describe the controls used to assure all BHHC encounter data entered into the reporting system is fully accounted for. (Include report examples, process flowcharts, etc. as necessary)
Click here to enter text.

38. What is the process for version control when the encounter data loading program code is revised?
Click here to enter text.

39. How many years of BHHC data are retained on-line? How is historical BHHC data accessed when needed?
Click here to enter text.

40. How complete are the BHHC data three months after the close of the reporting period? How is completeness estimated? How is completeness defined? Please attach copies of 2015 institutional and professional lag triangles with completeness percentages.
Click here to enter text.

41. Please describe your BH-MCOs policy and/or contract with providers reflects the completeness of data based on above question 40.
Click here to enter text.

Section Contact: Who is responsible for completing this section:

Contact Name and Title:	Click here to enter text.
Mailing address:	Click here to enter text.
Phone number:	Click here to enter text.
Fax number:	Click here to enter text.
E-mail address:	Click here to enter text.

IV. REPORTING

1. Please attach a flowchart outlining the structure of your DBMS(s), indicating data integration (i.e., claims files, encounter files, etc.).

2. In consolidating data for BHHC performance measurement (PM), how are the data sets for each measure collected:

    - By querying the processing system online?
    - By using extract files created for analytical purposes? If so, how frequently are the files updated? How do they account for claim and encounter submission and processing lags? How is the file creation process checked for accuracy?
    - By using a separate relational database or data warehouse (i.e., a performance measure repository)? If so, is this the same system from which all other reporting is produced?

    Click here to enter text.

3. Describe the procedure for consolidating BHHC claims/encounter, member, and provider data for PM reporting (whether it is into a relational database or file extracts on a measure-by-measure basis).
    Click here to enter text.

4. How many different sources of data are merged together to create the PM data files?
    Click here to enter text.

5. What control processes are in place to ensure data merges are accurate and complete?
    Click here to enter text.

6. What control processes are in place to ensure that no extraneous data are captured (e.g., lack of specificity in patient identifiers may lead to inclusion of non-eligible members or to double counting)?
    Click here to enter text.

7. What programming language(s) do your programmers use to create BHHC data extracts or analytic reports? How many programmers are trained and capable of modifying these programs?
    Click here to enter text.

8. Describe the process used to validate and test reporting code prior to deployment. Include any process flowcharts, test plans, etc.
    Click here to enter text.

9. Do you rely on any quantitative measures of programmer performance? If so, what method(s) do you use to measure the effectiveness of the programmer?
    Click here to enter text.

10. Approximately what percentage of your BH-MCO's programming work is outsourced?
    Click here to enter text.

11. If any programming work is outsourced, describe the oversight/validation process of the programs produced by the vendor(s).
    Click here to enter text.

12. Outline the steps of the maintenance cycle for the mandated BHHC performance measure reporting requirement(s). Include any tasks related to documentation, debugging, roll out, training, etc.
    Click here to enter text.

13. Please describe your BHHC report production logs and run controls. Please describe your BHHC PM data file generation process.

    Click here to enter text.

14. How are BHHC report generation programs documented? Is there a type of version control in place?

    Click here to enter text.

15. How does your BH-MCO test the process used to create BHHC PM data files?

    Click here to enter text.

16. Are BHHC PM reporting programs reviewed by supervisory staff?
    Click here to enter text.

17. Does your BH-MCO have internal back-ups for PM programmers (i.e., do others know the programming language and the structure of the actual programs)? Is there documentation?
    Click here to enter text.

18. How are revisions to BHHC claims, encounters, membership, and provider data systems managed in the DBMS(s)?
    Click here to enter text.

19. What is the process for version control when PM code is revised?
    Click here to enter text.

20. What provider data elements is your BH-MCO able to report on? (NPI, licensure, specialty, MPI, provider type, etc.)
    Click here to enter text.

21. Is claim/encounter data linked for Medicare/BHHC dual eligibles so that all encounter data can be identified for the purposes of PM reporting?
Click here to enter text.

22. How is BHHC continuous enrollment being defined? In particular, does your BH-MCO system have any limitations that preclude you from fully implementing continuous enrollment requirements exactly as specified in the State performance measure requirements?
Click here to enter text.

23. How do you handle breaks in BHHC enrollment--e.g. situations where a BHHC enrollee is disenrolled
Click here to enter text.

24. Please identify which data elements are captured in your DBMS and are available for reporting:
Note: ICD-9 should refer only to claims with a date of service prior to October 1, 2015.

Data Element	Yes/No
Recipient ID	Choose an item.
Servicing Provider NPI	Choose an item.
Servicing Provider Specialty	Choose an item.
Servicing Provider Type	Choose an item.
Facility Type	Choose an item.
UB 92 Type of Bill	Choose an item.
APR DRG	Choose an item.
MS DRG	Choose an item.
Admitting Diagnosis	Choose an item.
Primary ICD-9-CM Diagnosis Code	Choose an item.
Primary ICD-10-CM Diagnosis Code	Choose an item.
Secondary ICD-9-CM Diagnosis Code	Choose an item.
Secondary ICD-10-CM Diagnosis Code	Choose an item.
ICD-9-CM Procedure Code	Choose an item.
ICD-10-CM Procedure Code	Choose an item.
CPT4 Code	Choose an item.
CPT II Codes	Choose an item.

Data Element	Yes/No
HCPCS	Choose an item.
LOINC codes	Choose an item.
Revenue Codes	Choose an item.
Billed Amount	Choose an item.
Date of Service	Choose an item.
Date of Admission	Choose an item.
Date of Discharge	Choose an item.
Patient Status Code	Choose an item.
MPI	Choose an item.

25. Does your BH-MCO download the PH/BH Service History files on a weekly basis as they are posted/made available (please advise by file type):

Inpatient Click here to enter text.
Medical Click here to enter text.
Pharmacy Click here to enter text.
Revenue Code Click here to enter text.

26. Please indicate by file type, whether your BH-MCO stores the PH/BH Service History files. Describe whether the data is loaded to your reporting system or data repository.

Inpatient Click here to enter text.
Medical Click here to enter text.
Pharmacy Click here to enter text.
Revenue Code Click here to enter text.

27. If applicable, please indicate if any logic applied to the PH/BH Service History file data. Please describe logic. (i.e. handling of FFS, or adjustments or voids, or scrubbing).

Inpatient Click here to enter text.
Medical Click here to enter text.
Pharmacy Click here to enter text.
Revenue Code Click here to enter text.

28. Please advise if the PH/BH Service History data is included or integrated in your reporting system. Specify by file type whether the PH data is incorporated in your BH-MCO's development of the BH Performance Measure data files. Describe the reports the PH/BH Service History file data is included.

Inpatient Click here to enter text.
Medical Click here to enter text.
Pharmacy Click here to enter text.
Revenue Code Click here to enter text.

29. Please advise by file type, the earliest and latest date of service you have stored (Revenue Code file not included since there is no date of service on the file):

Inpatient Click here to enter text.
Medical Click here to enter text.
Pharmacy Click here to enter text.

30. Please advise by file type the volume of PH/BH Service History file data received and available for reporting and analysis by your BH-MCO:

Inpatient Click here to enter text.
Medical Click here to enter text.
Pharmacy Click here to enter text.
Revenue Code Click here to enter text.

31. Please advise the capability of the current system to capture and report Treatment Episode Date.
Click here to enter text.

32. Please advise whether the functionality being used for capturing the Treatment Episode Date.
Click here to enter text.

33. If there is currently no functionality being used for capturing the Treatment Episode Date, is there a plan to utilize it in the future. Please describe.
Click here to enter text.

Section Contact: Who is responsible for completing this section:

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E-mail address:	Click here to enter text.

V. PROMISE SUBMISSION

Encounter Data Submission

1. Using claims with dates of service in 2014 and 2015, how many unique encounters were submitted to the PROMISe system

	2015	2014
Institutional	Click here to enter text.	Click here to enter text.
Professional	Click here to enter text.	Click here to enter text.
Other	Click here to enter text.	Click here to enter text.
Total	Click here to enter text.	Click here to enter text.

2. Of the 2014 and 2015 encounters submitted above, how many were (are)
    1. Accepted by PROMISe on first submission.
    2. Denied by PROMISe on the first submission, but accepted on a resubmission.
    3. Denied by PROMISe on the first submission, and have not been accepted.

2015	Initially accepted	Denied, accepted on resubmission	Denied, not yet accepted	Total
Institutional	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Professional	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Other	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

2014	Initially accepted	Denied, accepted on resubmission	Denied, not yet accepted.	Total
Institutional	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Professional	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Other	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

3. If you indicated any volumes for the Other category in 1 or 2, please describe the type of encounters in this category:
   Click here to enter text.

4. When an encounter is submitted to PROMISe, please describe the process of tracking the encounter and identifying it as a successful submission. Attach any work flows, process diagrams, etc.
   Click here to enter text.

5. Explain in detail the process for reconciling the encounter data submitted to PROMISe.
Click here to enter text.

6. Does the encounter data extract process for PROMISe submission include a check against member eligibility at the time of service, regardless of claim payment status? If so, at what point in the extract process does this validation occur? How are encounters handled for members who were ineligible at the time of service?
Click here to enter text.

7. OMHSAS has instructed the BH-MCOs that certain encounters should not be submitted to PROMISe. Please list categories of encounters that are currently excluded by your PROMISe submission process.
Click here to enter text.

8. What is the reconciliation process for ensuring that all eligible BH-MCO processed claims are extracted and submitted to PROMISe? Are there any encounters, other than those in the categories listed in above question 7 that are not included in the PROMISe extract? If yes, please explain.
Click here to enter text.

9. Has your reconciliation process identified any types of encounters that pose challenges during the extraction process? If yes, please explain.
Click here to enter text.

10. Does your BH-MCO do any mapping or reformatting of any specific data elements prior to submitting the encounter data to PROMISe? If yes, please explain.
Click here to enter text.

11. Identify what PROMISe submission and reconciliation processes are fully automated and what processes are manual.
Click here to enter text.

12. Identify the number of secondary diagnosis codes submitted to PROMISe for Professional encounters:
Click here to enter text.

13. Identify the number of secondary diagnosis codes submitted to PROMISe for Institutional encounters:
Click here to enter text.

14. Explain the reason a principal or secondary diagnosis code may not be submitted to PROMISe.
Click here to enter text.

Denial and Resubmission Processes

15. In 2015, what was the average number of business days between the adjudication of a claim, and the initial submission to PROMISe
Click here to enter text.

16. When an encounter is denied by PROMISe, describe the process used to determine the reason for denial, and attempt a resubmission. Attach any work flows, process diagrams, etc.
Click here to enter text.

17. Describe the structure of the staff responsible for resubmission of encounters denied by PROMISe. Is there a dedicated department, or is the work assigned to different departments based on the denial reason.
Click here to enter text.

18. In 2015, of the encounters that were initially denied by PROMISe, what was the average number of business days between the initial denial and the date the encounters was accepted by PROMISe?
Click here to enter text. Days

19. How does your BH-MCO track encounters that are denied by PROMISe? Are there standard reports that identify outstanding encounters? If so, Please attach an example of a report.
Click here to enter text.

20. Are there instances where encounters would be denied by PROMISe, and never be resubmitted? If so, please describe when this would occur.
Click here to enter text.

21. Are enrollment or encounter data systems ever modified as a result of a PROMISe denial? If so, please describe what processes are used to ensure that the modifications to the systems are correct.
Click here to enter text.

22. Can the BH-MCO identify how many encounters are currently denied by PROMISe and are awaiting resubmission? If yes, please provide volume and the as of date.

Encounter Type	Number of Denied Encounters	As of Date
Institutional	Click here to enter text.	Click here to enter text.
Professional	Click here to enter text.	Click here to enter text.

23. What has the BH-MCO done or is planning to do to reduce the number of denied PROMISe encounters?
Click here to enter text.

Section Contact: Who is responsible for completing this section:

Contact Name and Title:	Click here to enter text.
Mailing address:	Click here to enter text.
Phone number:	Click here to enter text.
Fax number:	Click here to enter text.
E-mail address:	Click here to enter text.

REQUESTED MATERIAL

Section	Question Number	Attachment
Enrollment Systems	2	Applicable process diagrams, flowcharts, etc that describe the process that the BH-MCO uses to populate your enrollment system from the files received.
Enrollment Systems	7	Enrollment loading error process reports
Enrollment Systems	8	Enrollment loading completeness reports that ensure the system is fully accounted for.
Enrollment Systems	25	Enrollment reporting system load process
Enrollment Systems	27	Enrollment reporting system completeness reports
Claims Systems	9	Claim provider validation process documentation
Claims Systems	11	Process document/flowchart that describes the claim adjudication process from the time a claim is received, to the time a claim is loaded into the reporting DBMS(s).
Claims Systems	29	Regarding the system's editing capabilities that assure the BHHC claims are correctly adjudicated. Include a list of the specific edits that are performed on claims as they are adjudicated.
Claims Systems	37	Include report examples, and process flowcharts that describe the controls used to assure all BHHC encounter data entered into the reporting system is fully accounted for.
Claims Systems	40	2015 Physician and institutional lag and completeness triangles.
Reporting	1	Flowchart outlining the structure of the DBSM(s), indicating data integration (i.e. claim files, encounter files, etc.)
PROMISe Submissions	4	Workflow, process diagrams describing the PROMISe encounter data submission process
PROMISe Submissions	16	Workflow and process diagrams describing the process used to determine the reason for PROMISe denial, and attempt for a resubmission to PROMISe.
PROMISe Submissions	19	Report of how the BH-MCO tracks encounters that are denied by PROMISe including the outstanding claims report yet to be submitted to PROMISe