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

2016 Encounter Data Onsite Validation

Magellan Behavioral Health of Pennsylvania, Inc.

April 24, 2018

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

Table of Contents

List of Tables

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 and webinars 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 webinar 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 or webinar. 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 information system 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

Magellan Behavioral Health of Pennsylvania, Inc. (MBH), has participated in the BH HealthChoices contract since 1997. In 2016, MBH continued to service five counties for the HealthChoices product line. Their total average enrollment in 2015 was 336,743 members (Table 2).

MBH's 2016 EDV four-hour webinar was held on April 21, 2017. MBH, OMHSAS and IPRO attended the webinar.

Table 2 lists the PA BH counties where MBH 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
Bucks	59,321
Montgomery	79,738
Delaware	89,182
Lehigh	66,513
Northampton	41,989
Total	336,743

Enrollment Systems

MBH's primary source of enrollment information is the 834 Daily Eligibility File received from OMHSAS. 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 uploaded to the Claim Adjudication Payment System (CAPS). CAPS is MBH's proprietary system for member eligibility, claims pre-processing, adjudication and administration.

MBH also utilizes the following three files to validate and supplement the 834 daily eligibility file:

1. 834 Monthly Eligibility File –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 used to identify and terminate open eligibility for members for whom a termination record was never communicated on an 834 daily file.
2. 820 Monthly Capitation File –File is the primary source to terminate members. If a member does not appear on this file, they are terminated on MBH's eligibility system.
3. Monthly TPL File – This file contains new, changed or deleted third party liability (TPL) information.

MBH uploads the data from the 834 daily eligibility file upon receipt of the file into CAPS. The 834 monthly eligibility file, 820 monthly capitation file and the monthly TPL file are uploaded into CAPS within two business days of receipt of the files. Eligibility information may also be updated manually by MBH's Eligibility department staff.

MBH's primary source of enrollment data is the CAPS. Members in HealthChoices are assigned a single recipient identification number (Recipient ID) by DHS. MBH assigns an identifier that is placed at the beginning of the Recipient ID to the member record. An individual may be assigned multiple Recipient ID numbers by DHS in the event of an adoption. An individual may also be assigned more than one internal ID number if the member transfers from one HealthChoices county to another. If a member is assigned two Recipient IDs, the CAPS may assign two internal identifiers to the member. Upon identification, the two alternative ID records are linked. MBH retains the internal CAPS identification number until a new Recipient ID is issued by DHS.

MBH enrolls members on the effective date included on the 834 daily enrollment files. MBH disenrolls members typically on the last day of the month. Members that are not disenrolled on the last day of the month may be due to the member being transferred to a facility such as juvenile detention center or long term care facility. MBH may also disenroll a member on the date of death that is included on the 834 daily and monthly enrollment files. MBH members that enroll on or after the second day of the month are covered for the entire month.

MBH utilizes an Oracle® data warehouse for enrollment data reporting. MBH uses a Data Mirror to refresh the enrollment data reporting data warehouse with data from CAPS. MBH also stores member eligibility data on SQL Server databases for local HealthChoices reporting staff to access.

During the EDV webinar, IPRO requested and MBH demonstrated their enrollment system data entry, enrollment history and demographic screens.

As part of the EDV process, 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 webinar, 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 MBH on the discharge date or were enrolled with a different BH-MCO on the discharge date. IPRO indicated that there were zero member records with enrollment discrepancy. All members in the MBH's 2016 FUH PM member-level data file were enrolled on the discharge date. IPRO selected two member records to review during the webinar. The following data elements were reviewed during the EDV webinar on MBH's enrollment system for the two members: recipient ID#, date of birth, last and first name and enrollment and disenrollment dates for 2015.

During the webinar, IPRO requested and MBH demonstrated their enrollment system data entry, enrollment history and demographic screens.

The following observations were made:

- 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 MBH's enrollment system for the two records.
- Date of birth: IPRO was able to confirm that the date of birth on MBH's enrollment system matched the date of birth on IPRO's BH Eligibility DW for the two members.
- Enrollment history: The effective and expiration dates from MBH's enrollment system matched the dates on IPRO's BH Eligibility DW.

Claims/Encounter Systems

MBH receives and processes claims[1] from providers in three different modes: 837 files from providers, direct online entry via MBH's web site, and HCFA1500 and UB04 paper claims. Approximately 1.7 million claims with a date of service in 2015 were received and processed as of the date of the EDV webinar. Approximately 85% of MBH's claims are received electronically.

Once a claim is received, MBH performs a series of validation checks through the CAPS based on the standard rules established by the HCFA1500 and UB04 forms' completion guidelines for paper submission and for electronic claims submission, compliance with HIPAA 5010 implementation guide standards. MBH verifies the member's eligibility on the date of service. Claims that fail the validation checks are stopped from completing the auto-adjudication process and require manual intervention by a resolution specialist for adjudication. MBH pends claims for manual review when the following edits are met: 1)member is not eligible on the date of service, 2)benefits and services on the claim do not match the system benefits configuration, 3) provider is not eligible, 4) rates for the servicing provider are not loaded in the system, 5) prior authorization is not in the system, 6) claims that require coordination of benefits, 7) required data element is missing or incomplete on a claim, and 8) duplicate claims. Account specific electronic edits and algorithms such as the National Correct Coding Initiative (NCCI) rules are also programmed in the CAPS and are applied to the claim to determine the validity of the claims data. If a claim is pended for manual review as a required data element incomplete or missing and a valid data element could not be found after the manual review, then the claim is denied. CAPS validation includes checks for Current Procedural Terminology (CPT), revenue codes and diagnosis codes. Quality control reports are automatically produced from CAPS prior to payment of the claim.

MBH does not allow original claims data to be changed by the claims processors. If a corrected claim is required, it is received from the provider.

MBH monitors the overall standard regarding timely processing of claims. Based on MBH's ISCA response, 90% of all claims are processed within 14 days and 99% of claims are processed within 30 days. Approximately 75% of MBH's claims are auto-adjudicated. Based on the MBH's ISCA response, approximately 99% of their institutional and professional claims incurred in a 12 month period were paid within 15 months.

MBH audits a random sample on an average of 2% of all completed claims post disbursement including claims that are manually processed and auto-adjudicated. MBH audits 100% of high dollar amount claims prior to disbursement. MBH utilizes a threshold of $5,000 for paid or denied high dollar amount claims. The high dollar amount claims are placed on hold in CAPS. The claims auditor reviews and releases the claim within 48 hours if no errors are noted. If the claims auditor observes an error in the high dollar amount claim, then the claim is forwarded to the supervisor for review, corrective action and release of the claim. MBH audits 100% of claims processed by trainee claim processing associates prior to disbursement until the associate meets MBH's quality performance standards. MBH conducts a second-level audit by reviewing a sample of claims processed by a claims auditor on a monthly basis and measuring the accuracy and reliability. MBH utilizes a centralized audit database for documenting and reporting quality audit results. The audit reports are reviewed on a continuing basis by supervisors and on a monthly basis by senior management.

A claim received for a BH professional service performed during a PH inpatient stay is paid by MBH only for BH evaluation (CPT code 90791) performed by a BH provider. A claim received for continuing care where the primary diagnosis code is a covered BH diagnosis code and the service is rendered by a BH provider in a BH setting is also paid by MBH.

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

Table 3 presents the number of claims paid or denied in 2015.

Table 3: Paid and Denied Claims in 2015

Type of Claim/Encounter	Claims Paid	Claims Denied
Institutional	57,469	9,712
Professional	1,512,342	148,524

As per MBH's contract with providers, a provider can submit claims within 60 days following the date of service.

MBH utilizes SQL Server databases for encounter data reporting purposes. The encounter data reporting data bases are refreshed with data from CAPS in real time by using a Data Mirror. Data Mirror is an application that mirrors CAPS into the SQL Server databases. The SQL Server databases are automatically updated as changes are made to CAPS. MBH verifies the completeness of the data loaded into CAPS by utilizing standardized processes that include field level edits. Membership data in the reporting data warehouse is linked directly to and integrated with the eligibility information in CAPS. MBH stores claims and encounter data in their production CAPS system for the past 10 years. MBH stores claims and encounter data in their reporting data warehouse since the inception of their contract with DHS in 1997.

PROMISe Submission and Reconciliation Process

MBH creates the PROMISe submission extracts through a front-end user interface. The encounter claims that are extracted are stored in a staging table. The PROMISe submission extracts are created from the encounters stored in the staging table. At the time of creating the PROMISe submission file, reports indicating the count of records, total units and amount paid are created.

Prior to PROMISe submission, revenue, procedure and modifier codes are cross walked to a code based on the Behavioral Health Services Reporting Classification Chart (BHSRCC) grid in order to pass PROMISe validation. Diagnosis code is mapped to a code on the diagnosis code reference file that is provided by OMHSAS to all BH-MCOs on a monthly basis. Provider ID is validated with the Provider ID file containing all Medicaid providers provided by DHS on a weekly basis. Provider ID is mapped to '888888888' for providers that are not enrolled in Pennsylvania's Medicaid program. The provider MPI and location are derived prior to submitting the encounter to PROMISe.

MBH submits all MCO-paid claims to PROMISe. MBH submits to PROMISe the MCO-denied claims that are denied due to the following denial reason codes:

- DENY - Non participating (PAR) provider - No authorization on file
- DENY - CPT/bed type does not match certification by NON PAR provider
- DENY - Clinical Department denial
- DENY - PAR provider - No authorization on file
- DENY - CPT/Bed type does not match certification by PAR provider.
- DENY - Diagnosis code does not match certification by PAR provider.
- DENY - Non PAR provider - no out of network benefit.
- DENY - Coordination of benefits (COB) Primary carrier's explanation of benefits (EOB) does not match bill.
- DENY - COB-Denial for other insurance carrier (OIC) EOB with final determination
- Requested primary carrier's EOB.
- DENY - PAR provider - bill received after timely filing.
- DENY - Non PAR provider - bill received after timely filing
- DENY - PAR provider - Resubmission Beyond Timely Filing requirement
- DENY - PAR provider - Primary EOB Beyond Timely Filing requirement
- DENY - Non PAR provider - Primary EOB Beyond Timely Filing requirement
- DENY - Non PAR provider - Resubmission Beyond Timely Filing Requirement

MBH performs an eligibility check to ensure the member is enrolled on the date of service prior to submitting an encounter to PROMISe. Encounters for members who may have lost eligibility since adjudication will be identified and excluded from the PROMISe submission process. MBH only submits the service lines with a paid amount that is greater than zero on institutional encounters to PROMISe. Institutional service lines with zero paid amounts are not submitted to PROMISe.

In order to modify or correct information on an encounter that has been submitted and accepted by PROMISe, MBH submits a void record to PROMISe and then submits a new encounter representing the revised or corrected information. If an encounter that has not been submitted to PROMISe is adjusted, then MBH submits only the adjusted encounter to PROMISe.

MBH submits to PROMISe a new internal control number (ICN), common header and detail record for each institutional and professional service line.

MBH manually triggers the extraction of encounter data for PROMISe submission from Enterprise Manager. The validation of the encounter data in Enterprise Manager and the creation of the 837 encounter extracts from Visual Basic User Interface are automated. The submission of the 837 encounter extracts to PROMISe is a manual process.

MBH processes the U277 response files upon their receipt and loads them to an access database through a manual process. MBH tracks the submission of encounters to PROMISe and the U277 response files through a manual process. If a response file is received then a status indicator is updated for each matching record and the matching records are moved to data warehouse tables from the staging table. A record in the staging table after processing of U277 response file indicates that the encounter was not reconciled and is reviewed for auditing.

MBH reviews the PROMISe-rejected encounters for evaluation and correction. MBH reviews the rejection reasons based on the PROMISe error codes received on the U277 files.

MBH identifies all PROMISe-rejected encounters for correction and resubmission. After reconciling the U277 response files, a report is produced with the number of denial and reasons for denial. MBH reviews the rejection reason based on the PROMISe error code received in the U277 file. Based on the PROMISe rejection reason MBH prepares a course of action. MBH indicated that most of the denials are related to member eligibility and are not resubmitted to PROMISe.

MBH's ISCA response indicated that claims with a date of service in 2015 were submitted to PROMISe within 43 business days after claim adjudication.

According to MBH's ISCA response, claims with a date of service in 2015, MBH submitted the claims presented in Table 4 to PROMISe as of August 24, 2016.

Table 4: 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	14,609
Professional	2,572,147
Total	2,586,756

MBH indicated the status for the 2,586,756 claims that were submitted to PROMISe with date of service in 2015 (Table 5) 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 5: Status of Claims Submitted to PROMISe with 2015 Dates of Service

	Accepted		Denied, Accepted on Resubmission		Denied, Not Yet Accepted		
Type of Claim	#	% of Total[1]	#	% of Total[1]	#	% of Total[1]	Total
Institutional	14,450	99%	159	0%	32	0%	14,641
Professional	2,556,598	99%	15,548	0%	11,195	0%	2,583,341

[1] 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 less than 1% PROMISe denial rate for institutional and professional encounters (Table 5).

MBH has identified that 125 institutional and 3,682 professional claims were denied by PROMISe or are awaiting resubmission as of August 24, 2016 (Table 6).

Table 6: Denied or Not Yet Accepted Claims as of August 24, 2016

Claim Type	Denied or Not Yet Accepted Claims
Institutional	125
Professional	3,682

MBH indicated that the top three denial reason codes for original and resubmission encounters submitted and denied by PROMISe were as follows:

- Original submission of institutional encounters
  - 216: Invalid combination for institutional BH encounter
  - 297: BH claim is a duplicate of a previously paid claim
  - 415: Claim adjustment reason code missing or invalid

- Resubmission of institutional encounters
  - 415: Claim adjustment reason code missing or invalid
  - 216: Invalid combination for institutional BH encounter
  - 299: Recipient not in MCO on date of service (DOS)

- Original submission of professional encounters
  - 217: Invalid combination for professional BH encounter
  - 175: Match not found for original ICN/claim reference number (CRN) and paid status
  - 299: Recipient not in MCO on DOS

- Resubmission of professional encounters
  - 177: Original claim already adjusted
  - 299: Recipient not in MCO on DOS
  - 175: Match not found for original ICN/CRN, paid status

OMHSAS updates and distributes the BHSRCC grid 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. MBH crosswalks diagnosis codes, procedure codes, modifier codes and revenue codes prior to PROMISe submission. MBH maps the patient discharge status code to '01' indicating discharged to home or self-care, if qualifying continued stay records are not found.

MBH indicated that prior to July 1, 2016, they submitted up to two diagnosis codes to PROMISe for institutional and professional encounters. As of July 1, 2016, MBH submits up to 12 diagnosis codes to PROMISe for institutional and professional encounters. MBH stores diagnosis pointer code values only on manually entered paper claims in CAPS. MBH does not include the diagnosis code pointer values in the professional encounters submitted to PROMISe.

Prior to the EDV webinar, 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 five professional ICN records with discrepancies to review on MBH's claim system for accuracy during the EDV webinar. The following data elements were reviewed during the EDV webinar review on MBH'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 CPT codes.

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

- Type of Bill: During the EDV webinar, IPRO identified that all Type of Bill Codes values on MBH's claim system did not match the PROMISe Type of Bill values. IPRO followed up with MBH to discuss further discrepancies related to a couple of examples when the Type of Bill on MBH's claim system didn't match the PROMISe Type of Bill. During a follow-up discussion MBH advised, "There is no crosswalking of codes. We are not sure how the PROMISe Type of Bill value is being derived and/or populated. For this sample, the value of 112 was not reported by MBH."

- Discharge Status code: prior to the submission of institutional encounters to PROMISe, MBH maps the patient discharge status code to '01' indicating discharged to home or self-care, if qualifying continued stay records are not found.
- Procedure code: prior to the PROMISe submission of professional encounters, the procedure code is mapped to a code on MBH's internal crosswalk table.

- For one of the three FUH denominator PROMISe ICNs, MBH submitted an encounter with dates of service September 25, 2015 through October 7, 2015. During the webinar, IPRO observed claims on MBH's CAPS screen for the same member with dates of service October 8, 2015 and October 9, 2015 through October 10, 2015. As per PM specifications, the three claims should have been concatenated and submitted for the period September 25, 2015 through October 10, 2015 on the PM data file. As a follow-up item, MBH provided IPRO the PROMISe ICNs for the three claims. IPRO noticed that the three PROMISe ICNs had the same admit date, billing provider ID, diagnosis, revenue and type of bill codes in IPRO's BH PROMISe paid/accepted DW. On a follow-up call with OMHSAS and IPRO, MBH advised that the encounters were not concatenated as the encounter with a date of service October 8, 2015 was categorized as a sub-acute MH facility encounter and MBH does not include sub-acute MH facility encounters in the BH PMs.

Findings

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

Strengths

- MBH 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, MBH is able to link the adopted member records and the multiple identification numbers associated with the adopted child.
- MBH has less than 1% PROMISe denial rate for institutional and professional encounters submitted to PROMISe with date of service in 2015. MBH's process of identifying and resolving PROMISe rejections has resulted in very low PROMISe denial rate.

Opportunities for Improvement

- Consistent with the language contained in the HealthChoices Behavioral Health Agreement(s), providers of behavioral health services are required to comply with all federal and state laws, specifically governing participation in the MA Program, etc. and MBH is required to avoid the use of encounter data containing all "88888888's". MBH must utilize the PRV414 file to determine if the provider is enrolled in Medicaid. If the provider is not enrolled in Medicaid then MBH must work with the provider to enroll in Medicaid.
- MBH maps the patient discharge status code to '01' indicating discharged to home or self-care, if qualifying continued stay records are not found. IPRO recommends that MBH submit the patient discharge status code as received on the claim to PROMISe.
- MBH does not submit institutional service lines with zero paid amounts to PROMISe. IPRO recommends that MBH work with OMHSAS to submit all institutional service lines including service lines with zero paid amounts to PROMISe to ensure all data is captured for reporting and analysis purposes.

Corrective Action Needed

- Currently, MBH only submits up to 12 institutional diagnosis codes to PROMISe. MBH needs to provide a plan of action demonstrating MBH's intent to submit all diagnosis codes received on the claim to PROMISe.
- MBH needs to provide a plan of action demonstrating MBH's intent to include the type of bill code as received on the claim on institutional encounters submitted to PROMISe.
- MBH does not include sub-acute facility claims on their BH PM files. MBH to provide OMHSAS with detailed information and examples on the sub-acute facility claims; how they are received, how they are submitted to PROMISe and how they are handled in the PM inpatient acute care record identification. MBH to work with OMHSAS to identify how these records should be submitted to PROMISe and how the sub-acute claims should be handled for the BH PMs.

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 BH 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 information system 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 information system, 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.
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.
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.
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.
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:

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.

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