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

2016 Encounter Data Onsite Validation

Value Behavioral Health of Pennsylvania

February 27, 2018

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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 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 webinars 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 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

Value Behavioral Health of Pennsylvania (VBH), a Beacon Health Options Company, has participated in the BH HealthChoices contract since 1999. In 2016, VBH continued to service 13 counties for the HealthChoices product line. Their total average enrollment in 2015 was 281,161 members (**Table 2**).

The 2016 EDV onsite visit was held in VBH's offices in Trafford, PA on December 13, 2016. OMHSAS and IPRO attended the onsite visit. VBH and Beacon Health Options also attended the onsite visit.

Table 2 lists the PA BH counties where VBH 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
Armstrong	12,182
Beaver	27,482
Butler	19,587
Cambria	25,249
Crawford	15,306
Fayette	33,055
Greene	7,301
Indiana	12,846
Lawrence	16,873
Mercer	21,621
Venango	10,048
Washington	28,367
Westmoreland	51,244
Total	281,161

Enrollment Systems

VBH'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 applied to the Connects Administrative System (CAS). CAS is VBH's proprietary system. The Eligibility is updated based on files received. The 834 Daily Eligibility File is received and processed daily. Designated eligibility staff members also have access to DHS Client Information System (CIS) to look up eligibility and manually update CAS.

VBH also utilizes the following three 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 VBH's eligibility system.
3. Monthly TPL File – This file contains new, changed or deleted third party liability (TPL) information.

CAS is configured to load and validate member records included in the daily eligibility file based on the initial eligibility file setup. If the file loads do not map as designed and the error threshold is less than 2%, then the file is loaded. A CAS error report and electronic notice is automatically generated and sent to the business systems analyst (BSA). If the error threshold is greater than 2%, then the file does not load. Upon receipt of the notice, the BSA performs analysis of errors and follow-up with the client to obtain resolution to the errors. Once a resolution is obtained, the errors are corrected or sent back for further review. All critical quality errors with a potential to affect the management of care for a member or the payment of a claim are returned to the specialist for immediate correction. Feedback on quality is given to each eligibility specialist on a monthly basis. Overall quality is monitored by the Eligibility Processing Management Team. VBH creates error reports with error messages indicating why the record was not accepted. A rejected record is verified in the CIS system and coverage is updated as needed.

CAS is programmed to automatically generate system notices any time an attempt is made to disenroll more than 2% of a client's membership roster in a single file load. Once the notice is received, the BSA performs follow-up to verify appropriateness of member roster changes. A quality audit program is in place to assure the accuracy of eligibility on file. A 5% random sample is taken of electronic files loaded to CAS, inquiries and manual updates received and worked by each eligibility specialist. The quality audits are conducted by the eligibility processing technical advisors. Any quality errors that are discovered through the audit process are tracked by specialist on an audit tracking sheet. The tracking sheets are returned to the specialists on a weekly basis so the errors can be corrected.

VBH enrolls members on the effective date included on the daily 834 enrollment files. VBH's enrollment system contains logic to designate the effective and expiration dates in the following scenarios:

- If the BH effective date and HealthChoices Medicaid (MA) effective date are not identical, VBH selects the later of the dates. If the BH effective date is missing, VBH selects the HealthChoices MA effective date. **Table 3** illustrates examples of enrollment records with derived effective dates.
- If the BH expiration date and HealthChoices MA expiration date are not identical, VBH selects the earlier of the dates. HealthChoices disenrollment in a given county typically occurs on the last day of the month. HealthChoices eligibility terminations occurring mid-month are typically the result of a member being placed in some kind of facility (e.g., juvenile detention and long-term care). In these scenarios, VBH utilizes logic to extend the expiration date to the end of the month as the expiration date. **Table 3** illustrates examples of enrollment records with derived expiration dates.

VBH utilizes ELIGIBILITYCONNECT, a module of CAS, to determine eligibility based on the elements in the PROMISe management system table. The program status code and category of assistance group type are pivotal to the process of determination of eligibility. VBH identifies members with dual eligibility in Medicaid and Medicare as Rating Group "SSI

with Medicare." This is uploaded in SERVICECONNECT, a module of CAS, where historical eligibility as well as current status is displayed.

VBH utilizes a relational database for enrollment data reporting. This database is refreshed daily on a national level and weekly on a local level. VBH utilizes several internal controls to ensure the accuracy and completeness of data. Record counts, hash totals, and archiving are among the techniques used to make sure all records are accounted for.

During the onsite visit, IPRO requested and VBH 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 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 VBH on the discharge date. IPRO identified three member records for review during the onsite visit. Two member records of the three member records selected for review had enrollment history discrepancies. The following data elements were reviewed during the EDV onsite visit on VBH's enrollment system for the two members: recipient ID#, date of birth, last and first name and enrollment and disenrollment dates for 2015.

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 VBH's enrollment system for all three records.
- Date of birth: IPRO was able to confirm that the date of birth on VBH'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 VBH's enrollment system did not match the dates on IPRO's BH Eligibility DW. VBH's enrollment system contains logic to designate the effective and expiration dates in the following scenarios.
  - If the BH effective date and HealthChoices Medicaid (MA) effective date are not identical, VBH selects the later of the dates. If the BH effective date is missing, VBH selects the HealthChoices MA effective date. **Table 3** illustrates examples of enrollment records with derived effective dates.
  - If the BH expiration date and HealthChoices MA expiration date are not identical, VBH selects the earlier of the dates. HealthChoices disenrollment in a given county typically occurs on the last day of the month. HealthChoices eligibility terminations occurring mid-month are typically the result of a member being placed in some kind of facility (e.g., juvenile detention and long-term care). In these scenarios, VBH utilizes logic to extend the expiration date to the end of the month as the expiration date. **Table 3** illustrates examples of enrollment records with derived expiration dates.

Table 3: Enrollment Data for Members with Derived Effective and Expiration Dates

Recipient ID#	BH Effective Date	MA Effective Date	Derived Effective Date
1	Blank	08/20/2015	08/20/2015
2	02/15/2015	03/01/2015	03/01/2015
Recipient ID#	**BH Expiration Date**	**MA Expiration Date**	**Derived Expiration Date**
1	03/31/2015	03/01/2015	03/31/2015
2	06/15/2015	07/31/2015	06/30/2015

ID: identification; BH: behavioral health; MA: Medicaid.

Claims/Encounter Systems

VBH receives and processes claims[1] from providers in three different modes: 837 files from providers, direct online entry via VBH's provider portal accesses website (Provider Connect), and HCFA1500 and UB04 paper claims. Approximately 2.7 million claims with a date of service in 2015 were received and processed as of the date of the onsite visit. Approximately 90% of VBH's claims are received electronically (data not shown). Approximately 4,500 to 5,500 professional claims are received on a weekly basis via Provider Connect (data not shown).

Once a claim is received, VBH's first step is to perform a series of validation checks of the electronic data interchange (EDI) 837 file to verify the data format and provider number validation. Provider validation findings go through a two phase process, first when a claim enters into VBH's system a series of checks are performed to validate provider such as provider identification and file format. Failure of these validation steps cause the claim to be returned to the sender with error messages stating what is missing and/or need to be corrected. After the claim passes the EDI and provider validation another series of checks are done before the claim is adjudicated and finalized; approximately 76% of the claims are auto-adjudicated (data not shown).

Claims submitted with missing, incomplete or invalid data for a required field are populated with 'UNK' indicator in the field and the claim is denied. VBH verifies the procedure code and diagnosis code upon entry of the data into the claims processing system. The claims processing system validates the information based on preset tables that include all accepted, industry standard procedure code and diagnosis code information. If the information entered does not match the preset table, the claim receives an edit and is pended for review by the claims processor.

VBH claims processors have the ability to change information submitted on a claim form only if they receive written instructions from the provider. The written instruction is attached to each claim affected for auditing purposes.

VBH uses CAS Platform –CONNECTS for all services and utilization data. CONNECTS is the platform for care management, reporting, research, financial and claims payment. CONNECTS includes functions such as member eligibility, service authorizations and utilization, complaints/grievances, member call center, provider credentialing and enrollment, claims processing, encounter data reporting and outcome measurement.

Claims entered into the CONNECTS platform may be pended, if the claim information prevents the claim from processing correctly. Claims that would be denied for eligibility or authorization are also pended. The pended claims are submitted to the respective department for verification prior to denial. An open/pended claim report is generated on a daily basis and triggers the claim processors to check the pended claims. An inquiry is submitted to the clinical department for their review with responses returned within approximately 48 hours. If the response from clinical department does not answer the question posed to the team, the information is returned with a second request for a response. All pended claims are considered for payment within 45 calendar days.

VBH has alternative payment arrangements (APAs) with providers in all 13 counties for various services. VBH monitors pseudo-claims and reports submitted by the providers to assure services are provided and at the levels that meet the APAs approved by DHS. Annual reports are submitted to DHS to support the APAs and also to show the cost effectiveness of these arrangements. VBH indicated that the APAs are meeting the standards.

When the batch of claims is received by VBH for adjudication, the CONNECTS system looks at eligibility, authorization requirements, diagnosis, procedure code and service date. If these data elements are valid, the claim is adjudicated. If the data elements are not valid, then a hold code, such as "authorization required, not found" would be displayed on the claim record. If the hold code is related to eligibility or authorization, then the claims processor will pend the claim. Once the issue is identified (e.g., the authorization had the wrong place of service [POS] that kept it from attaching to the claim) and corrected, the claim is re-adjudicated with no override needed. The open claim report lists any override done for that posting. The claims supervisor reviews the open claim report prior to each posting.

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

Table 4 presents the number of claims paid or denied in 2015. The counts are based on service lines.

Table 4: Paid and Denied Claims in 2015

Type of Claim/Encounter	Claims Paid	Claims Denied
Institutional	86,892	99,486
Professional	2,305,989	325,329

Based on VBH's ISCA response, VBH processes a total of more than 40,000 claims each week, maintaining more than 99.9% administrative accuracy and 99% financial accuracy (data now shown). Overall, 95% of all claims that are received are adjudicated within 30 days of receipt (data now shown). VBH auto-adjudicates approximately 76% of the claims received.

VBH stores claims and encounter data in their reporting system from the inception of their contract with DHS in 1999. Historical data are accessed along with current data from their reporting system.

VBH claims data are virtually complete within three months after the close of a reporting period. VBH processes and adjudicates claims submitted in a timely manner. VBH indicated that claims adjudicated after 90 days of receipt are very rare and are tracked closely.

As per VBH's contract with providers, a provider can submit claims no more than 90 days following the date of service of covered services. VBH's standards for claim turnaround time are to pay 90% of "clean claims" within 30 days of initial receipt, 100% of "clean claims" within 45 days, and all claims within 90 days of receipt. Paper adjustment request for all claims, regardless of the adjustment reason, must be submitted within 90 days of the date of the most current payment voucher.

VBH utilizes a relational database at the local level in PA and a DW at the national level for encounter claims. The data for the local relational database is populated daily and weekly from their national DW. The national DW is updated from the CAS system that houses all modules of CONNECTS. PM reporting is done at both local and national level.

PROMISe Submission and Reconciliation Process

On a monthly basis, VBH creates the PROMISe submission extracts using a relational database in the CAS. All eligible encounters that are finalized in VBH's system at the time are submitted to PROMISe unless the information required in the extracts is not complete. Prior to submission, revenue, procedure, modifier and POS codes are cross walked to similar codes utilizing the Behavioral Health Services Reporting Classification Chart (BHSRCC) grid to pass PROMISe validation. Provider ID is mapped to '888888888' for providers that are not enrolled in Pennsylvania's Medicaid program.

VBH submits all MCO-paid and MCO-denied claims to PROMISe, with the exception of claims that with certain hold/reject codes. VBH does not submit APA-paid claims to PROMISe. VBH submits to PROMISe the MCO-denied claims that are denied due to the following denial reason codes:

- Approved authorization not on file,
- TPL,
- Exhausted benefit, and
- Timely filing.

VBH submits to PROMISe a new ICN, common header and detail record for each institutional and professional service line.

The extraction of 837 and processing of business exchange services (BES) and U277 response files are automated. The PA-rejected transactions that require manual data correction are reviewed. VBH tracks the submission of encounters to PROMISe and the U277 response file in historical files within the CAS system. If a response file is not received, then the status of transaction in the CAS is used to identify the absence of a response file, and appropriate follow-up is done, when the status is not as expected after the monthly responses are received.

VBH receives weekly reports that identify all PROMISe-rejected encounters for evaluation and correction. VBH reviews the rejection reasons and evaluates the issues that need to be resolved for resubmission of the claim. VBH also reaches out to OMHSAS contacts for additional information regarding the error. VBH's ISCA indicated that the average number of business days between initial denial and the date the encounter was accepted by PROMISe for high-volume rejections is a couple of months, whereas for a low-volume rejection, it may take longer. Encounters denied by PROMISe would never be resubmitted by VBH, if the rejection indicated that the member had a retrospective eligibility termination or if VBH identified a situation where the encounter should not have been extracted for PROMISe submission at all.

VBH does not conduct a second check of member eligibility prior to creating the PROMISe submission file. If a member had been ineligible at the time of service, then VBH would have denied the claim and it would not be submitted as an encounter on the 837 file.

In its ISCA response, VBH indicated that claims with a date of service in 2015 were submitted to PROMISe within 15-45 business days after claim adjudication by the BH-MCO (data not shown).

According to VBH's ISCA response, for claims with a date of service in 2015, VBH submitted the claims presented in **Table 5** to PROMISe as of January 24, 2017.

Table 5: Unique Encounters Submitted to PROMISe with 2015 Dates of Service

Type of Claim	Number of Claims with 2015 Dates of Service as of 1/24/2017
Institutional	65,390
Professional	1,799,080
Total	1,864,470

VBH indicated the status for the 1,864,470 claims that were submitted to PROMISe with date of service in 2015 (**Table 6**) 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 6: 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	49,712	81%	4,792	8%	6,981	11%	61,485
Professional	1,544,397	85%	221,756	12%	41,141	2%	1,807,294

[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 11% PROMISe denial rate for institutional encounters and a 2% PROMISe denial rate for professional encounters (**Table 6**).

VBH has identified that 142,259 institutional and 724,238 professional claims were denied by PROMISe or awaiting resubmission as of August 12, 2016 (**Table 7**).

Table 7: Denied or Not Yet Accepted Claims as of August 12, 2016

Claim Type	Denied or Not Yet Accepted Claims
Institutional	142,259
Professional	724,238

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. VBH crosswalks procedure codes, modifier codes and revenue codes prior to PROMISe submission.

VBH submits the principle, admitting, and the next four non-duplicate diagnosis codes to PROMISe for institutional encounters and up to 12 diagnosis codes to PROMISe for professional encounters.

Even though VBH is submitting secondary diagnosis codes to PROMISe, VBH's logic references the diagnosis code pointers and is altering, dropping and rearranging 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 8** 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 8: 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.

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 three professional PROMISe ICN records with discrepancies to review on VBH's claim system for accuracy during the EDV onsite visit. The following data elements were reviewed during the EDV onsite review on VBH'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, 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 three professional records:

1. Discharge dates: for institutional encounters, VBH utilizes the authorization end date instead of the claim's discharge date.
2. Diagnosis codes: for institutional encounters, VBH submits only up to six diagnosis codes to PROMISe. For professional encounters, VBH submits up to 12 diagnosis codes to PROMISe. For the diagnosis codes that VBH is submitting to PROMISe, VBH's logic alters, drops and rearranges the diagnosis codes based on the diagnosis pointer code referenced on the claim service line.
3. Revenue code: prior to the submission of institutional encounters to PROMISe, the revenue code received on the claim is mapped to a code on the BHSRCC grid.
4. POS code: prior to the submission of professional encounters to PROMISe, the POS code is mapped to a POS code of '99', if the code is not in the BHSRCC grid.
5. Procedure code: prior to the submission of professional encounters to PROMISe, the procedure code is mapped to a code in the BHSRCC grid.
6. Provider ID: prior to the submission of professional encounters to PROMISe, the provider ID is mapped to '888888888' for providers that are not enrolled in Pennsylvania's Medicaid program.

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

- VBH has spent considerable time and effort in educating its provider network about the HealthChoices benefits and billing requirements. This has translated into receiving approximately 90% of claims in an electronic format, which allows for timely and efficient adjudication as it eliminates errors in paper claims.
- VBH applies quality checks on claims staff to ensure a higher claim acceptance and adjudication rates.
- VBH 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.

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 VBH is required to avoid the use of encounter data containing all "88888888's". VBH must utilize the PRV414 file to determine if the provider is enrolled in Medicaid. If the provider is not enrolled in Medicaid then VBH must work with the provider to enroll in Medicaid.

Corrective Action Needed

- VBH needs to provide a plan of action demonstrating VBH's intent to work with OMHSAS on identifying member enrollment date issues instead of deriving the enrollment dates. VBH's enrollment system contains logic to designate the effective and expiration dates in the following scenarios:
  - If the BH effective date and HealthChoices Medicaid (MA) effective date are not identical VBH selects the later of the dates. If the BH effective date is missing, VBH selects the HealthChoices MA effective date.
  - If the BH expiration date and HealthChoices MA expiration date are not identical, VBH selects the earlier of the dates. HealthChoices disenrollment in a given county typically occurs on the last day of the month. HealthChoices eligibility terminations occurring mid-month are typically the result of a member being placed in some kind of facility (e.g., juvenile detention and long-term care). In these scenarios, VBH utilizes logic to extend the expiration date to the end of the month as the expiration date.
- VBH 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. VBH needs to provide a plan of action demonstrating the volume of encounters submitted to PROMISe with the diagnosis codes altered and impact of the logic, and provide a step-by-step plan to modify the PROMISe professional encounter submission logic.
- Currently, VBH only submits up to six institutional and 12 professional diagnosis codes to PROMISe. VBH needs to provide a plan of action demonstrating VBH's intent to submit all diagnosis codes to PROMISe.
- VBH utilizes the BHSRCC grid to map and assign the revenue, CPT and POS codes prior to submitting the encounter to PROMISe. VBH indicated that the BHSRCC grid utilized by VBH was outdated when compared to the most recent version of the BHSRCC grid available. VBH needs to provide a plan of action demonstrating VBH's intent to correct the issues with the BHSRCC grid and provide supporting documentation.

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.
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.

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