Commonwealth of Pennsylvania
Department of Public Welfare
Office of Mental Health and Substance Abuse Services

2013 Encounter Data Onsite Validation

Value Behavioral Health

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REPORT CONTENT

GLOSSARY OF TERMS

BH Eligibility Slice File	Quarterly eligibility file received by IPRO from Department of Public Welfare (DPW). The file contains date of birth, county, gender, race, ethnicity, recipient ID#, assistance/aid categories, effective and expiration dates.
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 HP.
PLE	Personal Level Encounter data. File requested by Mercer from the BH-MCOs on a quarterly basis that includes BH encounter data.
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 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.
PM FUH	Follow-up After Mental Health Hospitalization. This 2013 Behavioral Health performance measure 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 2013 Behavioral Health performance measure assessed the percentage of discharges for enrollees from inpatient acute psychiatric care that were subsequently followed by an inpatient acute psychiatric care readmission within seven and 30 days of the previous discharge. BH-MCOs are required to submit data files and source code to IPRO.
CIS	DPW's Client Information System that is available to the BH-MCOs to access enrollment information
PROMISe	Pennsylvania's Department of Public Welfare's (DPW's) claim processing and management information system provided by Hewlett Packard's Enterprise Services stands for Provider Reimbursement and Operations Management Information System (in electronic format). PROMISe accepts HIPAA 837 files for claims processing.
APA	Alternate Payment Arrangements include any payment arrangement between MCO and its providers other than Fee-for-Service. Some alternative payment arrangements call for the reporting of zero monetary amounts on the 837 transaction files.
MAID	Medical Assistance Identification Number. Assigned to a member by DPW.

INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) encourages States to implement the voluntary Encounter Data Validation (EDV) Protocol "due to the need for overall valid and reliable encounter data as part of any State quality improvement efforts. As Federal programs transition toward payment reform for demonstrated quality of care, validation of encounter data in the use of performance data will become increasingly significant. Transparency of payment and delivery of care is an important part of health reform as demonstrated in various provisions of the Affordable Care Act. Validation of encounter data can help States reach the goals of transparency and payment reform to support their efforts in quality measurement and improvement."

The CMS Encounter Data Validation Protocol consists of five activities:

1. Review of State requirements for collection and submission of encounter data
2. Review of each MCO's capability to produce accurate and complete encounter data
3. Analysis of MCO electronic encounter data for accuracy and completeness
4. Review of medical records. As appropriate review of medical records may be necessary to confirm findings. IPRO together with OMHSAS has assessed that there is no medical record activity to be conducted at this time but may be addressed at a future date.
5. Submission of findings

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 and resolve issues that arise in the encounter data submission process.

As part of CMS EDV protocol activity 1, IPRO has reviewed DPW requirements for collection and submission of encounter data to PROMISe. As PA Department of Public Welfare's (DPW's) EQRO, IPRO has an understanding of the state's Physical Health (PH) and Behavioral Health (BH) encounter data (ED) process.

On a weekly basis since 2005, IPRO receives encounter data extracts from PROMISe and loads them to IPRO's SAS data warehouse. For PH encounter data, IPRO loads the PROMISe paid/accepted Dental, Professional, Institutional and Pharmacy extracts. For BH encounter data, IPRO loads the PROMISe paid/accepted Professional and Institutional extracts. Since January 1, 2012, IPRO also loads the PROMISe denied BH encounter data to IPRO's data warehouse. As the weekly PH and BH encounter data extracts are loaded into IPRO's data warehouse IPRO conducts checks on the data elements and volumes received.

Table 1: Claim Header Volume Stored in IPRO's Data Warehouse as of 10/1/2013

Physical Health Encounter Type	Claim Header Claim Count	Behavioral Health Encounter Type	Claim Header Claim Count
Institutional	43,489,192	Institutional	985,220
Professional	130,255,024	Professional	119,737,974
Dental	2,809,484		
Pharmacy	203,420,425		

On a bi-weekly basis, IPRO attends the Encounter Action Team (EAT) technical meetings with DPW, Hewlett Packard (HP) and Mercer to discuss encounter data submission, issues and change order and defect statuses. On a monthly basis, IPRO also attends the technical PROMISe call with HP, 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 calls with OMAP and bi-weekly calls with Office of Mental Health and Substance Abuse Services (OMHSAS) to discuss PH and BH encounter data validation activities.

IPRO is familiar with DPW's requirements for collecting, processing and submitting of encounter data by the BH-MCOs to PROMISe. In addition in 2008, IPRO conducted similar encounter data validation activities for DPW's HealthChoices PH MCOs.

As part of CMS' EDV protocol activities 2, 3 and 5, IPRO reviewed and analyzed each BH-MCO's capability to produce encounter data and the BH-MCO's electronic PROMISe submission process to PROMISe for accuracy and completeness. IPRO conducted the following EDV BH-MCO activities during 2013 in addition to the ongoing monitoring and oversight activities:

- The BH-MCOs completed an encounter data survey. The BH-MCOs provided feedback on the processing of voided and adjusted encounter data to PROMISe;
- The BH-MCOs completed an Information Systems Capabilities Assessment (ISCA) tool that IPRO developed based on CMS' ISCA tool developed on 5/1/2002;
- IPRO analyzed information from the ISCA and conducted interviews with BH-MCO staff during the EDV onsite;
- IPRO identified the BH-MCOs strengths and opportunities for improvement.

OMHSAS' purpose for the 2013 BH-MCO EDV Onsite activities was to conduct an assessment of BH-MCO systems and processes with regards to encounter data processing and submissions to PROMISe. IPRO assessed the BH-MCO encounter data validation process through three steps:

1. BH ED Survey on Voided and Adjusted PROMISe encounters;
2. Information Systems Capabilities Assessment tool; and
3. Onsite interview of key MCO personnel and review of systems and encounter data submission process

The BH ED Survey focused on the BH-MCOs' activities and processes for handling voided and adjusted encounter submission to PROMISe. The ISCA findings and the onsites focused on the following areas:

- Enrollment Systems
- Claims and Encounter Systems
- Performance Measure (PM) Development
- PROMISe Submission and Reconciliation Process

I: ENCOUNTER DATA VALIDATION PROCESS

Step 1: BH ED Survey – Voided and Adjusted PROMISe Encounters

IPRO surveyed the BH-MCOs to identify how the BH-MCOs are submitting, processing and reconciling voided or adjusted HealthChoices encounters. Specifically, the survey asked the BH-MCOs to provide information on how they handle PROMISe encounter adjustments and voids and to provide examples of voided and adjusted encounters. The purpose of the survey was to assess the completeness and accuracy of voided and adjusted encounters in the PROMISe system.

The following assumptions were made:

- A paid/accepted PROMISe encounter may be adjusted or voided by the BH-MCO.
- An adjustment is always Frequency Code 7.
- Successful adjustments are written to a Paid Encounter File. Unsuccessful adjustments are written to Denied Encounter Extract file.
- A void is always Frequency Code 8.
- Both Successful and Unsuccessful voids are written to a Denied Encounter Extract File.

Step 2: ISCA

The BH-MCOs were requested to complete and return the ISCA tool to IPRO prior to the July onsite visit. IPRO modified the 5/1/2002 Version 1.0 ISCA found in CMS' appendix section of the External Quality Review Activity Protocol. IPRO tailored the questions for the BH-MCO, DPW 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 System (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 systems is capable of producing valid encounter data, performance measure 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 Load Process
    b. Enrollment Systems and Reporting
3. Claim Systems
    a. Claim Types and Volume
    b. Claims Processing
    c. Claims Reporting
4. Performance Measure Reporting
5. PROMISe Submission and Tracking

Step 3: Onsite Visit

IPRO conducted a one-day onsite review of each of the BH-MCOs. The purpose of the onsites was:

1. To be able to review the ED survey and ISCA findings with the appropriate BH-MCO staff, and discuss any outstanding questions regarding the ED Survey or ISCA responses;
2. To review the BH-MCO enrollment, claim/encounter and PROMISe systems and processes;
3. To view member and claim examples selected from the 2013 BH Performance Measure data files submitted on the BH-MCO's system screens.

II: GENERAL INFORMATION

Value Behavioral Health (VBH) has participated in the BH HealthChoices contract since 1999. In 2012, VBH serviced 13 counties for the HealthChoices product line. Their average enrollment in 2012 was 254,846 members.

The ED onsite was held in VBH's offices in Trafford, PA on July 16, 2013. OMHSAS and IPRO attended the onsite. The counties were invited to participate in the closing section.

Table 2 lists the PA BH Counties where VBH enrolled members during 2012 and the average monthly number of HealthChoices members enrolled for the period January 1, 2012 to December 31, 2012:

Table 2

BH-MCO County Name	Average Monthly HealthChoices Behavioral Health Enrollment
Armstrong County	10,858
Beaver County	25,555
Butler County	17,341
Cambria County	22,059
Crawford County	14,846
Fayette County	30,691
Greene County	7,130
Indiana County	11,018
Lawrence County	15,426
Mercer County	20,389
Venango County	9,103
Washington County	25,696
Westmoreland County	44,735

III: ENROLLMENT SYSTEMS

VBH's primary source of enrollment information is the 834 Daily Eligibility file received from DPW. The file is received daily by VBH, and the records are checked for errors and validated against VBH's current eligibility records. Records that pass validation are loaded into their enrollment system, Connects Administrative System (CAS). Records that fail the validation process are investigated to determine the cause of the error.

CAS will halt loading of the eligibility file, and generate a system notice, if more than 2% of records contain errors. CAS will also generate a system notice if the eligibility file contains information that will terminate 2% or more of the total membership.

VBH relies on DPW's Client Information System (CIS) when making manual eligibility changes and enrollment verifications. VBH conducts a quality audit of manual updates to their eligibility system. A random sample of manually updated records are reviewed for accuracy.

After each enrollment load process is completed, VBH has a series of detailed reports to validate that all records are accounted for in the CAPS Information System.

Internally, VBH's primary source of enrollment data is the CAS system. The CAS system assigns a unique ID number to each member. The member's ID does not change if the member switches counties within VBH's service area VBH can also identify a unique member that has dis-enrolled and subsequently re-enrolls in VBH. The member's previous enrollment spans and demographic history are also stored in the system.

The majority of members in HealthChoices are assigned a single MAID by DPW. However, in rare cases, such as adoption, or aging into a different program, a member could be assigned two MAIDs. If VBH identifies a member that is enrolled with two different IDs, VBH notifies DPW of the member. VBH does not combine the information from the two ID numbers.

VBH enrolls members and terminates members based on the effective and termination dates provided on the daily 834 enrollment files. Termination dates are the last day of the month, unless the termination reason is covered by the exceptions noted in Appendix V of the HealthChoices contract (e.g. death, incarceration).

VBH utilizes a relational data warehouse for enrollment data reporting. This database is refreshed weekly from CAS. The database is validated to ensure data completeness. VBH stores, and is able to report on enrollment and demographic categories.

VBH has well-documented procedures regarding how enrollment loading programs are tested and validated prior to being promoted to production.

During the onsite, IPRO requested VBH to demonstrate their enrollment system data entry and enrollment history and demographic screens. In addition, IPRO selected five member records from the 2013 Follow-up After Mental Health Hospitalization (FUH) Performance Measure (PM) data file to review in the enrollment system. The following elements were reviewed:

- Date of birth
- Last name
- First name
- Enrollment and disenrollment dates

These data elements were checked against the FUH PM member-level file submitted to IPRO. The PROMISe data elements matched the data submitted on the 2012 FUH PM member-level data file. IPRO

also compared the enrollment information to the data elements received by IPRO on the quarterly BH Eligibility Slice File.

1. First name and last name are not on the eligibility file.
2. The date of birth matched for all five records.
3. The effective date matched for one of the five members. Four of the members were enrolled on the BH Eligibility Slice File. However the file did not contain the earliest enrollment date.
4. All five members matched on expiration date.

IV: CLAIMS/ENCOUNTER SYSTEMS

VBH receives and processes claims[1] from providers in three different formats: 837 files from providers, direct online entry via VBH's provider accessed website, and HCFA1500 and UB04 paper claims. Approximately 2.8 million claims with a date of service in 2012 were received and processed as of the date of the onsite. VBH indicated that approximately 90% of the claims were received electronically.

All paper claims received by VBH are processed in their Latham, NY office. Once received, claims are date-stamped and logged to ensure all claims are accounted for.

VBH can alter the information on a claim if the provider provides written documentation of the change. The documentation is kept with the original claim for auditing purposes.

Claims missing required data elements are returned to the provider. During the adjudication process, procedure and diagnosis codes are checked for validity. If the claim does not pass the validation test, it is pended for manual review.

VBH's claim processing system is Connects Administrator System (CAS) Platform – ClaimsConnect. This system auto-adjudicates claims whenever possible.

VBH will pend claims for multitude of reasons as invalid information, missing authorization, or eligibility. Claims that are missing an authorization are forwarded to a clinical department for review. A claim cannot remain in pended status for more than 45 days. VBH runs daily reports on the pended claim queue to ensure claims are adjudicated within the timeframe.

VBH has a complete and well-documented process to monitor claims accuracy. On a monthly basis, a random sample of claims is pulled and reviewed for accuracy. The sample is constructed to ensure that the processors maintain 99% accuracy. In addition, 100% of high dollar claims are reviewed prior to payment. Per the ISCA, VBH reports a 99% financial accuracy for processed claims, and a 99.9% administrative accuracy.

VBH follows the HealthChoices Program Standards and Requirements (PSR) guidelines for processing timeliness: 90% of clean claims paid within 30 days or receipt, 100% of clean claims paid within 45 days, and 100% of all claims paid within 90 days. VBH reported on their ISCA response that 95% of all claims are adjudicated within 30 days of receipt.

For claims with dates of service in 2012, Table 3 indicates the volume of claims processed (MCO paid and MCO denied) by claim type. VBH reported table 3 at the claim line level, meaning that some lines of the claim are paid, while some are denied. For institutional claims, VBH will pay the room and board line, and deny the ancillary lines. This is the reason for the apparently high rate of institutional denials.

Table 3

	Claims Paid	**Claims Denied**
Institutional	19,121	28,088
Professional	2,533,221	242,088

VBH stores adjudicated claims data in a relational databases for reporting purposes. VBH's reporting data warehouse is updated on a regular basis, and reports are run to validate control totals and that all records have been loaded properly.

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

Based on sample lag reports submitted to IPRO and ISCA responses, VBH's claims data is approximately 96% complete three months after the close of a reporting period.

VBH stores claims data in their reporting system from the inception of their contract with DPW in 1999.

As part of the validation process, IPRO requested FUH PM claims for members sampled from the FUH PM. IPRO compared the dates of service, revenue codes, CPT codes, and provider information submitted on the claim to what was reported on the performance measure data files. No discrepancies were found between the PM data and the claims.

IPRO also compared the following encounters received on the 2013 FUH PM member-level data file to IPRO's BH PROMISe Data Warehouse:

- Two PROMISe Inpatient FUH ICNs were found on the paid/accepted Institutional table with the correct admission and discharge dates.
- One PROMISe Inpatient FUH ICNs was found with the correct admission date, and the discharge date from PROMISe was one day off from the performance measure discharge date.
- One PROMISe Inpatient FUH ICN was found with the correct discharge date, but an earlier admission date.
- Five PROMISe Professional FUH ICNs were found on the PROMISe paid/accepted Professional table.

V: PROMISE SUBMISSION AND RECONCILIATION PROCESS

VBH creates the PROMISe submission files on the 15th of every month based on claims adjudicated in the previous month. When a submission file is created, a status flag is assigned to each submitted encounter to indicate it has been submitted to PROMISe. When the PROMISe response file is received, the responses are matched to VBH's submitted data and the status flag is updated to an accepted or rejected status.

VBH does not currently submit MCO denied claims to PROMISe and only MCO paid encounters are currently submitted. Prior to submission, revenue, CPT4, HCPCS and modifier codes are cross-walked to similar codes utilizing the BHSRCC grid to pass PROMISe validations.

VBH does not conduct a second check of member eligibility prior to creating the PROMISe submission file.

VBH produces regular reports that detail the reasons and status of rejected claims. Rejections are manually worked and flagged for resubmission once the issue has been resolved. In certain cases, for example retroactive eligibility changes, PROMISe rejections are not resubmitted.

VBH is currently only submitting the first three ICD9-CM diagnosis codes received by the provider to PROMISe.

According to VBH's ISCA response, for claims with a date of service in 2012, VBH submitted the following claims to PROMISe as of 6/12/2013 (Table 4).

Table 4

	VBH Claim Volume with 2012 Dates of Service as of 6/12/2013
Institutional	53,367
Professional	2,223,061
Total	2,276,428

VBH indicated the status for the 2,072,283 claims that were submitted to PROMISe with date of service in 2012 as follows (Table 5):
1. Accepted by PROMISe on first submission;
2. Denied by PROMISe on the first submission, but accepted on a subsequent submission; and
3. Denied by PROMISe on the first submission, and have not been accepted.

Table 5

2012	Initially Accepted	% Initially Accepted	Denied, Accepted on Subsequent Submission	% Denied, Accepted on Subsequent Submission	Denied, Not Yet Accepted	% Denied, Not Yet Accepted	Total
Institutional	21,045	39.43%	0	0%	32,322	60.57%	53,367
Professional	1,705,960	76.74%	0	0%	517,101	23.26%	2,223,061

VBH has identified that the following encounters are denied by PROMISe or yet to be submitted as of 6/12/2013 and are awaiting resubmission (Table 6). VBH reviews detailed reports that indicate the denied PROMISe error status codes.

Table 6

Encounter Type	Number of Denied Encounters
Institutional	43,871
Professional	665,784

VBH has not corrected and resubmitted PROMISe denials since December 2011. VBH stated that they are working with OMHSAS to resolve a number of PROMISe issues prior to resubmitting the PROMISe denials encounters.

VBH submits voids to PROMISe when previously accepted encounters need to be removed from PROMISe. VBH uses Claim Frequency Code 8 to identify a PROMISe void. VBH does not submit adjustments to PROMISe, rather VBH will void an encounter and resubmit the encounter. The top three reasons why an encounter would be voided are:

1. Provider Billed Inappropriately
2. Receipt of Primary Carrier Explanation of Benefits
3. Corrected Claim Received

Per VBH's response to the encounter data survey, VBH submits about 4,660 voids to PROMISe per month.

OMHSAS updates and distributes the BHSRCC to the BH-MCOs semi-annually. The chart assists the BH-MCOs with determining the appropriate coding of services for both financial and encounter data reporting for HealthChoices. The BHSRCC 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. VBH uses the BHSRCC to map procedure and modifier codes prior to submitting the encounters to PROMISe. VBH retains the original and crosswalked code values in a file that is separate from their reporting DW for reporting the annual Performance Measures.

VI: STRENGTHS AND OPPORTUNITES FOR IMPROVEMENT

The review of VBH's encounter data systems and processes with regards to encounter data processing and submissions to PROMISe identified the following strengths and opportunities for improvement.

Strengths

Based on the following 2013 EDV activities: on responses provided by VBH on the BH ED Survey on Voided and Adjusted PROMISe encounters, ISCA and the onsite, IPRO found the following strengths in the encounter data processes:

- VBH has put in place very strict security controls regarding access to systems and specific line of businesses and screens. Only staff members who need access to specific system screens and line of businesses are given the ability to view and/or edit information.
- VBH has a seamless process in place to differentiate between the national and local PA HealthChoices processes and business needs.
- VBH's staff is knowledgeable and understands the HealthChoices product and business needs.
- VBH has spent considerable time and effort educating their provider network about the HealthChoices benefits, and VBH's billing requirements. This has translated to a faster and cleaner claim adjudication process.
- VBH has developed and maintained a comprehensive process for the initial PROMISe submission. Claims are submitted to PROMISe in a timely manner.

Opportunities for Improvement

Based on the following 2013 EDV activities: responses provided by VBH on the BH ED Survey on Voided and Adjusted PROMISe encounter survey, ISCA and the onsite, IPRO found the following areas in the encounter data processes where there are opportunities for improvement and recommendations:

- VBH only submits MCO paid encounters to PROMISe. The HealthChoices PS&R states that all valid encounters for eligible members must be submitted to PROMISe. This includes, but is not limited to, claims denied for timely filing and claims denied for lack of preauthorization. VBH should begin submitting all claims to PROMISe that meet this criteria.

  VBH Response:
  VBH welcomes the opportunity to work with OMHSAS to determine specific programming and/or crosswalk edit logic necessary to begin the inclusion of denied claims as part of our PROMISE encounter submissions. Utilizing our change management process, VBH will initiate a development project and determine a future system release date to implement the modified coding into our production system. VBH will engage with OMHSAS staff to ensure project activities are well coordinated throughout the development lifecycle. The implementation of new logic in our production system will only occur after successful internal testing and user acceptance testing is completed and appropriate signoffs/ approvals are received from all stakeholders.

- VBH is not correcting and resubmitting denied encounters to PROMISe, pending the resolution of a series of issues with OMHSAS. VBH has not corrected and resubmitted PROMISe denials since December 2011. As a result this is impacting several state performance reports and VBH must work closely with OMHSAS to resolve the issues and resubmit the encounters.

VBH Response:

VBH completed the program updates to our 837 extract process that were related to issues that prevented the records to be accepted by PROMISe. The most prevalent issue stemmed from our conversion to 5010 and the fact that we moved from MPI to the HIPAA mandated NPI in 5010. In discussions with OMHSAS it was determined that we should shift our program logic back to using MPI. Other issues that we worked jointly with OMHSAS on to rectify were:

- *COB handling related to Institutional vs. Professional services decision logic that was being applied as part of VBH programming;*
- *Introduction of a PO Box address bypass edit;*
- *Out of pocket Value code conversion logic for paper claims and;*
- *Modification for the contract segment values*

As a result of these updates we have seen a marked improvement in our acceptance rate which is now between 85% and 90% of all records sent for a submitted month. Earlier in the year, we began working with OMHSAS on a weekly basis to discuss and coordinate specific claims scenario testing cycles to confirm PROMISe import edit logic being applied at each level of encounter record validation. Both OMHSAS and VBH plan to continue these meetings until all claim encounter rejections related to IT programming logic. In addition, we have also began resubmitting our PROMISe denied claims from 2012 and 2013 after proposing a resubmission schedule to OMHSAS and obtained their approval. The resubmission schedule is as follows:

Date	*Weekday*	*Data Month/Qtr/Year*	*Record Totals*
11/22/13	*Friday*	*September Paid Claims*	*~170,000*
11/27/13	*Wednesday*	*October Paid Claims*	*~225,000*
12/02/13	*Monday*	*2012 Status 6 – PAFA*	*~29,000*
12/06/13	*Friday*	*2012 Status 6 – Other Parents*	*~370,000*
12/13/13	*Friday*	*November Paid Claims*	*~210,000*
12/20/13	*Friday*	*Q1 2013 Status 6*	*~410,000*
12/27/13	*Friday*	*Q2 2013 Status 6*	*~460,000*
01/03/14	*Friday*	*Q3 2013 Status 6*	*~340,000*
01/10/14	*Friday*	*December Paid Claims*	*~220,000*
01/17/14	*Friday*	*Q4 2013 Status 6*	*~165,000*
01/24/14	*Friday*	*2012-2013 Status 5*	*~260,000*

Last but not least, OMHSAS recently notified VBH that the PROMISe system was ready to accept the new 2013 CPT codes in the encounter file submissions. VBH has updated our encounter crosswalk tables and the new 2013 CPT codes are now being including in VBH monthly extracts or resubmission of historical data as applicable.

As a result of these updates we have seen a marked improvement in our acceptance rate which is now between 85% and 90% of all records sent for a submitted month. Earlier in the year, we began working with OMHSAS on a weekly basis to discuss and coordinate specific claims scenario testing cycles to confirm PROMISe import edit logic being applied at each level of encounter record

- VBH should consider a secondary check on eligibility at the date of service prior to including a claim on the PROMISe submission file. The second eligibility check would identify any encounters that may be rejected by PROMISe due to retroactive changes in the member's HealthChoices eligibility. Encounters that fail the eligibility check should then be excluded from the PROMISe submission.

VBH Response:
It is VBH's recommendation that 100% of paid claims are included in the PROMISe submission file and claims for those members with retroactive terminations are rejected back to VBH. When VBH receives the rejection the submission record will receive an appropriate status in our system and our Operations teams will be able to validate that the eligibility on PROMISe matches the eligibility as it exists on our system. Placing the claim in the error status will also prevent future related claims from being transmitted should the claim be subsequently reversed.

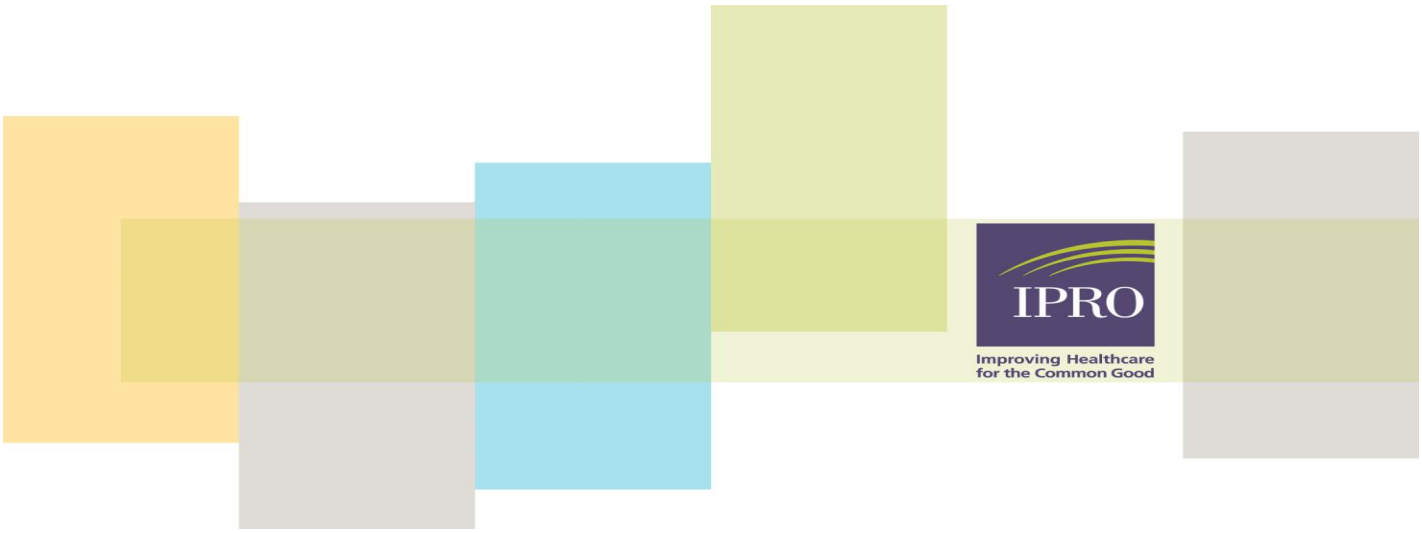
- When a member is assigned 2 MAIDs from DPW, VBH cannot combine the claims and enrollment information into a single ID. This could lead to incomplete information under a single MAID. VBH should consider implementing a procedure to allow two ID to be combined and enrollment and claim history of the two member records merged.

  VBH Response:
  VBH's system does not allow the merging of members when a claim has been paid under that ID, however, the system does allow for multiple IDs to be assigned to a member. VBH will update our processes so that when notified of a member with multiple IDs we will cross reference the multiple IDs by updating the records to include the other ID as an alternate ID.

Recommendations for the BH HealthChoices Program

Based on the five BH-MCO ED onsites conducted during July 2013 and conversations with OMHSAS, IPRO offers the following recommendations for the BH HealthChoices program to improve the PROMISe processes. These recommendations are not specific to any BH-MCO.

- OMHSAS should consider reinstating the bi-monthly PROMISe meetings with the BH-MCOs that would provide OMHSAS and the BH-MCOs a forum to discuss issues with PROMISe submissions, impacts of upcoming PROMISe change orders and communication regarding the ICD10 implementation.
- OMHSAS should consider providing the BH-MCOs a definitive and updated list of active PROMISe edit status codes (ESC) that apply to BH encounters submitted and rejected.
- OMHSAS and BH-MCO should develop an updated contact and email distribution list with updated staff that is involved with the PROMISe submission process.
- OMHSAS should consider further clarifying the 'Other' category on the BHSRCC. The BH-MCOs can provide OMHSAS with specific details.
- The BH-MCOs should be provided with the revised BHSRCC grid with ample lag time in order for the BH-MCOs to utilize the necessary resources to update their systems and processes appropriately. In addition, DPW can assist in improving the lag time of when CPT codes become effective on the national level and then effective in PROMISe.
- OMHSAS should consider a future encounter data validation activity of comparing the member-level data files received from a 2014 performance measure to PROMISe. OMHSAS can request the PROMISE ICN to be submitted on the PM file layout and conduct analysis on the encounters included in the denominator or numerator to identify volume of encounters received in PROMISe and accuracy of data elements received.
- BH-MCOs are only submitting the first three ICD9-CM diagnosis codes received by the provider to PROMISe. This could cause a loss of data in the PROMISe system. OMHSAS should work with the BH-MCOs to clarify the PROMISe edits for secondary diagnosis codes, and the BH-MCOs should begin to submit all diagnosis codes received from providers.



Commonwealth of Pennsylvania
Department of Public Welfare
Office of Mental Health and Substance Abuse Services

2013
Information Systems Capabilities Assessment For
Behavioral Health Managed Care Organizations

5/15/2013

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 Public Welfare' 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 Behavioral Health (BH) Managed Care Organization (MCO) system and process review. One component of this effort is for OMHSAS and IPRO to survey the HealthChoices Behavioral Health (i.e., Medicaid managed behavioral health care) BH-MCOs Information Systems (IS).

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 well.
- 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 **06/14/2013**. Please include any relevant attachments requested in the assessment. The completed assessment should be posted to IPRO's FTP site under the EQR\Other\OnSite\ sub-folder. Please send an email to Brian Behnke (bbehnke@ipro.org) advising the completed assessment has been posted.

This assessment will be followed by a one-day onsite visit. The 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 Brian Behnke (bbehnke@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 HealthChoices Behavioral Health membership in Pennsylvania (PA): Click here to enter text.

4. Average monthly HealthChoices Behavioral Health enrollment for the last three years.

HealthChoices Behavioral Health Enrollment	2012	2011	2010
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 HealthChoices Behavioral Health enrollment in 2012:

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 HealthChoices Behavioral Health enrollment by PA BH-Counties in 2012:

BH-MCO County Name	**Average Monthly HealthChoices Behavioral Health 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.
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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.

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

1. Enrollment File Loads and Eligibility System(s)

1a. 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 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.		

1b. 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.

1c. Please describe how HealthChoices Behavioral Health eligibility is updated, how frequently and who has "change" authority.

Click here to enter text.

1d. What software/programming language is used to load the enrollment file(s) into your eligibility system?

Click here to enter text.

1e. Does the program provide reports of records unable to be loaded? ☐YES ☐NO

1f. If yes, please describe the process used to determine how these records are handled. (Include attachments if necessary)

Click here to enter text.

1g. Describe the controls used to assure all HealthChoices Behavioral Health enrollment data entered into the system is fully accounted for. (Include report examples, process flowcharts, etc. as necessary)

Click here to enter text.

1h. What is the process for version control when the enrollment loading program code is revised?

Click here to enter text.

1i. How does your BH-MCO uniquely identify enrollees?

Click here to enter text.

1j. How does your BH-MCO handle enrollee disenrollment and re-enrollment in the HealthChoices Behavioral Health product line? Does the member retain the same ID?

Click here to enter text.

1k. 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

1l. Can your eligibility system track enrollees who switch from one BH-County to another?
☐Yes ☐No

1m. 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.

1n. 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.

1o. Under what circumstances, if any, can a HealthChoices Behavioral Health 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.

1p. How does your BH-MCO enroll and track newborns born to an existing HealthChoices Behavioral Health enrollee?

Click here to enter text.

1q. 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.

1r. 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.

1s. How is your BH-MCO notified of a death or termination? Please describe.

Click here to enter text.

1t. How is your BH-MCO notified of a newborn? Please describe.

Click here to enter text.

1u. Please describe how your BH-MCO provides eligibility information to your providers?

Click here to enter text.

2. Enrollment Reporting System

2a. What data base management system(s) (DBMS) do/does your BH-MCO use to HealthChoices Behavioral Health 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.

2b. 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☐

2c. Describe the process that is used to populate your reporting DBMS(s). Include process flowcharts as needed

Click here to enter text.

2d. What software/programming language is used to load the enrollment files into your reporting system?

Click here to enter text.

2e. Describe the controls used to assure all HealthChoices Behavioral Health enrollment data entered into the reporting system is fully accounted for. (Include report examples, process flowcharts, etc. as necessary)

Click here to enter text.

2f. What is the process for version control when the enrollment loading program code is revised?

Click here to enter text.

2g. How frequently is your enrollment DBMS(s) updated?

Click here to enter text.

2h. Are members with dual HealthChoices Behavioral Health 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.

2i. How does your BH-MCO identify and count HealthChoices Behavioral Health member months? HealthChoices Behavioral Health member years?

Click here to enter text.

2j. How does your BH-MCO identify HealthChoices Behavioral Health member disabilities? Programs Status Codes? Assistance Categories? Please describe how changes are tracked.

Click here to enter text.

2k. 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

1. Claims Types and Volume

1a. 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.

1b. Please document whether the following data elements (data fields) are required by your BH-MCO for providers, for each of the types of HealthChoices Behavioral Health 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-9-CM Procedure	☐	☐	☐
CPT/HCPCS	☐	☐	☐
DRG	☐	☐	☐
First Date of Service	☐	☐	☐
Last Date of Service	☐	☐	☐
Revenue Code	☐	☐	☐
Provider Specialty	☐	☐	☐

1c. How many diagnoses codes are captured on each claim?

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

1d. Can your BH-MCO distinguish between principal and secondary diagnoses?
☐Yes ☐ No

1e. If "Yes" to 1d, above, how does the BH-MCO distinguish between principal and secondary diagnoses?

Click here to enter text.

1f. For claims with dates of service in 2012, 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.

2. Claims Processing

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.

2a. Please explain what happens if a HealthChoices Behavioral Health 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 code?

Institutional Data:

Click here to enter text.

Professional Data:

Click here to enter text.

2b. 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.

2e. Under what circumstances can claims processors change HealthChoices Behavioral Health claims/encounter information?

Click here to enter text.

2f. How are HealthChoices Behavioral Health 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.

2g. If the data are received through an intermediary, what changes, if any, are made to the data.

Click here to enter text.

2h. Please estimate the percentage of HealthChoices Behavioral Health claims/encounters that are coded using the following coding schemes: Check off each coding scheme that applies.

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

2i. Identify all information systems through which service and utilization data for the HealthChoices Behavioral Health population is processed.

Click here to enter text.

2j. Please describe any major systems changes/updates that have taken place in the last three years in your HealthChoices Behavioral Health 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.

2k. In your opinion, have any of these changes influenced, even temporarily, the quality and/or completeness of the HealthChoices Behavioral Health data that are collected? If so, how and when?

Click here to enter text.

2l. What is your BH-MCO's policy regarding HealthChoices Behavioral Health claim/encounter audits? Are HealthChoices Behavioral Health encounters audited regularly? Randomly? What are the standards regarding timeliness of processing?

Click here to enter text.

2m. 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.

2n. Describe the HealthChoices Behavioral Health claims/encounter suspend ("pend") process including timeliness of reconciling pended services.

Click here to enter text.

2o. Describe how HealthChoices Behavioral Health 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.

2p. If any HealthChoices Behavioral Health 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.

2q. Beginning with receipt of a HealthChoices Behavioral Health claim in-house, describe the claim handling, logging, and processes that precede adjudication. When are HealthChoices Behavioral Health claims assigned a document control number and logged or scanned into the system? When are HealthChoices Behavioral Health 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.

2r. Discuss which decisions in processing a HealthChoices Behavioral Health 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.

2s. 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.

2t. Describe the system's editing capabilities that assure that HealthChoices Behavioral Health 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.

2u. 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.

2v. Describe all performance monitoring standards for HealthChoices Behavioral Health claims/encounters processing and recent actual performance results.

Click here to enter text.

2w. 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.

3. Claims Reporting System

3a. What data base management system(s) (DBMS) do/does your organization use to store HealthChoices Behavioral Health encounter data for reporting purposes?

Click here to enter text.

3b. 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☐

3c. Describe the process that is used to populate your reporting DBMS(s)

Click here to enter text.

3d. What software/programming language is used to load the enrollment files into your BH-MCO's reporting system?

Click here to enter text.

3e. Describe the controls used to assure all HealthChoices Behavioral Health encounter data entered into the reporting system is fully accounted for. (Include report examples, process flowcharts, etc. as necessary)

Click here to enter text.

3f. What is the process for version control when the encounter data loading program code is revised?

Click here to enter text.

3g. How many years of HealthChoices Behavioral Health data are retained on-line? How is historical HealthChoices Behavioral Health data accessed when needed?

Click here to enter text.

3h. How complete are the HealthChoices Behavioral Health data three months after the close of the reporting period? How is completeness estimated? How is completeness defined? Please attach copies of 2012 institutional and professional lag triangles with completeness percentages.

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

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

1b. In consolidating data for HealthChoices Behavioral Health 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.

1c. Describe the procedure for consolidating HealthChoices Behavioral Health 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.

1d. How many different sources of data are merged together to create the PM data files?

Click here to enter text.

1e. What control processes are in place to ensure data merges are accurate and complete?

Click here to enter text.

1f. 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.

1g. What programming language(s) do your programmers use to create HealthChoices Behavioral Health data extracts or analytic reports? How many programmers are trained and capable of modifying these programs?

Click here to enter text.

1h. 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.

1i. 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.

1j. Approximately what percentage of your BH-MCO's programming work is outsourced?

Click here to enter text. %

1k. If any programming work is outsourced, describe the oversight/validation process of the programs produced by the vendor(s).

Click here to enter text.

1l. Outline the steps of the maintenance cycle for the mandated HealthChoices Behavioral Health performance measure reporting requirement(s). Include any tasks related to documentation, debugging, roll out, training, etc.

Click here to enter text.

1m. Please describe your HealthChoices Behavioral Health report production logs and run controls. Please describe your HealthChoices Behavioral Health PM data file generation process.

Click here to enter text.

1n. How are HealthChoices Behavioral Health report generation programs documented? Is there a type of version control in place?

Click here to enter text.

1o. How does your BH-MCO test the process used to create HealthChoices Behavioral Health PM data files?

Click here to enter text.

1p. Are HealthChoices Behavioral Health PM reporting programs reviewed by supervisory staff?

Click here to enter text.

1q. 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.

1r. How are revisions to HealthChoices Behavioral Health claims, encounters, membership, and provider data systems managed in the DBMS(s)?

Click here to enter text.

1s. What is the process for version control when PM code is revised?

Click here to enter text.

1t. What provider data elements is your BH-MCO able to report on? (NPI, licensure, specialty, MPI, provider type, etc.)

Click here to enter text.

1u. Is claim/encounter data linked for Medicare/HealthChoices Behavioral Health dual eligibles so that all encounter data can be identified for the purposes of PM reporting?

Choose an item.

1v. How is HealthChoices Behavioral Health 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.

1w. How do you handle breaks in HealthChoices Behavioral Health enrollment--e.g. situations where a HealthChoices Behavioral Health enrollee is disenrolled one day and re-enrolled the next? Does this affect your continuous enrollment calculations?

Click here to enter text.

1x. Please identify which data elements are captured in your DBMS and are available for reporting:

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.
Secondary ICD-9-CM Diagnosis Code	Choose an item.
ICD-9-CM Procedure Code	Choose an item.
CPT4 Code	Choose an item.
CPT II Codes	Choose an item.
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.

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

1. Encounter Data Submission

1a. Using claims with dates of service in 2011 and 2012, how many unique encounters were submitted to the PROMISe system

	2012	2011
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.

1b. Of the 2011 and 2012 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.

2012	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.

2011	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.

1c. If you indicated any volumes for the Other category in 1a or 1b, please describe the type of encounters in this category:

Click here to enter text.

1d. 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.

1e. Explain in detail the process for reconciling the encounter data submitted to PROMISe.

Click here to enter text.

1f. 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.

1g. 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.

1h. 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 1g, that are not included in the PROMISe extract? If yes, please explain.

Click here to enter text.

1i. 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.

1j. 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.

1k. Identify what PROMISe submission and reconciliation processes are fully automated and what processes are manual.

Click here to enter text.

2. Denial and Resubmission Processes

2a. In 2012, 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. Days

2b. 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.

2c. 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.

2d. In 2012, 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

2e. 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.

2f. Are there instances where a encounters would be denied by PROMISe, and never be resubmitted? If so, please describe when this would occur.

Click here to enter text.

2g. 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.

2h. 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.

2i. 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	1b	Enrollment system loading process
Enrollment Systems	1e	Enrollment loading error process
Enrollment Systems	1f	Enrollment loading completeness reports
Enrollment Systems	2c	Enrollment reporting system load process
Enrollment Systems	2e	Enrollment reporting system completeness reports
Claims Systems	2	Claim process flowchart
Claims Systems	2t	Claim exception report.
Claims Systems	3e	Claim reporting system completeness process / reports.
Claims Systems	3h	Physician and institutional lag triangles.
Reporting	1a	Overview of information systems
PROMISe Submissions	1d	Workflow for PROMISe submissions
PROMISe Submissions	2b	Workflow for PROMISe denials
PROMISe Submissions	2e	PROMISe outstanding claims report