Pennsylvania’s Office of Mental Health and Substance Abuse Services

2022 Encounter Data Validation Study

Community Behavioral Health of Pennsylvania

July 2023

Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

ISO
9001:2015
CERTIFIED

Table of Contents

Introduction 3
Methodology 3
Findings 10
Summary of Findings 19

List of Tables

Table 1: Professional Claims File 4
Table 2: Institutional Inpatient Claims File – Inpatient Fields 6
Table 3: Institutional Outpatient Claims File – Outpatient Fields 8
Table 4: Number of Types of Records Received by Encounter Type 11
Table 5: Institutional Claims File – Outpatient Fields Not in Professional Format 12
Table 6: CBH Professional Encounter Type Discrepant Fields Match Frequencies and Findings 12
Table 7: CBH Institutional Inpatient Encounter Type Discrepant Fields Match Frequencies and Findings 13
Table 8: CBH Institutional Outpatient Encounter Type Discrepant Fields Match Frequencies and Findings 17

SAS® is a registered trademark of SAS Institute.

Introduction

The Pennsylvania Department of Human Services (DHS), Office of Mental Health and Substance Abuse Services (OMHSAS) has partnered with its external quality review organization (EQRO), IPRO, to conduct a behavioral health (BH) managed care organization (MCO) encounter data validation (EDV) study.

The Centers for Medicare & Medicaid Services (CMS) encourages states to implement the voluntary EDV protocol due to the need for overall valid and reliable encounter data as part of any state quality improvement efforts. As federal programs transition toward payment reform for demonstrated quality of care, validation of encounter data in the use of performance data will become increasingly important. Transparency of payment and delivery of care is an integral part of health reform. EDV can help states reach the goals of transparency and payment reform to support their efforts in quality measurement and improvement.

EDV is an ongoing process, involving the MCOs, state encounter data unit, and the EQRO. Improving encounter data reporting is an ongoing project across federal and state healthcare agencies. Encounter data that are accurate and reliable can lead agencies to drive healthcare improvements that can positively affect the overall population and those who have high-risk health issues. EDV activities conducted by state agencies or EQROs can help to identify incomplete data, perform missing-or incorrect data quality checks, and assess frequency and impact of late encounter data submissions.

BH MCOs are required to submit the encounter data files to the Provider Reimbursement and Operations Management Information System (PROMISe). IPRO receives weekly PROMISe professional and Institutional inpatient encounter data extracts from Gainwell Technologies and IPRO loads the data to a SAS® data warehouse.

During 2022, an EDV study was carried out by IPRO on behalf of OMHSAS to assess the completeness and accuracy of the BH MCOs encounter data submitted to PROMISe.

Methodology

IPRO requested BH MCO claims data residing in their claims system for the periods of services October 1, 2021, to December 31, 2021, for all encounter types and fields included in **Tables 1–3**. The state fiscal year (SFY) 2022 EDV study was conducted for the following participating Medicaid BH MCOs:

- Beacon Health Options of Pennsylvania (BHO),
- Community Behavioral Health (CBH),
- Community Care Behavioral Health Organization (CCBH),
- Magellan Behavioral Health of Pennsylvania (Magellan), and
- PerformCare for Pennsylvania (PerformCare).

IPRO requested that the BH MCOs provide all encounters with dates of service from October 1 to December 31, 2021, and submitted to the state between October 1, 2021, and March 31, 2022. The BH MCOs were requested to select all claims adjudicated by the BH MCO's vendors. The claims provided to IPRO included encounter submissions that were all paid (original, corrected, adjusted/voided, or paid at $0) encounter data and partial payments denied at the line level and paid at the header level. IPRO provided the BH MCOs documentation identifying the logic to be utilized in the identification of the claims to be selected. The BH MCOs submitted the claims by claim type to IPRO. IPRO provided the BH MCOs the identifying data elements that IPRO used to compare to the claims IPRO receives and stores on the weekly vendor extracts.

The BH MCOs are required to submit professional (837P) and institutional inpatient (837I) encounters to PROMISe; any institutional outpatient encounters received and processed by the BH MCO are converted, cross walked, and submitted to PROMISe as professional encounters. For the 2022 EDV study, IPRO requested the BH MCOs submit the institutional outpatient data as received from their providers.

Encounter Data Validation Study Methodology

IPRO utilized the following methodology for the EDV study:

1. The BH MCOs submitted all data elements in **Tables 1–3** by claim type obtained from their adjudicated source claims that corresponded to the audit period. To verify the source claims data, IPRO requested the BH MCOs include the internal control number (ICN), if available, obtained by the BH MCOs when the encounter was submitted and accepted by PROMISe.
2. IPRO imported the BH MCO files into SAS and stored the different encounter types separately.
3. IPRO compared the BH MCO source data (claims and encounters) to the encounter data received by PROMISe.
4. IPRO identified the discrepancies by comparing the source data for each data element. IPRO identified differences between the data element (**Tables 1–3**) values from the source data and the data element values included in IPRO's data warehouse (DW). Discrepancies were identified by data element.
5. Data elements with less than a 90% match rate were reviewed. IPRO reviewed discrepancies and categorized them for each encounter type (**Tables 6–8**).
6. IPRO selected a sample of up to 1,000 records for each encounter type and data element discrepancy category identified for each BH MCO. IPRO provided counts of all discrepancies by discrepancy category to OMHSAS and the BH MCOs.

Interviews with BH MCOs

IPRO scheduled teleconferences with OMHSAS and the BH MCOs for the following:

- a review of discrepant records comparing IPRO DW results to BH MCO claims screen and the 837-file string.
- a walkthrough by BH MCOs of the processes for receipt of claims, reconciliation, translation, and submission of claims data to OMHSAS, as well as a walkthrough of any recent system changes, since December 31, 2021, that have been implemented during the past year; review of any questions related to the information systems capability assessment (ISCA).
- a presentation by BH MCOs to IPRO and OMHSAS using the sampled discrepant records and how the claim was adjudicated; and
- a demonstration of all the steps identified by BH MCOs involved in the transfer and processing of source claims data and identification process steps where data could possibly be changed or altered.
- a review of discrepant records comparing IPRO DW results to BH MCO claims screen and the 837-file string.

The BH MCOs provided details on how several sample ICNs were adjudicated and displayed on their claim adjudication system and how each ICN's data elements appeared on the professional (837P) and institutional (837I) encounters submitted to PROMISe.

Data File Layout Request

The BH MCOs were provided the file layouts for each of the following file types:

- professional claims file,
- institutional inpatient claims file, and
- institutional outpatient claims file.

Professional Claims File

Table 1 defines the fields for the professional claims to be submitted by the BH MCOs.

Table 1: Professional Claims File

Professional Claims Field Name	Type	Description
BH_MCO_NAME	Char	BH MCO Name
PLAN CODE	Char	2-digit alpha code
RECIP_ID	Char	Unique number assigned to the recipient (9-digit PA member identification number)
PROMISe ICN	Char	PROMISe Internal Control Number If available, if submitted and accepted by PROMISe.
MCO ICN	Char	Unique control number assigned by the MCO

Professional Claims Field Name	Type	Description
NUM_ADJ_ICN	Char	The PROMISe ICN of the original claim if the claim is an adjustment
LINE_NUMBER	Num	The detail number for the specific detail on the claim (Number (4)) Include any leading zeros
DTE_FIRST_SVC_DTL	Date	Date on which the statement period on the claim began for the detailed line item (mm/dd/yyyy)
DTE_LAST_SVC_DTL	Date	Date on which the statement period on the claim ended for the detailed line item (mm/dd/yyyy)
PLACESVC	Char	A code to indicate where the service was provided (Place of service)
ICD-10 diagnosis – based on the header level diagnosis DO NOT INCLUDE DECIMALS		
DIAGCD1	Char	Primary Diagnosis
DIAGCD2	Char	Second diagnosis
DIAGCD3	Char	Third diagnosis
DIAGCD4	Char	Fourth diagnosis
DIAGCD5	Char	Fifth diagnosis
DIAGCD6	Char	Sixth diagnosis
DIAGCD7	Char	Seventh diagnosis
DIAGCD8	Char	Eighth diagnosis
DIAGCD9	Char	Ninth diagnosis
DIAGCD10	Char	Tenth diagnosis
DIAGCD11	Char	Eleventh diagnosis
DIAGCD12	Char	Twelfth diagnosis
Payment information		
PTMT_ADJ_DATE	Date	MCO Adjudication date (mm/dd/yyyy)
AMT_BH MCO_PAID_HDR	Num	The BH MCO paid amount from the header for header paid claims. Total paid amount of the claim (Number (12,2))
AMT_OTH_INS_PD_HDR	Num	The total TPL paid amount at the claim level (Number (12,2))
AMT_BH MCO_PAID_DTL	Num	The BH MCO paid amount from the detail for detail paid claims. Total paid amount of the line item (Number (12,2))
AMT_OTH_INS_PD_DTL	Num	The TPL paid amount from the detail (Number (12,2)
Procedure code information		
PROCCODE1	Char	Procedure/supplies/service code (i.e., CPT-4, CDT, and/or HCPCS)
QTY_UNITS_BILLED	Num	The units of service billed at the detail (Number (9,2))
MODIFIER1	Char	The first of up to 4 procedure/service/supplies modifier (if applicable)
MODIFIER2	Char	The second of up to 4 procedure/service/supplies modifier (if applicable)
MODIFIER3	Char	The third of up to 4 procedure/service/supplies modifier (if applicable)
MODIFIER4	Char	The fourth of up to 4 procedure/service/supplies modifier (if applicable)
Provider information		
BILLING_PROV_ID	Char	The billing provider PROMISe ID (MPI) 13-digit code including the service location
BILLING_PROV_NPI	Char	The billing provider NPI
RENDERING_PROV_ID	Char	The Rendering Provider PROMISe ID 13-digit code including the service location
RENDERING_PROV_NPI	Char	The Rendering Provider NPI
REFERRING _PROV_ID	Char	The Referring Provider PROMISe ID

Professional Claims Field Name	Type	Description
		9-digit code
REFERRING _PROV_NPI	Char	The Referring Provider NPI

BH: behavioral health; MCO: managed care organization; PA: Pennsylvania; PROMISe: Provider Reimbursement and Operations Management Information System; ICN: internal control number; ICD-10: International Classification of Diseases, 10th Edition; TPL: third-party liability; CPT-4: Current Procedural Terminology, 4th Edition; CDT: Current Dental Terminology; HCPCS: Healthcare Common Procedure Coding System; ID: identification; MPI: master provider index; NPI: National Provider Identifier.

Institutional Claims File – Inpatient

Table 2 defines the fields for the institutional claims to be submitted by the BH MCOs.

Table 2: Institutional Inpatient Claims File – Inpatient Fields

Institutional Inpatient Field Name	Type	Description
BH_MCO_NAME	Char	BH MCO Name
PLAN CODE	Char	2-digit alpha code
RECIP_ID	Char	Unique number assigned to the recipient (9-digit PA member identification number)
PROMISe ICN	Char	PROMISe Internal Control Number If available, if submitted and accepted by PROMISe
MCO ICN	Char	Unique control number assigned by the MCO
NUM_ADJ_ICN	Char	The PROMISe ICN of the original claim if the claim is an adjustment
LINE_NUMBER	Num	The detail number for the specific detail on the claim (Number (4)) Include any leading zeros
DTE_ADMISSION	Date	Date that the recipient was admitted by the provider for inpatient care (mm/dd/yyyy)
DTE_DISCHARGE	Date	Date that the recipient was discharged by the provider for inpatient care (mm/dd/yyyy)
DTE_FIRST_SVC_HDR	Date	Date on which the statement period on the claim began from the header paid claims (mm/dd/yyyy)
DTE_LAST_SVC_HDR	Date	Date on which the statement period on the claim ended from the header paid claims (mm/dd/yyyy)
DTE_FIRST_SVC_DTL	Date	Date on which the statement period on the claim began for the detailed line item (mm/dd/yyyy)
DTE_LAST_SVC_DTL	Date	Date on which the statement period on the claim ended for the detailed line item (mm/dd/yyyy)
ADMITTYP	Char	Admission type
DIS_STAT	Char	Patient discharge status code
TYPEBILL	Char	Type of bill 3-digit code
DRG	Char	DRG code (3-digit field; please submit value in this field only if it is an inpatient claim paid on a DRG rate as reported on the encounter)
ICD-10 diagnosis – based on the header level diagnosis DO NOT INCLUDE DECIMALS		
DIAGCD1	Char	Principal diagnosis
DIAGCD2	Char	Second diagnosis
DIAGCD3	Char	Third diagnosis
DIAGCD4	Char	Fourth diagnosis

Institutional Inpatient Field Name	Type	Description
DIAGCD5	Char	Fifth diagnosis
DIAGCD6	Char	Sixth diagnosis
DIAGCD7	Char	Seventh diagnosis
DIAGCD8	Char	Eighth diagnosis
DIAGCD9	Char	Ninth diagnosis
DIAGCD10	Char	Tenth diagnosis
DIAGCD11	Char	Eleventh diagnosis
DIAGCD12	Char	Twelfth diagnosis
DIAGCD13	Char	Thirteenth diagnosis
DIAGCD14	Char	Fourteenth diagnosis
DIAGCD15	Char	Fifteenth diagnosis
DIAGCD16	Char	Sixteenth diagnosis
DIAGCD17	Char	Seventieth diagnosis
DIAGCD18	Char	Eighteenth diagnosis
DIAGCD19	Char	Nineteenth diagnosis
DIAGCD20	Char	Twentieth diagnosis
DIAGCD21	Char	Twenty First diagnosis
DIAGCD22	Char	Twenty Second diagnosis
DIAGCD23	Char	Twenty Third diagnosis
DIAGCD24	Char	Twenty Fourth diagnosis
DIAGCD25	Char	Twenty Fifth diagnosis
Procedure codes DO NOT INCLUDE DECIMALS		
SURG1	Char	Surgical code 1
SURG2	Char	Surgical code 2
SURG3	Char	Surgical code 3
SURG4	Char	Surgical code 4
SURG5	Char	Surgical code 5
SURG6	Char	Surgical code 6
SURGDTE1	Date	Surgical date 1 (mm/dd/yyyy)
SURGDTE2	Date	Surgical date 2 (mm/dd/yyyy)
SURGDTE3	Date	Surgical date 3 (mm/dd/yyyy)
SURGDTE4	Date	Surgical date 4 (mm/dd/yyyy)
SURGDTE5	Date	Surgical date 5 (mm/dd/yyyy)
SURGDTE6	Date	Surgical date 6 (mm/dd/yyyy)
Payment information – inpatient claims are paid at the header.		
PTMT_ADJ_DATE	Date	MCO Adjudication date (mm/dd/yyyy)
AMT_BH MCO_PAID_HDR	Num	The BH MCO paid amount from the header for header paid claims. Total paid amount of the claim (Number (12,2))
AMT_OTH_INS_PD_HDR	Num	The total TPL paid amount at the claim level (Number (12,2))
AMT_BH MCO_PAID_DTL	Num	The BH MCO paid amount from the detail for detail paid claims. Total paid amount of the line item (Number (12,2))
Revenue code		
REVENUE_CODE	Char	Revenue center code Include any leading zeros
Provider information		

Institutional Inpatient Field Name	Type	Description
BILLING_PROV_ID	Char	The billing provider PROMISe ID (MPI) 13-digit code including the service location
BILLING_PROV_NPI	Char	The billing provider NPI
RENDERING_PROV_ID	Char	The Rendering Provider PROMISe ID 13-digit code including the service location
RENDERING_PROV_NPI	Char	The Rendering Provider NPI
REFERRING _PROV_ID	Char	The Referring Provider PROMISe ID 9-digit code
REFERRING _PROV_NPI	Char	The Referring Provider NPI

BH: behavioral health; MCO: managed care organization; PA: Pennsylvania; PROMISe: Provider Reimbursement and Operations Management Information System; ICN: internal control number; DRG: diagnosis-related group; ICD-10: International Classification of Diseases, 10th Edition; TPL: third-party liability; ID: identification; MPI: master provider index; NPI: National Provider Identifier.

Institutional Claims File – Outpatient

Table 3 defines the fields for the institutional outpatient claims to be submitted by the BH MCOs.

Table 3: Institutional Outpatient Claims File – Outpatient Fields

Institutional Outpatient Field Name	Type	Description
BH_MCO_NAME	Char	BH MCO Name
PLAN CODE	Char	2-digit alpha code
RECIP_ID	Char	Unique number assigned to the recipient (9-digit PA member identification number)
PROMISe ICN	Char	PROMISe Internal Control Number If available, if submitted and accepted by PROMISe
MCO ICN	Char	Unique control number assigned by the MCO
NUM_ADJ_ICN	Char	The PROMISe ICN of the original claim if the claim is an adjustment.
LINE_NUMBER	Num	The detail number for the specific detail on the claim (Number (4)) Include any leading zeros
DTE_FIRST_SVC_HDR	Date	Date on which the statement period on the claim began from the header paid claims (mm/dd/yyyy)
DTE_LAST_SVC_HDR	Date	Date on which the statement period on the claim ended from the header paid claims (mm/dd/yyyy)
DTE_FIRST_SVC_DTL	Date	Date on which the statement period on the claim began for the detailed line item (mm/dd/yyyy)
DTE_LAST_SVC_DTL	Date	Date on which the statement period on the claim ended for the detailed line item (mm/dd/yyyy)
TYPEBILL	Char	Type of bill 3-digit code
ICD-10 diagnosis – based on the header level diagnosis DO NOT INCLUDE DECIMALS		
DIAGCD1	Char	Principal Diagnosis
DIAGCD2	Char	Second diagnosis

Institutional Outpatient Field Name	Type	Description
DIAGCD3	Char	Third diagnosis
DIAGCD4	Char	Fourth diagnosis
DIAGCD5	Char	Fifth diagnosis
DIAGCD6	Char	Sixth diagnosis
DIAGCD7	Char	Seventh diagnosis
DIAGCD8	Char	Eighth diagnosis
DIAGCD9	Char	Ninth diagnosis
DIAGCD10	Char	Tenth diagnosis
DIAGCD11	Char	Eleventh diagnosis
DIAGCD12	Char	Twelfth diagnosis
DIAGCD13	Char	Thirteenth diagnosis
DIAGCD14	Char	Fourteenth diagnosis
DIAGCD15	Char	Fifteenth diagnosis
DIAGCD16	Char	Sixteenth diagnosis
DIAGCD17	Char	Seventieth diagnosis
DIAGCD18	Char	Eighteenth diagnosis
DIAGCD19	Char	Nineteenth diagnosis
DIAGCD20	Char	Twentieth diagnosis
DIAGCD21	Char	Twenty First diagnosis
DIAGCD22	Char	Twenty Second diagnosis
DIAGCD23	Char	Twenty Third diagnosis
DIAGCD24	Char	Twenty Fourth diagnosis
DIAGCD25	Char	Twenty Fifth diagnosis
ICD-10 procedure codes DO NOT INCLUDE DECIMALS		
SURG1	Char	Surgical code 1
SURG2	Char	Surgical code 2
SURG3	Char	Surgical code 3
SURG4	Char	Surgical code 4
SURG5	Char	Surgical code 5
SURG6	Char	Surgical code 6
SURGDTE1	Date	Surgical date 1 (mm/dd/yyyy)
SURGDTE2	Date	Surgical date 2 (mm/dd/yyyy)
SURGDTE3	Date	Surgical date 3 (mm/dd/yyyy)
SURGDTE4	Date	Surgical date 4 (mm/dd/yyyy)
SURGDTE5	Date	Surgical date 5 (mm/dd/yyyy)
SURGDTE6	Date	Surgical date 6 (mm/dd/yyyy)
Payment information		
PTMT_ADJ_DATE	Date	MCO Adjudication date (mm/dd/yyyy)
AMT_BH MCO_PAID_HDR	Num	This is the BH MCO paid amount from the header for header paid claims. Total paid amount of the claim (Number (12,2))
AMT_OTH_INS_PD_HDR	Num	The total TPL paid amount at the claim level (Number (12,2))
AMT_BH MCO_PAID_DTL	Num	The BH MCO paid amount from the detail for detail paid claims. Total paid amount of the line item (Number (12,2))
AMT_OTH_INS_PD_DTL	Num	The TPL paid amount from the detail (Number (12,2))
Procedure code and revenue code		

Institutional Outpatient Field Name	Type	Description
PROCEDURE_CODE	Char	Procedure code (if applicable)
UNITS_BILLED	Num	Units of service billed for payment (Number (9,2))
MODIFIER1	Char	The first of up to four procedures/services/supplies modifiers (if applicable)
MODIFIER2	Char	The second of up to four procedures/services/supplies modifiers (if applicable)
MODIFIER3	Char	The third of up to four procedures/services/supplies modifiers (if applicable)
MODIFIER4	Char	The fourth of up to four procedures/services/supplies modifiers (if applicable)
REVENUE_CODE	Char	Revenue center code Including any leading zeros.
Provider information		
BILLING_PROV_ID	Char	The billing provider PROMISe ID (MPI) 13-digit code including the service location
BILLING_PROV_NPI	Char	The billing provider NPI
RENDERING_PROV_ID	Char	The Rendering Provider PROMISe ID 13-digit code including the service location
RENDERING_PROV_NPI	Char	The Rendering Provider NPI
REFERRING _PROV_ID	Char	The Referring Provider PROMISe ID 9-digit code
REFERRING _PROV_NPI	Char	The Referring Provider NPI

BH: behavioral health; MCO: managed care organization; PA: Pennsylvania; PROMISe: Provider Reimbursement and Operations Management Information System; ICN: internal control number; ICD-10: International Classification of Diseases, 10th Edition; TPL: third-party liability; ID: identification; MPI: master provider index; NPI: National Provider Identifier.

Findings

Community Behavioral Health of Pennsylvania (CBH) EDV study call was conducted on October 12, 2022. A 2-hour remote meeting was held to review CBH's system for discrepancies of data fields present in the professional, institutional inpatient and institutional outpatient encounter types between the submitted EDV data file and the data submitted to PROMISe. The attendees of the CBH EDV study call included OMHSAS, XeoHealth, Allan Collautt Associates, Inc. (ACA), Behavioral HealthChoices Contractors (BHCC), IPRO and CBH.

Professional, Institutional Inpatient and Institutional Outpatient Claims Files

IPRO receives weekly encounter data extracts from Gainwell Technologies for PROMISe encounter data that were used in comparing the MCO encounter data study files received. IPRO receives and stores the following data tables in IPRO's data warehouse which consist of the following SAS data table:

- Institutional common header: containing claim header information for the ICN, including ICD-10-CM diagnosis codes 1-12, and member identification number for the Institutional inpatient encounters.
- Institutional header: containing claim header information for the ICN, including additional ICD-10-CM diagnosis codes 13-25, DRG code, ICD-10-CM procedure code, place of service code and type of bill for the Institutional inpatient encounters.
- Institutional detail: containing service line detail information for the ICN, including procedure codes, revenue codes and modifier codes 1-4 for the institutional inpatient encounters.

- Professional common header: containing claim header information for the ICN, including ICD-10-CM diagnosis codes 1-12, and member identification number for the Professional encounters.
- Professional detail (for Professional and Institutional Outpatient): containing claim header information for the ICN, including, ICD-10-CM procedure codes, modifier codes, place of service, and procedure codes for the Professional encounters.
- Institutional outpatient common header: member identification number, plan identification information, statement start and end date, diagnosis codes 1-12, payment adjudication date, amounts paid, billing and rendering provider ID and NPI

IPRO matched the EDV study to IPRO's DW encounter data tables for the paid/accepted PROMISe encounters by ICN, and IPRO identified there were records submitted on the EDV study file that were not included on the IPRO DW data tables. The majority of these ICNs that were not matched were identified as being adjusted or voided records where the ICN begins with a '7.'

Table 4 outlines the number of records received by encounter type, number of records matched to ICN, and the number of records that were voided that started with a '7'. Each of the three encounter types received for the EDV study were compared to multiple encounter data tables in IPRO's DW.

Table 4: Number of Types of Records Received by Encounter Type

Encounter Type	Number of Records Received by Encounter Type	Number of Records Matched to ICN	Number of Records that Were Voided that Started with 7
Professional (header)	907,417	905,070	1,333
Institutional inpatient (header)	7,920	7,753	68
Institutional outpatient (header)	2,833	2,829	4

ICN: internal control number.
Number of Records Received by Encounter Type: indicates the total number of records received on the EDV study file.
Number of Records Matched to ICN: indicates the number of records on the EDV study file that were matched to IPRO's DW tables, by ICN.
Number of Records that were Voided that Started with 7: indicates the number of records received on the EDV study file that were voided and the ICN began with a '7.'

Institutional Claims File – Outpatient

CBH submits professional (837P) and institutional inpatient (837I) encounters to PROMISe. Any institutional outpatient claims received by CBH are converted to professional encounters. For the EDV study, IPRO requested CBH to submit the institutional outpatient data as received from their providers. IPRO identified the institutional outpatient claim diagnosis codes that would not be included in the 837P encounter extract file, since the professional extract allows for a maximum of 12 International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes to be submitted to PROMISe. CBH submitted 2,833 institutional outpatient records on the EDV study file.

Table 5 identifies how many ICNs were submitted on the institutional outpatient EDV study file with values that were not submitted to PROMISe on the 837P for these data fields and would not be available to IPRO for the EDV study comparison and for subsequent reporting activities. There were no ICNs that had values in the data fields listed that were submitted on institutional outpatient EDV study file and not submitted to PROMISe.

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

Data Fields	CBH Counts of Data Values Present on EDV Study Not Submitted to PROMISe
DIAGCD13	0
DIAGCD14	0
DIAGCD15	0
DIAGCD16	0
DIAGCD17	0
DIAGCD18	0
DIAGCD19	0
DIAGCD20	0
DIAGCD21	0
DIAGCD22	0
DIAGCD23	0
DIAGCD24	0
DIAGCD25	0
SURG1	0
SURG2	0
SURG3	0
SURG4	0
SURG5	0
SURG6	0
SURGDTE1	0
SURGDTE2	0
SURGDTE3	0
SURGDTE4	0
SURGDTE5	0
SURGDTE6	0
REVENUE_CODE	0
REFERRING_PROV_ID	0
REFERRING_PROV_NPI	0
TYPEBILL	2,833

CBH: Community Behavioral Health of Pennsylvania; EDV: encounter data validation; PROMISe: Provider Reimbursement and Operations Management Information System.

CBH Professional Data Element Discrepancies and Findings

Table 6 details the CBH **professional** discrepant data element results.

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

Professional Encounter Data Element	CBH Percent Matching (%)	Reason for Discrepancy
PLAN_CODE	100.00	
RECIP_ID	100.00	
PROMISe_ICN	100.00	
MCO_ICN	100.00	
NUM_ADJ_ICN	100.00	
PLACESVC	98.49	

Professional Encounter Data Element	CBH Percent Matching (%)	Reason for Discrepancy
DIAGCD1	100.00	
DIAGCD2	100.00	
DIAGCD3	100.00	
DIAGCD4	100.00	
DIAGCD5	100.00	
DIAGCD6	100.00	
DIAGCD7	100.00	
DIAGCD8	100.00	
DIAGCD9	100.00	
DIAGCD10	100.00	
DIAGCD11	100.00	
DIAGCD12	100.00	
PTMT_ADJ_DATE	100.00	
AMT_BH_MCO_PAID_HDR	100.00	
AMT_OTH_INS_PD_HDR	99.85	
BILLING_PROV_ID	100.00	
BILLING_PROV_NPI	99.98	
RENDERING_PROV_ID	100.00	
RENDERING_PROV_NPI	100.00	
LINE_NUMBER	100.00	
DTE_FIRST_SVC_DTL	99.22	
DTE_LAST_SVC_DTL	99.22	
AMT_BH_MCO_PAID_DTL	99.79	
PROCCODE1	99.86	
QTY_UNITS_BILLED	98.60	
MODIFIER1	99.91	
MODIFIER2	100.00	
MODIFIER3	100.00	
MODIFIER4	100.00	

Yellow shading indicates match percentage less than 90%.
Grey shading indicates a BH MCO EDV study data extraction issue.
Light green shading indicates a difference in values attributed to the BHSRCC grid mapping.
CBH: Community Behavioral Health of Pennsylvania; BH: behavioral health; MCO: managed care organization; PROMISe: Provider Reimbursement and Operations Management Information System; ID: identification; EDI: electronic data interchange; ICN: internal control number; EDV: encounter data validation; N/A: Not applicable; NPI: National Provider Identifier.

CBH Institutional Inpatient Data Element Discrepancies and Findings

Table 7 details the CBH **institutional inpatient** discrepant data element results.

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

Institutional Inpatient Data Element	CBH Percent Matching (%)	Reason for Discrepancy
PLAN_CODE	100.00	
RECIP_ID	100.00	
PROMISe_ICN	100.00	
MCO_ICN	100.00	
NUM_ADJ_ICN	100.00	
DTE_ADMISSION	100.00	

Institutional Inpatient Data Element	CBH Percent Matching (%)	Reason for Discrepancy
DTE_DISCHARGE	28.34	**BH MCO response:** CBH reviewed the discrepant records and indicated that encounter value matched value sent to IPRO. DTP*096 indicates discharge time, and discharge date is determined by statement end date, which is DTE_LAST_SVC_HDR in this case. **Remote meeting discussion**: In the remote meeting, CBH advised IPRO that encounter information that was submitted to OMHSAS had the date of discharge stored in date of last service header (DTE_LAST_SVC_HDR). However, In the EDV study file the discharge date was mapped to DTE_DISCHARGE; therefore, there was a discrepancy. CBH reviewed the two discrepant ICNs that were resolved accurately. In the end, dates of discharges that IPRO received matched the claim screens shared by CBH. **Follow-up item:** CBH provided IPRO with claim screens and the 837I encounter extract string that supported the values CBH submitted to PROMISe. An updated match percentage was produced after matching the DTE_DISCHARGE to the statement end date from the Data Warehouse. The revised matched on all populated values of the DTE_DISCHARGE in the EDV Study file but did not match when there was a missing value for DTE_DISCHARGE in the EDV study file.
DTE_FIRST_SVC_HDR	34.48	**BH MCO response:** CBH reviewed the discrepant records and indicated that the EDV study file had a mapping issue or EDV study pull issue where admit date was mapped to DTE_FIRST_SVC_HDR. **Remote meeting discussion:** In the remote meeting, CBH advised IPRO that at the time of pulling the encounter information, the claim system was pointing to an incorrect field. CBH had corrected the discrepancy and was ready to send us a revised pull of the encounter data on the remote discussion day. Three ICN examples were reviewed in detail. CBH demonstrated that the values on their claim system and the 837I encounter extract string submitted to PROMISe were the same.

Institutional Inpatient Data Element	CBH Percent Matching (%)	Reason for Discrepancy
		Follow-up item: CBH provided IPRO with claim screens and the 837I encounter extract string that supported the values CBH submitted to PROMISe. An updated match percentage of 34.48% was produced after excluding those records which were missing ICNs in the data warehouse.
DTE_LAST_SVC_HDR	28.34	**BH MCO response:** CBH reviewed the discrepant records and indicated that the EDV study file had a mapping issue where discharge date (DTE_DISCHARGE) was mapped to DTE_LAST_SVC_HDR. **Remote meeting discussion:** In the remote meeting, CBH advised IPRO that at the time of pulling the encounter information, the member was still admitted. It was an interim bill explicitly confirmed by the claim EDI screens where DTP*096 was not given. There were three ICN examples that were reviewed in detail. CBH demonstrated that the values on their claim system and the 837I encounter extract string submitted to PROMISe were the same. **Follow-up item**: CBH provided IPRO with claim screens and the 837I encounter extract string that supported the values CBH submitted to PROMISe. An updated percentage was produced after excluding those records which were missing ICNs in the data warehouse. The records are not matching only for those ICN's where DTE_LAST_SVC_HDR in the EDV study file was not populated and is missing whereas the corresponding Data Warehouse variable END_DOS is populated.
ADMITTYP	100.00	
DIS_STAT	100.00	
TYPEBILL	0.00	**BH MCO response:** CBH reviewed the discrepant records and indicated that the EDV study file had a mapping issue where TYPEBILL was not a 3-digit code; a 2-digit code was provided instead. **Remote meeting discussion:** In the remote meeting, CBH advised IPRO that at the time of pulling the encounter information, this field was empty in their system. There were three ICN examples that were reviewed in detail. CBH demonstrated the values on

Institutional Inpatient Data Element	CBH Percent Matching (%)	Reason for Discrepancy
		their claim system and the 837I encounter extract string submitted to PROMISe were the same. The value has been corrected to 3-digit codes (112, 113 and 114) from 2-digit codes on their claims system. **Follow-up item:** CBH provided IPRO with claim screens and the 837I encounter extract string that supported the values CBH submitted to PROMISe.
DRG_C	99.63	
DIAGCD1	100.00	
DIAGCD2	100.00	
DIAGCD3	100.00	
DIAGCD4	100.00	
DIAGCD5	100.00	
DIAGCD6	100.00	
DIAGCD7	100.00	
DIAGCD8	100.00	
DIAGCD9	100.00	
DIAGCD10	100.00	
DIAGCD11	100.00	
DIAGCD12	100.00	
DIAGCD13	100.00	
DIAGCD14	100.00	
DIAGCD15	100.00	
DIAGCD16	100.00	
DIAGCD17	100.00	
DIAGCD18	100.00	
DIAGCD19	100.00	
DIAGCD20	100.00	
DIAGCD21	100.00	
DIAGCD22	100.00	
DIAGCD23	100.00	
DIAGCD24	100.00	
DIAGCD25	100.00	
SURG1	98.52	
SURG2	99.60	
SURG3	99.81	
SURG4	99.94	
SURG5	99.97	
SURG6	100.00	
SURGDTE1	98.52	
SURGDTE2	99.60	
SURGDTE3	99.81	
SURGDTE4	99.94	

Institutional Inpatient Data Element	CBH Percent Matching (%)	Reason for Discrepancy
SURGDTE5	99.97	
SURGDTE6	100.00	
PTMT_ADJ_DATE	100.00	
AMT_BH_MCO_PAID_HDR	100.00	
AMT_OTH_INS_PD_HDR	98.90	
LINE_NUMBER	100.00	
DTE_FIRST_SVC_DTL	99.83	
DTE_LAST_SVC_DTL	99.83	
AMT_BH_MCO_PAID_DTL	100.00	
REVENUE_CODE	100.00	
BILLING_PROV_ID	100.00	
BILLING_PROV_NPI	99.74	
RENDERING_PROV_ID	100.00	
RENDERING_PROV_NPI	100.00	

Yellow shading indicates match percentage less than 90%.
Grey shading indicates a BH MCO EDV study data extraction issue.
Light green shading indicates a difference in values attributed to the BHSRCC grid mapping.
CBH: Community Behavioral Health of Pennsylvania; BH: behavioral health; MCO: managed care organization; PROMISe: Provider Reimbursement and Operations Management Information System; EDI: electronic data interchange; ICN: internal control number; EDV: encounter data validation; N/A: Not applicable; NPI: National Provider Identifier; BHSRCC: Behavioral Health Services Reporting Classification Chart.

CBH Institutional Outpatient Data Element Discrepancies and Findings

Table 8 details the CBH **institutional outpatient** discrepant data element results.

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

Institutional Outpatient Data Element	CBH Percent Matching (%)	Reason for Discrepancy
PLAN_CODE	100.00	
RECIP_ID	100.00	
PROMISe_ICN	100.00	
MCO_ICN	100.00	
NUM_ADJ_ICN	100.00	
DIAGCD1	100.00	
DIAGCD2	100.00	
DIAGCD3	100.00	
DIAGCD4	100.00	
DIAGCD5	100.00	
DIAGCD6	100.00	
DIAGCD7	100.00	
DIAGCD8	100.00	
DIAGCD9	100.00	
DIAGCD10	100.00	
DIAGCD11	100.00	
DIAGCD12	100.00	
PTMT_ADJ_DATE	100.00	
AMT_BH_MCO_PAID_HDR	100.00	
AMT_OTH_INS_PD_HDR	95.58	
BILLING_PROV_ID	100.00	
BILLING_PROV_NPI	100.00	

Institutional Outpatient Data Element	CBH Percent Matching (%)	Reason for Discrepancy
RENDERING_PROV_ID	99.49	
RENDERING_PROV_NPI	99.65%	
LINE_NUMBER	100.00	
DTE_FIRST_SVC_HDR	0.00	**BH MCO response:** CBH reviewed the discrepant records and indicated that the 837P information was submitted to the state. However, the statement date segment is not present in the 837 professional claim type; therefore, not present in EDV study file. **Remote meeting discussion:** In the remote meeting, CBH advised IPRO that there is a mismatch between the encounter and extract, because statement date is not part of a professional claim. An assumption has been made in PROMISe to derive the date of service to header. PROMISe pulls the information from detail and then populates on header. **Follow-up item: Remote meeting discussion:** During the remote meeting, CBH advised this was an EDV study pull issue because the institutional inpatient programming logic was used for institutional outpatient.
DTE_LAST_SVC_HDR	0.00	**BH MCO response:** CBH reviewed the discrepant records and indicated that the 837P information was submitted to the state. However, the statement date segment is not present in the 837 professional claim type; therefore, not present in EDV study file. **Remote meeting discussion**: In the remote meeting, CBH advised IPRO that there is a mismatch between the encounter and extract, because statement date is not part of a professional claim. PROMISe derives the information from detail and populates on the header. **Follow-up item: Remote meeting discussion:** During the remote meeting, CBH advised this was an EDV study pull issue because the institutional inpatient programming logic was used for institutional outpatient.
DTE_FIRST_SVC_DTL	100.00	
DTE_LAST_SVC_DTL	100.00	
AMT_BH_MCO_PAID_DTL	100.00	
PROCEDURE_CODE	100.00	
UNITS_BILLED	100.00	
MODIFIER1	100.00	
MODIFIER2	100.00	
MODIFIER3	100.00	
MODIFIER4	100.00	

Yellow shading indicates match percentage less than 90%.
Grey shading indicates a BH MCO EDV study data extraction issue.
Light green shading indicates a difference in values attributed to the BHSRCC grid mapping.
CBH: Community Behavioral Health of Pennsylvania; BH: behavioral health; MCO: managed care organization; PROMISe: Provider Reimbursement and Operations Management Information System; ID: identification; ICN: internal control number; EDV: encounter data validation; NPI: National Provider Identifier; BHSRCC: Behavioral Health Services Reporting Classification Chart.

Summary of Findings

Based on IPRO's review of the CBH EDV study file values for the sampled records, identification and research of the discrepant values, review of the discrepant reason codes received from the BH MCO, and discussions with the BH MCO and OMHSAS during and following the teleconferences, there are no major encounter data issues. However, there are areas that require further research by encounter type by the BH MCO, OMHSAS and IPRO.

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

Challenges identified as a result of the EDV study and review of the discrepant data elements included:

Institutional Inpatient Claims:

- CBH advised that the type of bill was incorrectly mapped on the EDV study file. The EDV study file provided only included the first two digits of the type of bill.

Institutional Outpatient Claims:

- The following data elements were not submitted on the EDV study file since they are not present on an 837P encounter data extract: DTE_FIRST_SVC_HDR and DTE_LAST_SVC_HDR.

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

To circumvent the issue of cross walking the procedure codes and modifiers based on OMHSAS's Behavioral Health Services Reporting Classification Chart (BHSRCC) grid, CBH communicates with the providers to submit claims information based on the applicable BHSRCC grid for the date of service.