Pennsylvania's Office of Mental Health and Substance Abuse Services

2022 Encounter Data Validation Study

PerformCare for Pennsylvania

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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 including 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 to 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
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))

Professional Claims Field Name	Type	Description
		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 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
DIAGCD5	Char	Fifth diagnosis
DIAGCD6	Char	Sixth diagnosis
DIAGCD7	Char	Seventh diagnosis
DIAGCD8	Char	Eighth diagnosis
DIAGCD9	Char	Ninth diagnosis
DIAGCD10	Char	Tenth diagnosis

Institutional Inpatient Field Name	Type	Description
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		
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

Institutional Inpatient 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; 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
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

Institutional Outpatient Field Name	Type	Description
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		
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)

Institutional Outpatient Field Name	Type	Description
		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

PerformCare for Pennsylvania (PerformCare) EDV study call was conducted on October 17th, 2022. PerformCare's incoming data (claims) and submitted data (encounters) were reviewed 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 PerformCare's EDV study call included OMHSAS, Allan Collautt Associates, Inc. (ACA), AmeriHealth Caritas, Behavioral HealthChoices Contractor (BHHC), IPRO and PerformCare.

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)	400,422	400,062	336
Institutional inpatient (header)	2,269	2,263	1
Institutional outpatient (header)	81	80	0

ICN: internal control number.

Institutional Claims File – Outpatient

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.

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

Data Fields	PerformCare Counts of Data Values Present on EDV Study Not Submitted to PROMISe
DIAGCD13	19
DIAGCD14	15
DIAGCD15	14
DIAGCD16	6
DIAGCD17	6
DIAGCD18	6
DIAGCD19	6
DIAGCD20	6
DIAGCD21	6
DIAGCD22	6
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	81
REFERRING_PROV_ID	78
REFERRING_PROV_NPI	81
TYPEBILL	81

EDV: encounter data validation; PROMISe: Provider Reimbursement and Operations Management Information System.

PerformCare Professional Data Element Discrepancies and Findings

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

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

Professional Encounter Data Element	PerformCare Percent Matching (%)	Reason for Discrepancy
PLAN_CODE	0.00	**BH MCO response:** PerformCare reviewed the discrepant records and indicated that the MCO misinterpreted the specification to send County Code. **Remote meeting discussion:** During the remote meeting, PerformCare advised that they misinterpreted the file specifications. All the county codes PerformCare sent do correspond to the MCO Plan Code in the discrepancy file.
RECIP_ID	99.99	
PROMISe_ICN	100.00	
MCO_ICN	0.00	**BH MCO response:** PerformCare reviewed the discrepant records and indicated that the MCO sent the Claim ID as it existed in Facets®[1] instead of adjudicated source Claim ID. **Remote meeting discussion:** During the remote meeting, PerformCare advised that the plan added prefix and suffix to the number. The ID would have to be matched on the substring. Vendor ACA adds to this Claim ID when submitting encounters to PROMISe. They did not send that Claim ID because PerformCare believed IPRO would want to tie this to the original source in Facets. **Follow-up item:** PerformCare provided claim screen prints.
NUM_ADJ_ICN	99.99	
PLACESVC	96.80	
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	98.11	
AMT_OTH_INS_PD_HDR	98.26	

Professional Encounter Data Element	PerformCare Percent Matching (%)	Reason for Discrepancy
BILLING_PROV_ID	100.00	
BILLING_PROV_NPI	88.26	**BH MCO response:** PerformCare reviewed the discrepant records and indicated that the MCO submitted NPI on the claim, but on the encounter only MPISLC is submitted. Call notes indicate that MPISLC is the Master Provider Index with service location code. **Remote meeting discussion:** During the remote meeting, PerformCare advised that PROMISe derives and assigns the NPI provided by IPRO. No value is submitted to the 837 for Billing NPI.
RENDERING_PROV_ID	99.63	
RENDERING_PROV_NPI	84.24	**BH MCO response:** PerformCare reviewed the discrepant records and indicated that the MCO submitted NPI on the claim, but on the encounter only MPI is submitted. **Remote meeting discussion:** During the remote meeting, PerformCare advised that no NPI is submitted to 837. The rendering provider PROMISe ID 13-digit code including the service location is submitted.
LINE_NUMBER	100.00	
DTE_FIRST_SVC_DTL	99.42	
DTE_LAST_SVC_DTL	99.42	
AMT_BH_MCO_PAID_DTL	99.80	
PROCCODE1	88.69	**BH MCO response:** PerformCare reviewed the discrepant records and indicated that the MCO submitted the adjudicated source procedure code as submitted on the claim and not how it was cross walked to the BHSRCC. **Remote meeting discussion:** During the remote meeting, PerformCare advised that the discrepancy is due to the data warehouse containing the BHSRCC grid cross walked value. PerformCare indicated that the specification stated to provide the source claims data from the originally adjudicated claims.
QTY_UNITS_BILLED	99.83	
MODIFIER1	46.33	**BH MCO response:** PerformCare reviewed the discrepant records and indicated that it submitted the adjudicated source Mod1 as submitted on the claim and not how it was cross walked to the BHSRCC. **Remote meeting discussion:** During the remote meeting, PerformCare advised that PerformCare

Professional Encounter Data Element	PerformCare Percent Matching (%)	Reason for Discrepancy
		cross walked the modifier code based on the BHSRCC value prior to submitting to PROMISe.
MODIFIER2	78.36	**BH MCO response:** PerformCare reviewed the discrepant records and indicated that the MCO submitted the adjudicated source Modifier 2 as submitted on the claim and not how it was cross walked to the BHSRCC.
MODIFIER3	98.98	
MODIFIER4	99.97	

Yellow shading indicates a percent match rate of 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.
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BH: behavioral health; MCO: managed care organization; EDV: encounter data validation; ICN: internal control number; PROMISe: Provider Reimbursement and Operations Management Information System; ID: identification; ACA: Allan Collautt Associates, Inc.; NPI: National Provider Identifier; MPI: Master Provider Identifier; BHSRCC: Behavioral Health Services Reporting Classification Chart; BHSRCC: Behavioral Health Services Reporting Classification Chart.

PerformCare Institutional Inpatient Data Element Discrepancies and Findings

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

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

Institutional Inpatient Data Element	PerformCare Percent Matching (%)	Reason for Discrepancy
PLAN_CODE	0.00	**BH MCO response:** PerformCare reviewed the discrepant records and indicated that the MCO misinterpreted the specifications to send County Code. **Remote meeting discussion:** During the remote meeting, PerformCare advised that they misinterpreted the file specifications. All the county codes PerformCare sent do correspond to the MCO Plan Code in the discrepancy file.
RECIP_ID	100.00	
PROMISe_ICN	100.00	
MCO_ICN	0.00	**BH MCO response:** PerformCare reviewed the discrepant records and indicated that the MCO sent the Claim ID as it existed in Facets®[1] instead of adjudicated source Claim ID. **Remote meeting discussion:** During the remote meeting, PerformCare advised that the plan added prefix and suffix to the number. The ID would have to be matched on the substring. Vendor ACA adds to this Claim ID when submitting encounters to PROMISe. They did not send that Claim ID, because PerformCare believed IPRO would want to tie this to the original source in Facets.
NUM_ADJ_ICN	100.00	
DTE_ADMISSION	99.96	
DTE_DISCHARGE	50.51	**BH MCO response:** PerformCare reviewed the discrepant records and indicated that most of the inpatient claims matched on Discharge Status and Date Last Svc HDR (Statement End Date). Since Statement

Institutional Inpatient Data Element	PerformCare Percent Matching (%)	Reason for Discrepancy
		End Date is supposed to be used as Discharge Date when Patient Discharge Status <> 30, PerformCare is unsure why approximately 50% did not match. **Remote meeting discussion:** During the remote meeting, PerformCare advised that the discharge date is derived from status and statement date but cannot explain why discharge date didn't match other than in PROMISe. **Follow-up item:** PerformCare provided claim screen prints with explanation. The records not matching, had a patient status code of 30 without a date of discharge populated in the EDV study file.
DTE_FIRST_SVC_HDR	99.47	N/A
DTE_LAST_SVC_HDR	100.00	N/A
ADMITTYP	100.00	N/A
DIS_STAT	100.00	N/A
TYPEBILL	62.26	**BH MCO response:** PerformCare reviewed the discrepant records and indicated that DHS processed the 837 transactions with Facility Type 86 as outpatient claim types. **Remote meeting discussion:** During the remote meeting, PerformCare advised that ACA used the companion guides to submit type 11 to PROMISe for all facility claims. If Facility Type 86 is submitted, it would process as institutional outpatient and not inpatient. To ensure RTF/Facility Type 86 encounters are processed as inpatient claims in PROMISe, the MCO's vendor, ACA, has been submitting them with Facility Type 11. The discrepancy is related to the BHSRCC grid and the allowable values for type of bill that can be submitted on the encounter.
DRG	95.54	
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	99.78	
DIAGCD11	99.82	
DIAGCD12	99.82	
DIAGCD13	99.82	
DIAGCD14	99.91	
DIAGCD15	99.91	
DIAGCD16	100.00	
DIAGCD17	100.00	
DIAGCD18	100.00	

Institutional Inpatient Data Element	PerformCare Percent Matching (%)	Reason for Discrepancy
DIAGCD19	100.00	
DIAGCD20	100.00	
DIAGCD21	100.00	
DIAGCD22	100.00	
DIAGCD23	100.00	
DIAGCD24	100.00	
DIAGCD25	100.00	
SURG1	100.00	
SURG2	100.00	
SURG3	100.00	
SURG4	100.00	
SURG5	100.00	
SURG6	100.00	
SURGDTE1	100.00	
SURGDTE2	100.00	
SURGDTE3	100.00	
SURGDTE4	100.00	
SURGDTE5	100.00	
SURGDTE6	100.00	
PTMT_ADJ_DATE	100.00	
AMT_BH_MCO_PAID_HDR	100.00	
AMT_OTH_INS_PD_HDR	95.85	
LINE_NUMBER	100.00	
DTE_FIRST_SVC_DTL	99.87	
DTE_LAST_SVC_DTL	99.87	
AMT_BH_MCO_PAID_DTL	100	
REVENUE_CODE	100.00	
BILLING_PROV_ID	100.00	
BILLING_PROV_NPI	92.44	
RENDERING_PROV_ID	100.00	
RENDERING_PROV_NPI	0.00	**BH MCO response:** PerformCare reviewed the discrepant records and indicated that the MCO submitted adjudicated source on the claim instead of MPISLC. Call notes indicate that MPISLC is the Master Provider Index with service location code. The mismatch is because PROMISe derived something different. **Remote meeting discussion:** During the remote discussion meeting PerformCare advised that the value derived by PROMISe did not match NPI. The RENDERING_PROV_NPI is completely blank in the Data Warehouse and therefore was not matched to BILLING_PROV_NPI in the EDV study file.

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PerformCare Institutional Outpatient Data Element Discrepancies and Findings

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

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

Institutional Outpatient Data Element	PerformCare Percent Matching (%)	Reason for Discrepancy
PLAN_CODE	0.00	**BH MCO response:** PerformCare reviewed the discrepant records and indicated that MCO misinterpreted the specifications to send County Code. All the county codes PerformCare sent do correspond to the MCO Plan Code in the discrepancy file. **Remote meeting discussion:** During the remote meeting, PerformCare advised that they misinterpreted the file specifications.
RECIP_ID	100.00	
PROMISe_ICN	100.00	
MCO_ICN	0.00	**BH MCO response:** PerformCare reviewed the discrepant records and indicated that the MCO sent the Claim ID as it existed in Facets®[1] instead of adjudicated source Claim ID. Vendor ACA adds to this Claim ID when submitting encounters to PROMISe. They did not send that Claim ID, because PerformCare believed IPRO would want to tie this to the original source in Facets. **Remote meeting discussion:** During the remote meeting, PerformCare advised that the plan added prefix and suffix to the number. The ID would have to be matched on the substring.
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	100.00	
BILLING_PROV_ID	100.00	
BILLING_PROV_NPI	100.00	
RENDERING_PROV_ID	100.00	
RENDERING_PROV_NPI	100.00	
LINE_NUMBER	100.00	

Institutional Outpatient Data Element	PerformCare Percent Matching (%)	Reason for Discrepancy
DTE_FIRST_SVC_HDR	76.25	**BH MCO response:** PerformCare reviewed the discrepant records and indicated that the MCO submitted Statement Begin Date on the claim, but they do not send this information to PROMISe. **Remote meeting discussion:** During the remote meeting, PerformCare advised that they do not send this information to PROMISe when they convert to professional claim type, since the statement period does not exist on the professional claim.
DTE_LAST_SVC_HDR	63.75	**BH MCO response:** PerformCare submitted Statement End Date on the claim, but the MCO does not send this information to PROMISe. **Remote meeting discussion:** During the remote meeting, PerformCare advised that they do not send this information to PROMISe when they convert to professional claim type, since the statement period does not exist on the professional claim.
DTE_FIRST_SVC_DTL	100.00	
DTE_LAST_SVC_DTL	100.00	
AMT_BH_MCO_PAID_DTL	92.86	
PROCEDURE_CODE	85.71	**BH MCO response:** PerformCare reviewed the discrepant records and indicated that only some of the adjudicated source claims were submitted, and ACA renumbers the lines to start with '1' to accommodate sequential service line numbers on the encounter data extract. **Remote meeting discussion:** During the remote meeting, PerformCare advised that ACA confirmed the procedure codes present on the outgoing encounter data extract file. **Follow-Up Item:** An updated match percentage was recorded using the procedure code in the EDV Study File and both columns of the discrepant records were fully populated. Procedure code and modifier codes may be changed by the BH MCO to align to OMHSAS's BHSRCC grid.
UNITS_BILLED	100.00	
MODIFIER1	100.00	
MODIFIER2	100.00	
MODIFIER3	100.00	
MODIFIER4	100.00	

Yellow shading indicates a percent match rate of 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.
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Summary of Findings

Based on IPRO's review of the PerformCare 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 PerformCare submit institutional outpatient claims as professional. As a result, the diagnosis codes from 13 to 25 would 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 PerformCare is following OMHSAS companion guidelines for submission of encounters.

The way a provider registers NPI, taxonomy, and zip code with the BH MCO may be different than how the provider registers with OMHSAS. This results in the PRV430 not having the same combinations that are used by the BH MCO to correctly identify the provider.

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

Professional Claims:

- Since providers have multiple National Provider Identifiers (NPIs), when PerformCare submits an NPI that is different than what is in the PRV430, the encounter is denied by PROMISe; therefore, the BH MCOs are not submitting any values for Billing Provider NPI and Rendering Provider NPI.
- Procedure code and modifier codes may be changed by the BH MCO to align with OMHSAS's Behavioral Health Services Reporting Classification Chart (BHSRCC).

Institutional Inpatient Claims:

- According to PerformCare the date of discharge for most of the inpatient claims matched on Discharge Status and Date Last Service Header (Statement End Date). Since Statement End Date was supposed to be used as Discharge Date when Patient Discharge Status not equal to 30, IPRO utilized this logic and noted that the records not matching had a patient status code not equal to 30 without a date of discharge populated in the EDV study file. For future EDV studies, IPRO will work closely with OMHSAS to ensure the correct date data elements are utilized.
- Type of bill code for example 863 is mapped, since the 863 code is not submitted to PROMISe by PerformCare and ACA; PerformCare indicated that a type of bill of 863 would be denied.
- Type of bill may not match, since the MCO applies logic based on adjustments and interim bills, which would impact the 3rd digit of the type of bill.
- Since providers have multiple NPIs, if PerformCare submits an NPI that is different than what is in the PRV430, the encounter will be denied by PROMISe; therefore, the BH MCOs are not submitting any values for Billing Provider NPI and Rendering Provider NPI.

Institutional Outpatient Claims:

- Since providers have multiple NPIs, if PerformCare submits an NPI that is different than what is in the PRV430, the encounter will be denied by PROMISe; therefore, the BH MCOs are not submitting any values for Billing Provider NPI and Rendering Provider NPI.
- Procedure code and modifier codes may be changed by the BH MCO to align with OMHSAS's semi-annual BHSRCC.

The primary reason identified for the data element discrepancies is related to the utilization of OMHSAS's Behavioral Health Services Reporting Classification Chart (BHSRCC) and the cross walking of data element values for submission of encounters to PROMISe. PerformCare reviews the encounter data submission process related to the BHSRCC requirements and data element mapping which is tied to encounter data reporting requirements.

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