

Office of Program Support

Operations and Procedures Manual

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Introduction

The Office of Program Support (OPS) is within the Bureau of Financial Operations and provides oversight, coordination and monitoring to the Behavioral Health and Children's Rehabilitative Services Contractors. This document is a reference guide describing the procedural requirements between the Contractors, the Arizona Department of Health Services/Office of Program Support (ADHS/OPS), and the Arizona Health Care Cost Containment System (AHCCCS).

The Operations and Procedures Manual is available on the ADHS website (<http://www.azdhs.gov/bhs/ops.pdf>) and is to be used as the first point of reference when procedural questions arise.

Individuals with questions should contact the Office of Program Support between the hours of 8:00 A.M. to 5:00 P.M. Monday through Friday.

Definitions

Aged Pended Encounter	An encounter that has pended for more than 120 calendar days, after the initial processing date at AHCCCS, without resolution
AHCCCS	Arizona Health Care Cost Containment System
AHCCCSA	Arizona Health Care Cost Containment System Administration
AHCCCS Error	A pended encounter which AHCCCS acknowledges to be the result of its own and has been communicated to the Contractor by way of an edit alert, e-mail, phone conversation, typed letter or other forum
Check Register	A detailed log of all checks written and paid to providers for services rendered by a Contractor. The check register should include, but is not limited to, check number, date the check was written, check amount, and provider name and ID
Client Information System (CIS)	A data system used by ADHS
Contract Year/Fiscal Year	A period from July 1 of a calendar year through and including June 30 of the following year
Contractor	A Regional Behavioral Health Authority, Tribal Regional Behavioral Health Authority or Children's Rehabilitative Service Site contracted by ADHS to provide or monitor the provision of services
CRN	Claim Reference Number, used to track and review encounters in the PMMIS system at AHCCCS
CRS	Children's Rehabilitative Service
Days	A calendar day unless otherwise specified

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DBHS	Division of Behavioral Health Services
ADHS Error	A pending encounter which ADHS acknowledges to be the result of its own error and has been communicated to the Contractor by way of an edit alert, e-mail, phone conversation, typed letter or other forum
Deleted Encounter	A pending encounter that has been deleted from the PMMIS system at AHCCCS by request from a Contractor because the encounter was sent to ADHS in error or should not have been sent to AHCCCS by ADHS
Encounter	A record of a covered service rendered by a provider to a person enrolled with a capitated Contractor on the date of service
Enrollment	The process by which a person is enrolled into the Contractor and ADHS data system
Fee-For-Service (FFS)	A fee paid for each service based on actual utilization of services using payment rates set for units of care provided
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the person or some other person. It includes any act that constitutes fraud under applicable Federal or State Law
GSA	Geographic Service Area
ICN	Internal control number used in the CIS system
Override (of Encounter)	A process performed by a Contractor to bypass a pending status on an AHCCCS encounter which will allow the encounter to adjudicate cleanly
Pending Encounter	An encounter that was sent to AHCCCS from ADHS that did not cleanly adjudicate but resulted in an error, known as a “pending”
Provider	Provider refers to any individual/organization providing services to a Contractor’s enrolled/eligible members (any individual/organization that the Contractor will receive a claim/encounter from)
Quarter	Three months of the state fiscal year as broken into four quarters. July 1 through September 30 is referred to as the first quarter of the state fiscal year
Regional Behavioral Health Authority (RBHA)	An organization under contract with the ADHS to coordinate the delivery of behavioral health services to eligible and/or enrolled persons in a geographically specific service area of the state
T/RBHA	A reference to both RBHAs and Tribal RBHAs

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Definitions

Tribal RBHA	A Native American Indian tribe under Intergovernmental Agreement with ADHS to coordinate the delivery of behavioral health services to eligible and enrolled persons who are residents of the Federally recognized Tribal Nation that is the party to the Intergovernmental Agreement
Voided Encounter	An encounter previously accepted at ADHS or AHCCCS, but was voided by request from a Contractor because the encounter was sent to ADHS in error or should not have been sent to AHCCCS by ADHS

Related Information Resources

The Contractor should use the following resources in addition to this manual:

- CRS Regional Contractors Policy and Procedures Manual
- Client Information System (CIS) File Layout and Specifications Manual
- ADHS/DBHS Covered Behavioral Health Services Guide
- ADHS/DBHS Demographic User's Guide (DUG)
- ADHS/Office of Program Support Tidbits Newsletter
- The ADHS Contract with each Contractor
- AHCCCS Encounter Resources, including
 - Encounter Reporting Manual
 - Medical Policy Manual
 - Encounter Keys and Claims Clues Newsletters
 - Technical Interface Guidelines (TIG)
 - AHCCCS Behavioral Health Services Technical Interface Guidelines
- Coding Documentation
 - UB-92 Manual/UB-04 Manual
 - ICD-9-CM Diagnosis & Procedure Code Manual
 - Physician's Current Procedural Terminology (CPT) Manual
 - HCFA Common Procedures Coding System (HCPCS) Manual
 - First Data Bank Blue Book
 - HIPAA Guidelines via www.cms.hhs.gov/HIPAAGenInfo

Provider Registration

Introduction:

All providers are required to register with the AHCCCS Administration and obtain an AHCCCS provider identification number.

Providers are required to:

- Complete an application
- Sign a provider agreement
- Sign all applicable forms, and
- Submit documentation of their applicable licenses and/or certificates

Information may be obtained by calling the AHCCCS Provider Registration Unit at:

Phoenix area: (602) 417-7670 (Option 5)
In-state: 1-800-794-6862 (Option 5)
Out of state: 1-800-523-0231, Ext. 77670

AHCCCS Provider Registration materials are available on the AHCCCS Web site at www.ahcccs.state.az.us.

National Provider Identifier (NPI)

As of May 2007, all providers are required to obtain a National Provider Identifier (NPI) when providing/billing for services. Providers can apply for an NPI online at <https://nppes.cms.hhs.gov> or can call the NPI enumerator to request a paper application at 1-800-465-3203.

Health Care Providers *must* communicate their National Provider Identifier's [NPIs] directly to the AHCCCS Administration,

The following outlines 3 Options for getting the required NPI information to the AHCCCS Administration:

Option 1: An electronic mailbox has been established for providers to forward a copy of their NPI notification via e-mail. This e-mail address can only accept copies of the statement e-mailed to the provider from the NPI enumerator. Please note that the Provider AHCCCS ID number also needs to be included in the e-mail for identification purposes. This e-mail address is NationalProviderID@azahcccs.gov.

Option 2: Providers may submit a copy of the NPI notification received from the NPI enumerator, either via mail or fax. Again, the provider's name and AHCCCS ID

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number need to be included on the document. The information should be mailed or faxed to:

AHCCCS
Provider Registration Unit
P.O. Box 25520
Phoenix, AZ 85002
Mail Drop 8100
FAX: (602) 256-1474

Option 3: NPI numbers will also be accepted via written notification. Notification must include the provider's name, AHCCCS ID number, NPI number and signature of the provider or an authorized signor.

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Communication

Introduction

The Office of Program Support is separated into functional teams. Each team is assigned a specific set of duties and tasks to perform pertaining to the following research areas:

- Data Validation/coding, Deliverables, Eligibility/Enrollment/Demographics, Encounters/Pends

To ensure that communications are tracked and monitored, all communications from contractors to the Office of Program Support must be submitted via OPS e-mail: OPS@azdhs.gov. Contractors are not to contact Office of Program Support staff directly. The Office of Program support will provide an e-mailed response to the Contractor acknowledging receipt of the communication within three business days, with an expected response within 30 days.

Communication Procedures

- Communications from Contractors to the Office of Program Support
 - E-mail with request, question, or information is sent to OPS@azdhs.gov.
 - The communication is entered into the Office of Program Support Database and a Record ID number is automatically assigned for tracking and monitoring.
 - The e-mail is forwarded to the appropriate Office of Program Support team or individual to address the inquiry.
 - A receipt response e-mail including the assigned Record Id is provided to the contractor.
 - The original e-mail, as well as any subsequent incoming or outgoing communications related to the original, is saved in the appropriate assigned folder in the OPS Microsoft Outlook database.
- Communications from the Office of Program Support to Contractors
 - Office of Program Support staff will compose the communication and e-mail it to OPS@azdhs.gov along with any special instructions and the addresses of the individuals to whom the communication should be e-mailed.
 - The communication is entered into the Office of Program Support Database as either a response or a new communication and a Record ID is automatically assigned for tracking and monitoring.
 - E-mail the communication to OPS@azdhs.gov with any special instructions
 - The e-mail response will then be sent to the Contractor from OPS@azdhs.gov.
 - The original sent, as well as any subsequent incoming or outgoing communications related to the original, is saved in the appropriate assigned folder in the OPS Microsoft Outlook database.

Enrollment and Demographics

All Behavioral Health providers are required to conduct an intake and assessment that includes the collection of demographic and clinical data. These Intakes and Demographic collections are subject to monitoring by the Office of Program Support.

For information and guidance the Contractor should refer to the Demographic User's Guide (DUG). The DUG can be found at the following Web location:

<http://www.azdhs.gov/bhs/provider/ddsug.pdf>

Misc. Enrollment/Intake Clarifications

Intakes on Adopted Clients

If a client is adopted:

- The Contractor must close any intake currently open for the client
- A new intake must be submitted for the client with their new name, new AHCCCS ID and new SSN
- The new intake must not overlap a previous intake for the client
- If the client's AHCCCS ID or SSN have not changed, they must be omitted from the new intake
- If the client's first name and last name have not changed, the intake must be submitted with an override "O" action code
- The new intake must be submitted without a client ID so the system will issue a new client ID
- All future intake submissions for the client must contain the new client ID, intakes submitted without the new client ID may be posted to the old client ID in error

AHCCCS issues a new AHCCCS ID to all of their adopted clients. AHCCCS will only link the old and new AHCCCS IDs in PMMIS if requested to do so by the adoption source. ADHS data system client IDs must follow suit; the Contractor should only request ADHS link the client IDs on adopted clients if AHCCCS has linked the IDs in PMMIS.

Encounter Submission

Submission Schedules (SS)

Introduction

The Office of Program Support requires all Contractors to establish and adhere to a Submission Schedule when submitting encounters to the Arizona Department of Health Services (ADHS) for each form type (CMS-1500, UB-04, NCPDP or Dental). A Contractor's Submission Schedule is monitored and scored as part of the yearly Administrative Review.

Setting a Submission Schedule

Upon completion of encounter testing with ADHS, a new Contractor is given 90 days to select a set Submission Schedule which must be adhered to. For all Contractors, CMS-1500 files must be submitted at least bi-weekly, whereas UB-04, NCPDP and Dental encounter files may be submitted according to any of the three following schedules:

- **Monthly** The Contractor must submit at least one encounter file for a specific form type, per GSA if applicable, in the period of one month.
- **Bi-weekly** The Contractor must submit at least one encounter file for a specific form type, per GSA if applicable, every two weeks.
- **Weekly** The Contractor must submit at least one encounter file for a specific form type, per GSA if applicable, every week.

Monitoring

The Office of Program Support will monitor the Contractor's encounter submissions using the "Daily Detail Encounter Acceptance Report" (SS Attachment 1). The Office of Program Support will follow the procedures listed in the Encounter Acceptance Rates Policy, of this manual, to produce the report.

Test Environment

A Contractor may be placed into the testing environment if it fails to adhere to the established Submission Schedule for any form type during the period of one fiscal year quarter. Complete information regarding being placed in "Test" can be found in the Test Criteria Section of this manual.

Administrative Review Scoring

Contractor Submission Schedules are monitored as part of the Contractor's yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review Section of this manual.

Daily Detailed Encounter Acceptance Report

Arizona Department of Health Services/Division of Behavioral Health Services Daily Detail Encounter Acceptance Report - GSA - 6/12/08 - 6/30/08						
Process Date	Total Enc.	Processed Enc.	Void %	Accepted	Rejected	% Accepted
CMC-1500						
6/6/2008	13,833	13,833	0.00%	13,646	191	98.66%
6/16/2008	34,907	34,907	0.03%	36,504	337	99.05%
6/20/2008	26,083	26,083	1.51%	26,033	52	99.81%
6/27/2008	12,684	12,684	1.34%	12,173	511	95.97%
Total	87,507	87,507	1.38%	87,356	1,091	98.17%
MC/PP						
6/16/2008	15,688	15,688	0.00%	14,934	734	95.32%
6/20/2008	19,949	19,949	0.00%	19,775	174	99.13%
6/24/2008	11,051	11,051	0.00%	10,215	836	92.44%
6/25/2008	147	0	100.00%	144	3	97.96%
6/26/2008	9,018	9,018	0.00%	8,183	835	90.74%
Total	55,833	55,686	147	53,251	2,582	95.38%
UB						
6/27/2008	799	799	0.00%	663	136	82.98%
Total	799	799	0	663	136	82.98%
Grand Total	144,139	89,245	1,533	141,270	3,809	97.33%

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Data Submission Acceptance Rate (AR)

Introduction

Contractors are required to maintain an acceptance rate of 90% or greater for the following submission types: Intake/Closures, Encounters, and/or Demographics. Acceptance rates are significant as they may be the first indication of possible systemic problems. The Office of Program Support monitors acceptance rates daily. In addition, acceptance rates are scored as part of each Contractor's yearly Administrative Review for Encounters and Demographics.

Importing Daily Encounter Acceptance Reports

Contractor's place daily encounter files on the FTP server to be processed. The files are processed through the new-day batch process on a nightly basis by the ADHS IT Department. Encounter acceptance rates are calculated by the ADHS IT Department based on the number of rejected encounters versus the number of accepted encounters. ADHS IT then places a text file containing all of the encounter acceptance data into the M:\Common\Program Support directory and in turn notifies the Office of Program Support by e-mail when completed. The Office of Program Support imports the text file into the Department's established MS Access database.

Reviewing Daily Encounter Acceptance Reports

The Office of Program Support reviews the Contractor's acceptance rates on a daily basis using the Daily Detail Encounter Acceptance Report (AR Attachment 1). The following are the steps to be performed for the RBHA and CRS Site:

RBHA

1. Open the "Daily Enc Submission Rpt DB" database by double-clicking on the desktop shortcut. If the shortcut is not available, go to the following target location: M:\Program Support Staff\Daily_encounters_database, then double-click on the Daily enc submission rpt_db.mdb file.
2. Select "Reports" from the Daily Encounters Main Switchboard screen.
3. When the Criteria Selection Form appears, click on the "Report:" drop-down dialogue box and select "Daily Detail Encounter Acceptance Report".
4. Enter a Start Date: in the format MM/DD/YYYY.
5. Enter an End Date: in the format MM/DD/YYYY.
6. Use the "RBHA" drop down dialogue box to select the RBHA number of which the report should reflect.
7. Enter Notes in the "Notes" text box when applicable. To view notes at any time, check the "Collect all notes" box. Once notes are entered for a specific date, the notes will always be in the database.
8. Click on "Print". The report will appear and is broken down by form type in Snapshot format.
9. Print the report by clicking on the "File" menu and selecting "Print". Store the printout in a three ring binder specific to the RBHA.

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CRS

1. Open the “CRS_Daily_Encounter” database by double-clicking on the desktop shortcut. If the shortcut is not available, go to the following target location: M:\Program Support Staff\Daily_encounters_database, then double-click on the CRS_Daily_Encounter file.
2. When the Criteria Selection Form appears, click on the “Report:” drop-down dialogue box and select “Daily Encounter Acceptance”.
3. Enter a Start Date: in the format MM/DD/YYYY.
4. Enter an End Date: in the format MM/DD/YYYY.
5. Use the “Site” drop down dialogue box to select the CRS Site number of which the report should reflect.
6. Enter Notes in the “Notes” text box when applicable. To view notes at any time, check the “Collect all notes” box. Once notes are entered for a specific date, the notes will always be in the database.
7. Click on “Print”. The report will appear and is broken down by form type in Snapshot format.
8. Print the report by clicking on the “File” menu and selecting “Print”. Store the printout in a three ring binder specific to the CRS Site.

Analyzing Data

The Office of Program Support will examine the Contractor’s encounter submissions to ensure a minimum 90% acceptance rate is achieved for each encounter form type. For any encounter form type that does not meet the 90% acceptance rate threshold, an explanation of the cause(s) is/are mandatory from the Contractor.

Contractor Documentation

Contractors are required to provide ADHS with an explanation within 2 business days, when acceptance rates fall below the minimum 90% acceptance rate. The Office of Program Support will maintain this documentation by adding the explanations, provided by the Contractor, to the Daily Encounter Acceptance Report database. ADHS will consider systemic problems when analyzing the encounter acceptance rates.

Results

If 90% minimum acceptance rates are not maintained for any one form type during the period of a quarter, a letter is sent to the Contractors CFO before the end of the quarter notifying them that they could be placed in the testing environment (See Test Criteria Section of this manual). If the Contractor continues to average below 90% acceptance rates through the remainder of the quarter, the Contractor will be placed in the test environment at the end of the quarter.

Administrative Review Scoring

Contractor Acceptance rates are monitored as part of the Contractor’s yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review Section of this manual.

Arizona Department of Health Services/Division of Behavioral Health Services
Daily Detail Encounter Acceptance Report - (CONTRACTOR) (CONTRACTOR #)
1/1/2008 - 1/31/2008

<i>Process Date</i>	<i>Processed Enc.</i>	<i>Rejected</i>	<i>% Rejected</i>	<i>Accepted</i>	<i>% Accepted</i>	<i>Voids</i>	<i>% Voids</i>
<i>CMS-</i>							
1/8/2008	54	4	7.41%	50	92.59%	0	
1/14/2008	81	2	2.47%	79	97.53%	0	
1/22/2008	78	5	6.41%	73	93.59%	0	
1/28/2008	64	0	0.00%	64	100.00%	0	
<i>Total</i>	277	11	3.97%	266	96.03%	0	
<i>DENTAL "CRS ONLY"</i>							
1/14/2008	3	0	0.00%	3	100.00%	0	
1/28/2008	16	0	0.00%	16	100.00%	0	
<i>Total</i>	19	0	0.00%	19	100.00%	0	
<i>NCPDP</i>							
1/14/2008	129	2	1.55%	127	98.45%	0	
<i>Total</i>	129	2	1.55%	127	98.45%	0	
<i>UB</i>							
1/8/2008	1	1	100.00%	0	0.00%	0	
1/14/2008	18	1	5.56%	17	94.44%	0	
1/22/2008	15	0	0.00%	15	100.00%	0	
1/28/2008	7	1	14.29%	6	85.71%	0	
<i>Total</i>	41	3	7.32%	38	92.68%	0	
<i>Grand Total</i>	466	16	3.43%	450	96.57%	0	

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Test Criteria (TC)

Introduction

There are several scenarios that may require a Contractor to submit data into the ADHS test environment, rather than directly into production, for all encounter form types and demographic records.

Conditions for placing a Contractor into the testing environment

- A new contract has been awarded.
- System modifications have been implemented in an ADHS Data System (i.e. “Covered Services and HIPAA”) or as requested by the Office of Program Support.
- The Contractor fails to maintain an average 90% or greater acceptance rate for the period of one fiscal year quarter
- The Contractor fails to adhere to the established submission schedule for the period of one fiscal year quarter.
- Submission volumes drop 50% from the number of records submitted during the previous fiscal year quarter compared with the most recent fiscal year quarter completed.
- Upon removal from the testing environment, due to satisfactory completion of the test criteria, a Contractor may be moved back into test if any one of the first three submissions to production does not meet the 90% acceptance threshold. The Contractor will then have to achieve a 90% or greater acceptance rate, on a minimum of 3 additional test files, before being placed back into the production environment.

Monitoring

The Office of Program Support is responsible for monitoring all aspects of the Contractor’s submissions. If any of the above conditions are met; the Office of Program Support will send the preliminary warning letter to the Contractor (attachment 1). The Office of Program Support will continue to monitor the Contractor and, if conditions exist at the end of the quarter, a letter will be sent to advise that the Contractor has been placed in Test (attachment 2). The Office of Program Support will monitor test submissions to determine when the Contractor can be moved back to production.

Testing Environment

The Office of Program Support will work closely with any Contractor that has been placed in the testing environment to ensure test files are submitted appropriately and to offer assistance when system problems are identified. For data submissions that have been restricted to the test environment, the Contractor must coordinate the submission of test files with the Office of Program Support until the test criteria has been satisfactorily met.

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Test Criteria for New Contactor

Overview

The goal is to have Contractor 837I, 837P, 837D, NCPDP, Demographic, 834 Intake and Closure files accepted and completed through the testing process prior to the predetermined “Go Live” date. To accomplish this; the Contactor must submit test files, containing at least the outlined criteria, to ADHS and pass with a minimum acceptance rate of 90%.

Encounter Testing

Contractor Responsibility

1. Successfully submit a minimum of 5 encounters files for form types 837I, 837P, 837D & NCPDP to ADHS for testing.
 - a. The test files must contain no less than 50 encounters and no more than 20,000 encounters.
 - b. At least 1 file must contain multiple void records for each form type.
 - c. Test data in a submitted file cannot be repeated in a different test file.
 - d. At least 1 file should contain a volume of records that is similar to the daily average for each form type.
 - e. The test records need to contain a variety of different data in the fields. For example, there should be at least 5 different occurrences for each of the following (unless otherwise noted):
 - i. Procedure Code (837P & 837D)
 - ii. Procedure Codes with Modifiers (837P)
 - iii. Revenue Code (837I)
 - iv. Diagnosis Code (837P, 837I & 837D)
 - v. AHCCCS Provider IDs (all)
 - vi. Provider NPI (all)
 - Prescriber NPI (NCPDP)
 - Pharmacy NPI (NCPDP)
 - Attending Physician NPI (837I)
 - Group Biller NPI (all)
 - vii. Prescriber ID (NCPDP)
 - viii. Group Biller ID (all)
 - ix. Provider Type (all)
 - x. Bill Type (837I) [3 different occurrences]
 - xi. NDC Code (NCPDP)
 - xii. Client ID (all)
 - xiii. Admission Date (837I)
 - xiv. Admission Source (837I) [3 different occurrences]
 - xv. Encounter Processed Date (837P, 837I)
 - xvi. Patient Status (837I) [3 different occurrences]
 - xvii. Service Start Date (837P, 837I)
 - xviii. Service End Date (837P, 837I)

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- xix. Date of Service (837D)
 - xx. Place of Service (837P & 837D)
 - xxi. Category of Service (837P, 837I)
 - xxii. Admit Hour (837I)
 - xxiii. Discharge Hour (837I)
 - xxiv. Units of Service (837P, 837I & 837D)
 - xxv. RX Order Date (NCPDP)
 - xxvi. Prescription Number (NCPDP)
 - xxvii. Prescriber Locator Code (NCPDP)
 - xxviii. Financial Category (837D)[3 different occurrences]
 - xxix. Subcapitated Code (837D)[3 different occurrences]
2. Notification of test file availability
 - a. The Contractor must notify the Office of Program Support when test files are posted on the FTP server.
 - b. The e-mail notification should identify the data each test files contains (see Example 1)
 3. In the event a test file fails to meet acceptance criteria, identify root cause(s), make necessary corrections/edits and resubmit another test file containing similar types of records.
 4. The RBHA must promptly notify the Office of Program Support of issues impacting the ability to submit test data or have records accepted into the system.
 5. The Office of Program Support will conduct a walkthrough, at the Contractor's site, to oversee the entry of 5 paper claims for each form type.

Demographic Testing

Minimum Test Criteria

1. Initial Demographic:
 - Minimum of 10 Initial Demographic transactions.
 - Minimum 2 records for each of the following age groups: under 3, 17, 18+
 - Minimum 2 Adult SMI, 2 Adult non-SMI, 2 Children - with SED, 2 Children – non SED
 - Both male and female clients.
2. Full Update:
 - Minimum of 4 Full Demographics against converted clients.
 - Minimum of 2 adult and 2 children.
 - Both male and female clients.
3. Change Demographic:
 - Minimum of 8 Change Demographics. 4 against converted clients and 4 against new clients (these are dependent on the Initial Demographic being submitted).
 - Minimum of 2 adult and 2 children.
 - Both male and female clients.
4. Disenrollment Demographic:
 - Minimum of 3 Crisis disenrollments (1 per each crisis “reason for disenrollment” code)
 - Minimum of 4 disenrollments, consisting of 2 converted clients and 2 new clients.

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- Minimum of 2 short disenrollments of new clients. (less than 45 days from intake)

Contractor Responsibilities

1. Load source data into Contractor system to support integration testing.
2. Contractor will use the testing criteria listed above to create test files containing a variety of transaction types.
3. Process demographic test data within Contractor system, as needed, and then submit the test transactions to ADHS using appropriate file naming conventions and an automated FTP process.
 - The directory for testing will be the Contractor's directory on the FTP server.
 - Filenames will follow the production standard: udemogxx.darbha
**

** 'xx' will be substituted with the valid Contractor ID.

4. Submit sufficient test records to validate Contractor system edits are in place to prevent ADHS Pre-Processor errors.
5. At least 1 file should contain a volume of records that is similar to the average for that file type.
6. Notify the Office of Program Support when the test file will be sent and of what type of data/records will be included in the file.

Intake Testing

Minimum Test File Criteria

1. Test File #1:
 - Minimum of 20 'add' records submitted.
 - Minimum of 10 brand new clients that are NOT in either the ADHS or AHCCCS systems.
 - Minimum of 10 existing clients that do not yet have an intake with the Contractor.
 - Minimum of 10 change records against converted intakes.
2. Test File #2:
 - Minimum of 5 change records against add intakes from Test File #1.
 - Minimum of 3 override records.
 - Any test, as needed, per test results of Test File #1.
3. Test File #3:
 - Retesting of all error conditions identified in Test Files 1 & 2.

Contractor Responsibilities

1. Load source data into Contractor system to support integration testing.
2. Process intake test data within Contractor system, as needed, and submit the Test Files to ADHS using appropriate file naming conventions and an automated FTP process.

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- The directory for testing will be the Contractor's directory on the FTP server.
- Filenames will follow the production standard: hintkexx.hipaa **

** 'xx' will be substituted with the valid Contractor ID.

3. Submit sufficient test records to validate Contractor system edits are in place to prevent ADHS Pre-Processor errors.
4. At least 1 file should contain a volume of records that is similar to the average for that file type.
5. Notify the Office of Program Support when the test file will be sent and of what type of data/records will be included in the file.

Closure Testing

Minimum Test File Criteria

1. Test File #1:
 - Minimum of 20 closures with Action Code 'A'. (10 against converted data and 10 against new intakes added by the Contractor in previous files for Intake testing)
2. Test File #2:
 - Minimum of 7 closures with Action Code 'C'. (5 against the converted data closed in Test File #1 and 2 against the non-converted data closed in Test File #1)
 - Any test, as needed, per test results of Test File #1.
3. Test File #3:
 - Retesting of all error conditions identified in Test Files 1 & 2.

Contractor Responsibilities

1. Load source data into Contractor system, as needed, to support integration testing.
2. Process intake test data within Contractor system, as needed, and submit the Test Files to ADHS using appropriate file naming conventions and an automated FTP process.
 - The directory for testing will be the Contractor's directory on the FTP server.
 - Filenames will follow the production standard: hclsrex.hipaa **

** 'xx' will be substituted with the valid Contractor ID.

3. Submit sufficient test records to validate Contractor system edits are in place to prevent ADHS Pre-Processor errors.
4. At least 1 file should contain a volume of records that is similar to the average for that type of file.
5. Notify the Office of Program Support when the Test File will be sent and of what type of data/records will be included in the file.

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Testing Criteria for Established Contractor

Overview

The goal is for an Established Contractor, who has been placed into test due to one of the aforementioned conditions, to satisfy all elements of the testing requirements and begin submitting to the production environment for the affected form type. To accomplish this; the Contractor must submit test files, containing at least the outlined criteria, to ADHS and pass with a minimum acceptance rate of 90%.

Encounter Testing

Contractor Responsibility

1. Successfully submit 5 files of the affected form type to ADHS for testing.
 - a. The test files must contain no less than 50 encounters and no more than 20,000 encounters.
 - b. At least 1 file must contain multiple void records.
 - c. Test data in a submitted file cannot be repeated in a different test file.
 - d. At least 1 file should contain a volume of records that is similar to the Contractor's daily average for the affected form type.
 - e. The test records need to contain a variety of different data in the fields. For example, there should be at least 5 different occurrences for each of the following (unless otherwise noted):
 - i. Procedure Code (837P & 837D)
 - ii. Procedure Codes with Modifiers (837P)
 - iii. Revenue Code (837I)
 - iv. Diagnosis Code (837P, 837I & 837D)
 - v. AHCCCS Provider IDs (all)
 - vi. Provider NPI (all)
 - Prescriber NPI (NCPDP)
 - Pharmacy NPI (NCPDP)
 - Attending Physician NPI (837I)
 - Group Biller NPI (all)
 - vii. Prescriber ID (NCPDP)
 - viii. Group Biller ID (all)
 - ix. Provider Type (all)
 - x. Bill Type (837I) [3 different occurrences]
 - xi. NDC Code (NCPDP)
 - xii. Client ID (all)
 - xiii. Admission Date (837I)
 - xiv. Admission Source (837I) [3 different occurrences]
 - xv. Encounter Processed Date (837P, 837I)
 - xvi. Patient Status (837I) [3 different occurrences]
 - xvii. Service Start Date (837P, 837I)
 - xviii. Service End Date (837P, 837I)
 - xix. Date of Service (837D)
 - xx. Place of Service (837P & 837D)
 - xxi. Category of Service (837P, 837I)

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- xxii. Admit Hour (837I)
 - xxiii. Discharge Hour (837I)
 - xxiv. Units of Service (837P, 837I & 837D)
 - xxv. RX Order Date (NCPDP)
 - xxvi. Prescription Number (NCPDP)
 - xxvii. Prescriber Locator Code (NCPDP)
 - xxviii. Financial Category (837D)[3 different occurrences]
 - xxix. Subcapitated Code (837D)[3 different occurrences]
2. Notification of test file availability
 - f. The Contractor must notify the Office of Program Support when test files are posted on the FTP server.
 - g. The e-mail notification should identify the data each test files contains (see Example 1)
 3. In the event a test file fails to meet acceptance criteria, identify root cause(s), make necessary corrections/edits and resubmit another test file containing similar types of records.
 4. The Contractor must promptly notify the Office of Program Support of issues impacting the ability to submit test data or have records accepted into the system.

Demographic Testing

Minimum Test Criteria

1. Initial Demographic:
 - Minimum of 20 Initial Demographic transactions.
 - Minimum 2 records for each of the following age groups: under 3, 17, 18+
 - Minimum 2 Adult SMI, 2 Adult non-SMI, 2 Children - with SED, 2 Children – non SED
 - Both male and female clients.
2. Full Update:
 - Minimum of 20 Full Demographic transactions.
 - Both male and female clients.
3. Change Demographic:
 - Minimum of 20 Change Demographics transactions.
 - Both male and female clients.
4. Disenrollment Demographic:
 - Minimum of 20 Disenrollment Demographic transactions.
 - Minimum of 3 Crisis disenrollments (1 per each crisis “reason for disenrollment” code)
 - Minimum of 5 short disenrollments of new clients. (less than 45 days from intake)

Contractor Responsibilities

1. Contractor will use the testing criteria listed above to create test files containing a variety of transaction types.
2. Submit the test transactions to ADHS using appropriate file naming conventions and an automated FTP process.

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- The directory for testing will be the Contractor's directory on the FTP server.
- Filenames will follow the production standard: udemogxx.darbha
**

** 'xx' will be substituted with the valid Contractor ID.

3. Submit sufficient test records to validate Contractor system edits are in place to prevent ADHS Pre-Processor errors.
4. At least 1 file should contain a volume of records that is similar to the average for that file type.
5. Notify the Office of Program Support when the test file will be sent and of what type of data/records will be included in the file.

Intake Testing

Minimum Test File Criteria

1. Test File #1:
 - Minimum of 20 'add' records submitted.
2. Test File #2:
 - Minimum of 10 change records against add intakes from Test File #1.
 - Minimum of 5 override records.
 - Any test, as needed, per test results of Test File #1.
3. Test File #3:
 - Retesting of all error conditions identified in Test Files 1 & 2.

Contractor Responsibilities

1. Load source data into Contractor system to support integration testing.
2. Process intake test data within Contractor system, as needed, and submit the Test Files to ADHS using appropriate file naming conventions and an automated FTP process.
 - The directory for testing will be the Contractor's directory on the FTP server.
 - Filenames will follow the production standard: hintkexx.hipaa **

** 'xx' will be substituted with the valid RBHA number.

3. Submit sufficient test records to validate Contractor system edits are in place to prevent ADHS Pre-Processor errors.
4. At least 1 file should contain a volume of records that is similar to the average for that file type.
5. Notify the Office of Program Support when the test file will be sent and of what type of data/records will be included in the file.

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Closure Testing

Minimum Test File Criteria

1. Test File #1:
 - Minimum of 20 closures with Action Code 'A'.
2. Test File #2:
 - Minimum of 20 closures with Action Code 'C'; 10 of these should be against records closed in Test File #1
 - Any test, as needed, per test results of Test File #1.
3. Test File #3:
 - Retesting of all error conditions identified in Test Files 1 & 2.

Contractor Responsibilities

1. Load source data into Contractor system, as needed, to support integration testing.
2. Process intake test data within Contractor system, as needed, and submit the Test Files to ADHS using appropriate file naming conventions and an automated FTP process.
 - The directory for testing will be the Contractor's directory on the FTP server.
 - Filenames will follow the production standard: hclsrex.x.hipaa **

** 'xx' will be substituted with the valid Contractor ID.

3. Submit sufficient test records to validate Contractor system edits are in place to prevent ADHS Pre-Processor errors.
4. At least 1 file should contain a volume of records that is similar to the average for that type of file.
5. Notify the Office of Program Support when the Test File will be sent and of what type of data/records will be included in the file.

Office of Program Support Responsibility

1. Communication with ADHS/ITS and Contractor during the testing phase to assist wherever possible. This will include but is not limited to:
 - a. Explanation of file failure reasons to Contractor
 - b. Meeting with ADHS/ITS to evaluate Contractor progress
 - c. Notifying Contractor if there is an issue that would require testing to be stopped for a period of time greater than 24 hours
2. Daily evaluation of all testing results, communication of results to each Contractor and communication with ADHS/ITS if results require research beyond the expertise of the Office of Program Support.
3. Determination of a Contractor satisfying testing requirements and having ADHS/ITS move the Contractor's files to production processing.

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Example 1

When an e-mail notification is sent to the Office of Program Support, all data contained in each file should be outlined as follows:

Subject Test Files – (837I, 837P, 837D or NCPDP) Contractor ID

Body

(Contractor Name) is submitting an (837I, 837P, 837D or NCPDP) test file for the (designated time) test run. The files meet the following criteria:

- a. (volume of encounters) i.e. 100 encounters
- b. (if the file contains voids; how many and what percentage that number represents)
 - i.e. 7 voids which represent 7% of the total encounter file
- c. N/A
- d. (indicate if the file represents an average daily encounter submission)
- e. (identify data criteria represented in test file)
 - i.e. File variability:
 - 1. Procedure Codes – 12
 - 2. Diagnosis Codes – 10
 - 3. Provider NPIs - 20

Encounter Submission Initial Testing Criteria Letter Template

[Date]

[Recipient]
[Contractor or Agency]
[Address]
[City, State Zip]

Dear [Dr. /Mr. /Ms.] [Recipient],

The Office of Program Support continually monitors Contractor data submissions and acceptance rates in the CIS system. [Contractor] has had an average acceptance rate lower than 90% for [submission type] during the (1st, 2nd, 3rd or 4th) Qtr of FY [YY]. If [Contractor] continues to average below 90% on acceptance rates, for (submission type), throughout the remainder of the quarter; [Contractor] will be placed in the test environment. [Contractor] must then amend all system issues and adhere to the testing criteria outlined in the Office of Program Support Operations and Procedures Manual to return to the production environment.

If the Contractor experiences technical difficulties within their system that are unable to be corrected internally, the Contractor should contact the Office of Program Support for assistance.

Thank you for your attention to this matter. Please feel free to contact me at (phone #) should you have any questions.

Sincerely,

[Name]
OPS Representative

Enclosures

c: [IT Manager], ADHS/DBHS
Contract Compliance File

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TC Attachment 2

Encounter Submission Final Testing Criteria Letter Template

[Date]

[Recipient]
[Contractor or Agency]
[Address]
[City, State Zip]

Dear [Dr. /Mr. /Ms.] [Recipient],

The Office of Program Support continually monitors Contractor data submissions and acceptance rates in the CIS system. As advised in the letter dated [insert date of first letter] [Contractor] has had an acceptance rate lower than 90% for [form type] for the (1st, 2nd, 3rd, 4th) Qtr. of FY (YY) and will be placed into the test environment effective [insert date]. [Contractor] must correct their system and adhere to the testing criteria, outlined in the Office of Program Support Operations and Procedures Manual, to return to the production environment.

If the Contractor experiences technical difficulties within their system that are unable to be corrected internally, the Contractor should contact the Office of Program Support for assistance.

Thank you for your attention to this matter. Please feel free to contact me at (phone #) should you have any questions.

Sincerely,

[Name] OPS Representative

Enclosures

c: [IT Manager], ADHS/DBHS
Contract Compliance File

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Submission Timeliness/210 Report (ST)

Introduction

Contractors are required to submit all encounters to ADHS within 210 calendar days from the ending date of service. Failure to submit an encounter within 210 calendar days will result in an untimely encounter and will be scored as part of each Contractor's yearly Administrative Review. In addition, encounters submitted greater than 210 days may result in a timeliness error during the AHCCCS Data Validation study.

Collecting the Data

The ADHS/IT department produces an encounter file that identifies all encounters submitted greater than 210 days from the end date of service. IT places the text file containing all of the encounter data into the M:\Common\Program Support directory and notifies the Office of Program Support by e-mail when the file is ready to import. The Office of Program Support imports the text file into the departments' established MS Access database(s)

Accessing the 210 Report

The following are steps necessary to access the 210 report for RBHA Contractors:

1. Open the "Daily enc submission rpt" database by double-clicking on the desktop shortcut. If the shortcut is not available, go to the following target location: M:\Program Support Staff\Daily_encounters_database, then double-click on the Daily enc submission rpt_db.mdb file.
2. Select "Reports" from the Daily Encounters Main menu.
3. When the Criteria Selection menu appears, click on the "Report:" drop-down dialogue box and select "Over 210 Days Summary Report".
4. Enter a Start Date: in the format MM/DD/YYYY.
5. Enter an End Date: in the format MM/DD/YYYY.
6. Use the "RBHA" drop down dialogue box to select the appropriate RBHA.
7. Enter Notes in the "Notes" text box when applicable. To view notes at any time, check the "Collect all notes" box. Once notes are entered for a specific date, the notes will always be in the database.
8. Click on "Print". The report will appear with separate line for each form type.
9. Print the report by clicking on the "File" menu and selecting "Print".

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The following are steps necessary to access the 210 report for CRS Contractors:

1. Open the “CRS_Daily_Encounter” database by double-clicking on the desktop shortcut. If the shortcut is not available, go to the following target location: M:\Program Support Staff\Daily_encounters_database, then double-click on the CRS_Daily_Encounter.mdb file.
2. Click on the “Report:” drop-down dialogue box and select “Over 210 Days Summary Report”.
3. Enter a Start Date: in the format MM/DD/YYYY.
4. Enter an End Date: in the format MM/DD/YYYY.
5. Use the “Site” drop down dialogue box to select the appropriate CRS Site.
6. Enter Notes in the “Notes” text box when applicable. To view notes at any time, check the “Collect all notes” box. Once notes are entered for a specific date, the notes will always be in the database.
7. Click on “Print”. The report will appear with separate line for each form type.
8. Print the report by clicking on the “File” menu and selecting “Print”.

Reviewing the 210 Report

The Office of Program Support will review the 210 report to identify issues Contractors are having submitting timely encounters

Contractors are required to provide an explanation if:

- More than five percent of their encounters are submitted over 210 days past the end date of service.
- An increase in untimely encounters is noted.

Administrative Review

Encounters submitted to ADHS greater than 210 days from the end date of service are evaluated and scored as part of the yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review Section of this manual.

210 Report

Arizona Department of Health Services/Division of Behavioral Health Services
 Greater than 210 days Summary Report - 1/1/2007 - 3/31/2007

Daily Encounter Summary

GSA -

	Total Enc.	Processed Enc.	Voids	Void %	Accepted	Rejected	% Accepted	210 PD	210 %
DRUG	54,030	54,030	0	0.00%	52,586	1,444	97.33%	270	0.51%
HCEA	227,016	223,704	3,312	1.46%	222,580	4,466	98.05%	1,771	0.80%
UB	1,401	1,398	3	0.21%	1,310	91	93.50%	63	4.81%
Grand Total	282,447	279,132	3,315		276,476	6,001		2,104	

% Accepted Formula: ((SUM(ACCEPTED)/SUM(TOTAL)))*100
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Tuesday, May 29, 2007

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Aged Pends/Pend Sanctions (AP)

Introduction

For each Contractor, ADHS produces a Pended Encounter File at the conclusion of each AHCCCS encounter processing cycle. This file contains all encounters pending in the AHCCCS PMMIS system. The Contractors must resolve all pended encounters from the AHCCCS PMMIS system within 120 calendar days of the original AHCCCS processing date. Failure to resolve AHCCCS pended encounters within 120 days is known as an aged pended encounter and is subject to sanction. The exceptions are encounters that pended due to AHCCCS or ADHS error.

AHCCCS Pended Encounters Cycle

The AHCCCS encounter cycle normally takes approximately one week to complete. The output from the encounter cycle includes Pended Encounters file produced by AHCCCS at the conclusion of each encounter processing cycle. As soon as ADHS receives the file, it is reviewed for errors, placed into manageable file formats and promptly placed on the respective Contractor FTP server.

The Office of Program Support will immediately send a notification via e-mail to all the Contractors stating that AHCCCS Pend files are available on the Office of Program Support FTP server (AP Attachment 1). The e-mail will include the due dates for each step of the pend correction process due to ADHS. Contractors are to immediately begin working pends to meet all deadlines. The Contractors have the ability to work on correcting pended encounters throughout the month. All questions regarding the AHCCCS pended encounters should be directed to the Office of Program Support.

The Contractors have 120 days from the date the encounter was processed at AHCCCS to correct pended encounters. Ideally the Contractor should submit encounter pend corrections to ADHS within 90 days. This will provide ADHS adequate time to process and send the pend correct action to AHCCCS. If encounters are not corrected within 120 days of the original AHCCCS processing date, Contractors are liable for sanctions.

Monitoring Pended Encounters

To be proactive in reducing and/or eliminating sanctions due to aging pended encounters, the Office of Program Support will work with Contractors to address encounters pended more than 90 days. The Office of Program Support will take the following steps to monitor pended encounter corrections:

1. Access “M:\Program Support Staff\AHCCCS Reports\HP_079999” and locate the Aging Pended Encounters snapshot files for each Contractor, titled, “OPS_Pend_Rpt_Aging_RBHA_XX” (XX being the Contr identifier). This file is available when the AHCCCS pend files are placed on the Office of Program Support FTP server for each Contractor.

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2. Print copies of the snapshot file for distribution and discussion at group meetings. Make sure to address all pended encounters that have been pending greater than 90 days and have the Contractor explain why the pend error is unresolved.
3. Follow up with the Contractor throughout the month to ensure the Contractor has been able to correct aging pends and/or understand how to correct them.
4. Ensure IT has completed System Service Request (SSR) for adjudication of pended encounters due to ADHS error.
5. Communicate with the AHCCCS Technical Assistant Representative to ensure override requests are completed in a timely fashion.

Voiding, and Overriding of Encounters

A Contractor may void or override a pended encounter however pended encounters must not be voided or overridden in order to avoid sanctions for failure to correct pended encounters within 120 days. The Contractor must document all Title XIX and Title XXI encounters voided or overridden and maintain a record of the CRNs with appropriate reasons for the actions. See Encounter Reconciliation Log section of this manual.

Preliminary Sanctioning Process

AHCCCS on a quarterly basis distributes to ADHS Office of Program Support via the AHCCCS FTP server their preliminary findings of sanctionable aged pended encounters (AP Attachment 2). The preliminary findings are divided into aged pended encounters that are excluded from sanction (AP Attachment 3) and those that are being sanctioned (AP Attachment 4). A summary of all sanctionable pended encounters are also placed on the FTP server by AHCCCS in the form of an Excel spreadsheet. The Office of Program Support Encounter Manager or Supervisor is responsible for moving these files to the M:\Program Support Staff\Encounters\Pend Sanctions folder. The Encounter Manager then provides each Contractor with a letter defining the preliminary results and includes a spreadsheet summary of the sanctionable aged pended encounters specific to the Contractor for review and comment (AP Attachment 5).

Challenge Preliminary Findings

The Contractor is responsible for identifying any pends that they want to challenge in the preliminary report. Each challenge must be supported by additional documentation. Types of additional documentation include, but are not limited to:

- PMMIS screen prints
- CIS screen prints
- Screen prints from the Contractor's internal system

The Office of Program Support will review all challenges from the Contractor and determine the documentation that will be forwarded to AHCCCS for consideration of reducing sanctions.

Final Sanction Determination

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Once AHCCCS reviews all challenges and/or additional documentation, a final decision is made as to which pended encounters are sanctionable (AP Attachment 6). The sanctions are then calculated (AP Attachment 7) according to age category. Office of Business Operations is notified of the final sanction amounts and funds are withheld from the Contractor's capitation payment the following month. The Office of Program Support will send a letter to each Contractor advising them of any final sanction amounts (AP Attachment 8). Whether sanctions are waived or not, a Contractor is still responsible for correcting all pended encounters unless the error is on behalf of AHCCCS or ADHS.

Sanctions are imposed according to the following schedule:

0 – 120 Days	121 – 180 Days	181 – 240 Days	241 – 360 Days	361 + Days
No Sanction	\$5 per month	\$10 per month	\$15 per month	\$20 per month

Administrative Review Scoring

Aged pended encounters are monitored as part of the Contractor's yearly Administrative Review. Administrative Review standards can be found in the Administrative Review Section of this manual.

AHCCCS Pends Availability and Correction Due Dates E-mail

IMPORTANT INFORMATION - December 2006 Pend Data

1) Pend Files are Ready

Your current pend file (APEND_rr.txt) is available on the OPS FTP server in the password protected zip file (APEND_rr.ZIP).

**Please note that your file contains all pended records (hard and soft). Do not work the soft edits.

<u>Month</u>	<u>Contractor</u>	<u>Records</u>	<u>FTP to Contractor</u>
2006-12	02	6,344	Y
2006-12	08	12,127	Y
2006-12	15	842	Y
2006-12	22	575	Y
2006-12	26	3,168	Y
2006-12	27	1,245	Y

2) Pend Reporting

Reports of all encounters pended at AHCCCS for the month of December 2006 have been generated and placed in your respective Contractor directory on the FTP server.

3) Pend Processing Deadlines

A) DelDup File (AHCCCS Pend Overrides, & Subvention Deletions) **Due By: Noon 12/28/2006**

Use only the following combinations of Error and Reason Codes.

<u>Error Code</u>	<u>Reason Code</u>
A001	A001 Per RBHA review, not a duplicate encounter
R410	D012 Recipient not AHCCCS eligible during dates of service (R410, R480)
R480	D012 Recipient not AHCCCS eligible during dates of service (R410, R480)
R660	D017 Recipient does not have MHS enrollment at AHCCCS during dates of service (R660)
H280	D018 Encounter not eligible to adjust (H280)
N027	D019 Drug not elig for Medicaid coverage (N027)

B) All other error codes should be adjudicated either through on-line correction of applicable data fields in the CIS system, or through submission of a full void transaction in the normal daily process.

All pended encounter on-line corrections and void transactions must be completed in CIS by 11:00 am 1/2/2007.

4) Pend Error Questions

Please feel free to contact the Office of Program Support should you have any questions, or should you require any additional information.

Note:

This communication, generated by the Office of Program Support on a monthly basis, is entered into the OPS email Database, assigned a Record ID number and is sent to the Contractor from OPS@azdhs.gov. The original, as well as any subsequent incoming or outgoing communications related to the original, is saved in the OPS Microsoft Outlook database.

Preliminary Sanction Summary

Preliminary Sanction Summary			
Quarter Ending:		June, 2006	
Plan ID:	079999	Plan Name:	ADHSBHS
TSN:	79		
Age Category	Total Encounters	Sanction Amount	
181-240 Days	2	\$20	
241-360 Days	4	\$80	
TSN:	80		
Age Category	Total Encounters	Sanction Amount	
121-180 Days	1	\$5	
241-360 Days	4	\$80	
TSN:	81		
Age Category	Total Encounters	Sanction Amount	
121-180 Days	4	\$20	
181-240 Days	3	\$30	
TSN:	84		
Age Category	Total Encounters	Sanction Amount	
121-180 Days	1	\$5	
Plan Total	Total Encounters	Sanction Amount	
	19	\$200	

Pended Encounters Excluded from Preliminary Sanctions

Summary of Encounters Excluded From Preliminary Sanctions

Quarter Ending: June, 2006

Plan ID: 079999 Plan Name: ADHSBHS

<i>Error Code</i>	<i>Error Description</i>	<i>Form Type</i>	<i>TSN</i>	<i>Total</i>
A951	FORCE PEND FOR CONTRACTOR CORRECTIONS	A	79	6
A951	FORCE PEND FOR CONTRACTOR CORRECTIONS	A	80	90
A951	FORCE PEND FOR CONTRACTOR CORRECTIONS	I	93	12
A951	FORCE PEND FOR CONTRACTOR CORRECTIONS	I	79	28
P210	IHS SERVICE PROVIDERS ARE FEE FOR SERVICE ONLY	A	81	78
P210	IHS SERVICE PROVIDERS ARE FEE FOR SERVICE ONLY	A	80	295
P340	PROVIDER SPECIFIC RATE NOT ON FILE FOR DOS	I	79	2
P340	PROVIDER SPECIFIC RATE NOT ON FILE FOR DOS	I	93	3
P353	RATE NOT FOUND ON PROV TYP TBL	I	79	6
R410	RECIPIENT NOT ELIGIBLE FOR AHCCCS SERVICES ON SERVICE DATES	A	80	1
R480	RECIPIENT NOT ENROLLED ON SERVICE DATES	C	81	6
R600	MEDICARE COVERAGE INDICATED BUT NOT BILLED	A	81	12
R600	MEDICARE COVERAGE INDICATED BUT NOT BILLED	A	83	36
R632	MEDICARE APPROVED AND PAID NOT BOTH PRESENT	A	83	2
V151	OR RM BILL-ICD9 AND/OR HCPCS MUST = SURGICAL	I	79	6
V152	OR RM BILL-NO SURG ICD9 AND/OR HCPCS CODE PRESENT	I	79	3
Z610	EXACT DUPLICATE FOUND	I	79	6
Z615	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	I	80	1
Z615	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	I	79	6
Z620	NEAR DUPLICATE FOUND	I	93	2
Z720	EXACT DUPLICATE FOUND	A	81	4
Z720	EXACT DUPLICATE FOUND	A	83	8
Z720	EXACT DUPLICATE FOUND	A	79	12
Z725	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	A	83	1
Z725	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	A	79	58
Z725	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	A	93	210
Z725	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	A	80	272
Z745	NEAR DUPLICATE FROM DIFFERENT HEALTH PLANS	A	80	3
Z745	NEAR DUPLICATE FROM DIFFERENT HEALTH PLANS	A	93	12
Z760	NEAR DUPLICATE FOUND - FROM-THROUGH DATES OVERLAP	A	81	1
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	94	8
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	84	47
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	83	129
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	93	352
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	79	510
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	80	6,505
<i>Plan Total</i>				8,733

Preliminary Encounter Sanctions Error Summary

Preliminary Encounter Sanctions Error Summary

Quarter Ending: June, 2006

Plan ID: 079999 Plan Name: ADHSBHS

<i>Error Code</i>	<i>Error Description</i>	<i>Form Type</i>	<i>Total</i>
D010	PRIMARY DIAGNOSIS NOT ON FILE (FOR DOS)	A	1
D305	INAPPROPRIATE DIAGNOSIS SEQUENCE	A	1
D305	INAPPROPRIATE DIAGNOSIS SEQUENCE	A	1
N004	NDC CODE NOT ON FILE	C	1
N004	NDC CODE NOT ON FILE	C	5
R660	DHS MHS ENC RCP MUST BE ON MHS ENROLL	A	4
T005	PSYCH BED W/OUT PSYCH DX-INVALID	I	1
V020	REVENUE CODE NOT ON FILE FOR DOS	I	1
V045	NO ACCOMMODATION BILLING - BILL IS I/P OR LTC	I	4
<i>Plan Total</i>			19

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AP Attachment 5

Preliminary Sanction Letter Sent to Contractors

[Date]

[Recipient]
[Contractor]
[Address]
[City, State Zip]

Dear [Mr. / Ms.] [Recipient]:

The purpose of this letter is to inform you of the preliminary results of sanctionable pended encounters for the quarter ending [month, year]. According to your contract, [Contractor] is required to resolve all pended encounters within 120 calendar days of the original processing date.

Please retrieve the spreadsheet listing your sanctionable pended encounters for the quarter ending [month, year] which includes preliminary sanction amounts from ADHS' OPS FTP server. Please enter your responses to any items believed not to be sanctionable into the designated area of the spreadsheet. Return the spreadsheet by placing it on ADHS' OPS FTP server with any supporting documentation being mailed to the Office of Program Support Encounter Unit, attention [Encounter Manager].

If we do not hear from you by [Month Day, Year], we will use the preliminary results as the final sanction amount. The Arizona Department of Health Services/Office of Program Support's Encounter Unit will evaluate and, if appropriate, submit a challenge to AHCCCS for final review.

Should you have any questions regarding this matter, please feel free to contact me at (602) [phone number].

Sincerely,

[Name], Eligibility/Encounter Manager
Bureau of Financial Operations

Enclosures

c: [Name], Deputy Director, ADHS
[Name], Chief Financial Officer, ADHS
Contract Compliance File

Error Summary Final

Error Summary Final

Quarter Ending: June, 2006

Plan ID: 079999 Plan Name: ADHS/BHS

<i>Error Code</i>	<i>Error Description</i>	<i>Form Type</i>	<i>Total</i>
D010	PRIMARY DIAGNOSIS NOT ON FILE (FOR DOS)	A	1
D305	INAPPROPRIATE DIAGNOSIS SEQUENCE	A	2
N004	NDC CODE NOT ON FILE	C	6
R660	DHS MHS ENC RCP MUST BE ON MHS ENROLL	A	2
T005	PSYCH BED W/OUT PSYCH DX-INVALID	I	1
<i>Plan Total</i>			12

Final Sanction Summary

Final Sanction Summary Quarter Ending: June, 2006			
Plan ID:	079999	Plan Name:	ADHS/BHS
TSN:	79		
	Age Category	Total Encounters	Sanction Amount
	181-240 Days	1	\$10
TSN:	80		
	Age Category	Total Encounters	Sanction Amount
	121-180 Days	1	\$5
	241-360 Days	2	\$30
TSN:	81		
	Age Category	Total Encounters	Sanction Amount
	121-180 Days	4	\$20
	181-240 Days	3	\$30
TSN:	84		
	Age Category	Total Encounters	Sanction Amount
	121-180 Days	1	\$5
Plan Total		Total Encounters	Sanction Amount
		12	\$100

Final Sanction Letter Sent to Contractors

[Date]

[Recipient]
[Contractor]
[Address]
[City, State Zip]

Dear [Mr./Ms.] [Name]:

The purpose of this letter is to inform you of the final results of sanctionable pended encounters for the quarter ending [Month, Year].

In a letter dated [Month Day, Year], [Contractor] was provided an opportunity to review the preliminary results, and provide input to items believed to be sanctioned in error. AHCCCS has completed their review of the errors [Enter amount of sanction or amount waived] for all aged pended encounters for this quarter.

Please note that, when sanctions are waived, the Contractor is still liable for correcting all pended encounters unless the error is due to an AHCCCS error.

Should you have any questions regarding this matter, please contact [Name], Encounter Unit Manager at (602) [phone number].

Sincerely,

[Name]
Chief Financial Officer

c: [Name], Deputy Director, ADHS
Contract Compliance File, ADHS

Office of Program Support Operations and Procedures Manual

Encounter Reconciliation Log (RL)

Introduction

The Office of Program Support requires each Contractor to maintain and submit a quarterly reconciliation log of all encounters that have been overridden or voided from the AHCCCS PMMIS system. The quarterly reconciliation logs are scored as part of each Contractor's yearly Administrative Review.

Submitting Encounter Reconciliation Logs

The Contractor is required to submit the reconciliation log to the Office of Program Support no later than the 30th of the month following the end of the quarter. For example, for quarter ending March 31, 2008, the report is due by April 30, 2008. One week prior to the end of each quarter the Office of Program Support will send an e-mail to each Contractor stating that the reconciliation log is due. If the 30th of the month falls on a holiday or weekend, the Office of Program Support will advise the Contractor of any extension. The Contractor will submit the reconciliation log file to the FTP server according to the required File Layout (RL Attachment 1). The Contractor will send an e-mail to the Office of Program Support and will copy the Office of Program Support Encounter Manager when the logs have been placed on the FTP server. Once the Office of Program Support receives the e-mail from the Contractor stating that the log is available, it will be reviewed for accuracy.

Quarterly Encounter Reconciliation Log Submission Schedule

<u>Review Quarter</u>	<u>Due Date At ADHS/OPS</u>
Ending March 31	April 15
Ending June 30	July 15
Ending September 30	October 15
Ending December 31	January 15

Comparing the Encounter Reconciliation Logs for Accuracy

ADHS keeps a record of each encounter the Contractors override or void from the AHCCCS PMMIS system to reconcile against the quarterly Encounter Reconciliation logs submitted by each Contractor. ADHS will use the following criteria to compare the Contractor's logs to the related encounter data in the ADHS system.

- ICN/Line Number/CRN: The encounter ICN, line number and CRN must match the ADHS database records ICN, line number and CRN for each related encounter found
- Codes: The Procedure, NDC, or Revenue code for the service provided must match the ADHS database records procedure, NDC or revenue code for each related encounter found.

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- Units: Indicates the number of units for each related encounter found
- Contractor ID: The Contractor ID must match the ADHS database records Contractor ID for each related encounter found.
- Provider ID: The Provider ID must match the ADHS database record's provider ID for each related encounter found.
- NPI: The National Provider Identifier (NPI) must match the ADHS database record's NPI for each related encounter found.
- Start/Enc Date: the start date and end date must match the ADHS database records start and end date for each related encounter found.
- Error Code 1-4: Indicates the AHCCCS pend errors that caused the encounter record to pend at AHCCCS (if applicable).
- Type of Transaction: Indicates the type of action taken relating to the record. V = Void transaction or O = Override transaction.
- ADHS Client ID: The Client ID must match the ADHS database record's Client ID for each related encounter found.
- Client AHCCCS ID: The Client AHCCCS ID, assigned by AHCCCS, must match the ADHS database record's AHCCCS ID for each related encounter found.
- Form Type: Indicate the form type for this encounter. A = CMS 1500, B = UB, C = NCPDP, or D = Dental
- Reason Code/Description: Indicates the reason for the override or voided encounter from the AHCCCS PMMIS system. If applicable, the reason code must appear in the log and must match the record for each related encounter found. Contractors must use one of the Office of Program Support approved reason codes (RL Attachment 2).
- Record Missing: If a Contractor's log is missing encounter records when compared to the ADHS database records for each related encounter, the number of missing records will be calculated in the findings.

Findings

Upon completion of a Contractors Encounter Reconciliation log review, an e-mail will be sent to the Contractor identifying any errors that have been discovered as well as a final score for that quarter's log.

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Administrative Review Scoring

Contractor submissions of Encounter Reconciliation Logs are monitored as part of the Contractor's yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review Section of this manual.

Encounter Reconciliation Log

File Name: Enc_Recon_log MMDDYYYY_Contractor_ID

Format: comma quote delimited file

Claims and Encounters Reconciliation Log Record Layout

Field Name	Type	Remarks
CRN	X(14)	
ICN Number	X(11)	
Line Number	X(2)	
Procedure NDC Revenue Code	X(11)	
Units	Number (7,1)	
Contractor ID	X(2)	
Provider ID Number	X(6)	Must match original submission
National Provider Identifier (NPI)	X(10)	Must match original submission
Service Begin Date	DATE	MM/DD/YYYY
Service End Date	DATE	MM/DD/YYYY
Error Code 1	X(4)	If applicable
Error Code 2	X(4)	
Error Code 3	X(4)	
Error Code 4	X(4)	
Type of Transaction	X(1)	V = Void Transaction
		O = Pend Override
ADHS Client ID	X(10)	
AHCCCS Client ID	X(9)	
Form Type	X(1)	A= CMS 1500, B = UB, C-NCPDP, D = Dental
Reason Code	X(4)	If applicable
Void/Override Reason Description	X(200)	

Contractors must maintain a log containing the fields listed above for every encounter that is voided or overridden from the PMMIS system at AHCCCS.

Approved Override Code

A001 Per Contractor review, not a duplicate encounter

Approved ADHS Deletion Codes

D012 Recipient not AHCCCS eligible/enrolled during dates of service (R410, R480)

D017 Recipient does not have MHS enrollment at AHCCCS during dates of service (R660)

D018 Encounter not eligible to adjust (H280)

D019 Drug not eligible for Medicaid coverage (N027)

DITS Per Contractors request deleted by ITS

DOPS Per Contractor request deleted by OPS

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Check Register Review (CR)

Introduction

The Office of Program Support requires all Contractors to submit check registers for all Fee-For-Service (FFS) paid claims on a quarterly basis to ensure the Contractor is submitting timely and accurate encounter data. Check register reviews are scored as part of each Contractor's yearly Administrative Review.

Timeframes to be followed

- The 1st business day of the month following the end of the fiscal year quarter to be reviewed, the Office of Program Support will send an e-mail to the Contractor(s) requesting the check register for the appropriate fiscal year quarter.
- The Contractor will be given ten (10) business days to return the check register to the Office of Program Support.
- Within five (5) business days, the Office of Program Support will submit a request to the Contractor for copies of either the first paid claim on the checks where a single claim was paid or the third paid claim on the checks where multiple claims were paid.
- The Contractor will be given ten (10) business days to submit the requested documents to the Office of Program Support.
- The Office of Program Support will review the submitted documents and provide the Contractor with the outcome within ten (10) business days from the day the second request was received. The Contractors will be sent a preliminary letter summarizing the findings along with a spreadsheet of the claims reviewed.
- The Contractor will have ten (10) business days from the date of the preliminary letter to review the preliminary outcome and submit any challenges of the decision to the Office of Program Support.
- The Office of Program Support will have five (5) business days from the date that the challenge is received to notify the Contractor of their final score for the review period.

Check Register Request

On the first business day of each quarter, the Office of Program Support will send a request to each Contractor via e-mail stating that the Contractor's check register from the previously ended quarter is due to the Office of Program Support (CR Attachment 1). The Contractor is given ten (10) business days from the date of the e-mail to submit their check register.

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Check Register Received

On receipt of the Contractor's check register, the Office of Program Support will begin the check register review with the sample selection process. The Office of Program Support will randomly select 20% of the checks (to include checks for each form type and not to exceed a total of 75) from the Contractor's Check Register. The Office of Program Support will list the checks chosen via the sample selection process for the check register review on the Check Register Claim Request spreadsheet (CR Attachment 2).

Within five (5) business days of receiving the check register the Office of Program Support will submit a second request (CR Attachment 3) and the Check Register Claim Request spreadsheet, via e-mail, to the Contractor. The Contractor will have ten (10) business days from the date of the second e-mail request to submit copies of either the first paid claim on the checks where a single claim was paid or the third paid claim on the checks where multiple claims were paid.

Due to the Protected Health Information (PHI) included on the claims, the Contractor should submit the requested documents (if scanned copies) via FTP server, VPN server, Secure E-mail, or have the hard copies delivered directly to the Office of Program Support.

Requested Documents Received

On receipt of the copied claims, the Office of Program Support will verify all claim copies requested have been provided by the Contractor. After verifying that all documents are received, the Office of Program Support will sequentially number the claim copy documents.

Document Review Process

A Check Register Review Encounter Summary spreadsheet (CR Attachment 4) will be created by the Office of Program Support. The Office of Program Support will include in the spreadsheet specific information obtained from the claim document and the corresponding information found in the ADHS system for each of the claims.

The information obtained from each of the selected claims will be:

- Client ID
- Provider ID
- Begin Date of Service
- End Date of Service
- Service Code (Revenue Code, CPT/HCPCS, or NDC)
- Modifier
- Units
- Billed Amount
- Diagnosis Code

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The information obtained from the ADHS system for each of the claims is as follows:

- Claim Number
- Begin Date of Service
- End Date of Service
- Service Code (Revenue Code, CPT/HCPCS, or NDC)
- Modifier
- Units
- Billed Amount
- Diagnosis Code
- ADHS System Add Date

Encounter Errors

Each selected claim is reviewed for correctness, timeliness, and omission. Determinations for each of these categories are defined as follows:

Correctness: Any clean claim paid by the Contractor that has been submitted and accepted by ADHS where the ADHS system information does not match the corresponding claim information is considered a correctness error.

The ADHS system information is compared to the corresponding claim information keyed into the encounter summary spreadsheet. If an error is found, the claim will be flagged as a correctness error in the appropriate 'Error Found' column of the encounter summary spreadsheet.

The Contractors must adjust all correctness errors found and resubmit to ADHS within thirty (30) days from the date the final letter was sent to the Contractors.

Timeliness: Any encounter for a clean paid claim that is not submitted to ADHS within 210 calendar days from the end date of service billed is considered a timeliness error.

The number of days from the claim end date of service to the ADHS system add date is calculated by subtracting the claim end date of service from the ADHS system add date and the result of this calculation is auto-populated into the 'Day Count' column on the encounter summary spreadsheet.

Any reviewed claim that has been accepted into the ADHS system with a 'Day Count' greater than 210 days will be flagged with a Timeliness error in the appropriate 'Error Found' column of the encounter summary spreadsheet.

If both a correctness and timeliness error are found on a single encounter, only the correctness error is calculated into the score.

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Contractors must submit all clean paid claims to ADHS within 210 days from the end date of service.

Omissions: Any encounter for a clean paid claim that has not been submitted to ADHS and the number of days from the claim end date of service to the date the Office of Program Support receives the claim copies is greater than 210 days is considered an omission.

The number of days from the claim end date of service to the date the Office of Program Support receives the claim copies is calculated by subtracting the claim end date of service from the date the claim copies are received and the result of this calculation is auto-populated into the 'Day Count' column on the encounter summary spreadsheet.

If the number of days from the end date of service billed to the Office of Program Support received date is:

- less than 210 days, the Office of Program Support will make a note in the Comments field of the spreadsheet indicating that the claim has not yet been encountered to ADHS.
- greater than 210 days, the claim will be flagged as an omission error in the appropriate 'Error Found' column of the encounter summary spreadsheet.

If any omissions are identified during the course of the review, the score will automatically default to a Non Compliance 0% rating.

Contractors must submit all omitted claims to ADHS within thirty (30) days from the date the final letter was sent to the Contractors.

Scoring the Check Register Review

The Contractor's Check Register Review score is calculated by dividing the number of correct claims by the total number of claims reviewed. If any omissions are identified during the course of the review, the score will automatically default to a Non Compliance 0% rating. Score and compliance ratings are based on the Score Rating table below. Corrective action will be requested as applicable.

Score Rating	
90-100%	Full Compliance
75-89%	Substantial Compliance
50-74%	Partial Compliance
0-49%	Non Compliance

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Preliminary Findings

Within ten (10) business days from receipt of the check and claim copies, the Office of Program Support will prepare and issue the preliminary findings. The Office of Program Support will mail a hard copy of the Check Register Review Preliminary Letter (CR Attachment 5) and the Check Register Review Encounter Summary spreadsheet of the claims reviewed to the Contractor. An e-mail notification will also be sent to the Contractor with the Check Register Review Preliminary Letter and Check Register Review Encounter Summary spreadsheet attached.

Challenges

The Contractors have ten (10) business days to challenge the preliminary findings of a Check Register Review from the date of the preliminary letter. Challenges are to be e-mailed to the Office of Program Support within the ten (10) business days allowed.

Final Score

The Office of Program Support must take into consideration any timely challenges submitted by the Contractor before calculating the final score of the quarterly Check Register Review. The final score must be determined within five (5) business days from the date the Office of Program Support receives any challenges of the decision from the Contractor.

The Office of Program Support will mail a hard copy of the Final letter to the Contractor stating the number of errors and the final score (CR Attachment 6). An e-mail notification will also be sent to the Contractor with the Check Register Review Final Letter and Check Register Review Encounter Summary spreadsheet attached.

Correction of Errors

It is the expectation of the Office of Program Support that all correctness and omission errors will be corrected and/or submitted within thirty (30) days from the date of the final letter. The Office of Program Support will monitor the ADHS system to ensure corrections are made and omitted claims are submitted in a timely manner. Additionally, adjustments of an encounter must be completed and accepted into the ADHS system within 210 calendar days from the end date of service billed to be considered timely.

Admin Review Scoring

The Check Register Review process is monitored as part of the Contractor's yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review section of this manual.

Check Register Email Request Template

[Date of Request]

In accordance with the following schedule the Office of Program Support is beginning the [1st, 2nd, etc.] Quarter, fiscal year [year], Check Register Review process. Please submit Fee-For-Service (FFS) check registers for the months of [i.e. October, November, and December] [Year], to my attention by [10 Business Day's from Date of Request].

<u>Quarterly Review Month</u>	<u>Check Register Requested</u>
October 2006	1 st quarter, fiscal year 2007
January 2007	2 nd quarter, fiscal year 2007
April 2007	3 rd quarter, fiscal year 2007
July 2007	4 th quarter, fiscal year 2007

If you have any questions please do not hesitate to contact me.

[OPS Representative]

[Title]

[Phone]

[Fax]

[Email Address]

FFS Claims Request Template

Subject: [Identify current fiscal year and quarter], FFS Claims Request

Dear [Recipient],

Thank you for your response to the previous check register request. The ADHS/OPS has reviewed the check register for the quarter ending [Enter date], and has randomly selected a 20% sample of checks associated with the Fee-For-Service (FFS) paid claims. The next step in the review process will be to examine the paid FFS claims. Please submit copies of the third paid claim from each of the checks listed on the attached spreadsheet. If the identified check contains less than three paid claims, please provide a copy of the first paid claim. The documents should be sent to my attention by [End of Month].

Please feel free to contact me should you have any questions or require any additional information.

Thank you,
[OPS Representative]
[Title]
[Phone]
[Fax]
[Email Address]

Check Register Review Encounter Summary Template

Document Number	Client ID	Provider ID	Claim					ADHS System							PMMS								Error Found			Comments				
			Begin Date of Service	End Date of Service	Service Code	Modifier	Units	Billed Amount	Diagnosis Code	CIS / CRS Add Date	Day Count	CRN	Begin Date of Service	End Date of Service	Service Code	Modifier	Unit	Billed Amount	Diagnosis Code	PMMS Add Date	Encounters	Omission	Time	Service Code	Modifier	Diagnosis Code	Units	Billed Amount	Comments	
1																														
2																														
3																														
4																														
5																														
6																														
7																														

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CR Attachment 5

Check Register Review Preliminary Letter Template

[Date]

[Recipient]
[Contractor]
[Street Address]
[City, State Zip]

Dear [Mr. /Ms.] [Recipient]:

The Arizona Department of Health Services/Office of Program Support (ADHS/OPS) has concluded its preliminary findings of the [*first, second, etc.*] quarter, fiscal year [year] Fee-For-Service (FFS) Check Register Review. The claims in the attached Check Register Review Summary have been researched to determine if omission, correctness or timeliness errors exist. If a claim has both a correctness and timeliness error, only the correctness error has been calculated in the findings. If any omissions were identified during the course of the review, the score was automatically defaulted to a 0% rating.

Type of Error	Encounters Reviewed	Number of Errors	Compliance Rate
Correctness			%
Omission			%
Timeliness			%
Total			%

Score Rating	
90-100%	Full Compliance
75-89%	Substantial Compliance
50-74%	Partial Compliance
0-49%	Non Compliance

The preliminary score of this review is []%, which represents [*Score Rating*] Compliance. Any challenges must be presented to the Office of Program Support within ten (10) business days from the date of this letter. If you have any questions regarding your score or the Check Register Review process, please do not hesitate to contact [Name of OPS Representative] at (602) [Phone Number].

Sincerely,

[Name]
Encounters Unit Manager

Enclosures

c: Contract Compliance File

Office of Program Support
Operations and Procedures Manual

CR Attachment 6

Check Register Review Final Letter Template

[Date]

[Recipient]
[Contractor]
[Street Address]
[City, State Zip]

Dear [Mr./Ms.] [Recipient],

The Arizona Department of Health Services/Office of Program Support (ADHS/OPS) has completed the [*first, second, etc.*] quarter, fiscal year 2007 Fee-For-Service (FFS) Check Register Review. The claims in the Check Register Review Summary were reviewed to determine if omission, correctness or timeliness errors exist. If a claim has both a correctness and timeliness error, only the correctness error has been calculated in the findings. If any omissions are identified during the course of the review, the score will automatically default to a 0% rating.

Type of Error	Encounters Reviewed	Number of Errors	Compliance Rate
Correctness			%
Omission			%
Timeliness			%
Total			%

Score Rating	
90-100%	Full Compliance
75-89%	Substantial Compliance
50-74%	Partial Compliance
0-49%	Non Compliance

The final score of this review is [enter %]%, which represents [*Score Rating*] Compliance. It is the expectation of the Office of Program Support that all correctness errors will be corrected and submitted, in addition to all omitted claims, to ADHS within 30 days from the date of this letter. If you have any questions regarding your score or the Check Register Review process, please do not hesitate to contact [Name of OPS Representative] at (602) [phone number].

Sincerely,

[Name]
Encounters Unit Manager

Enclosures

c: Contract Compliance File

Office of Program Support

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Special Day Runs (SD)

Introduction

The Office of Program Support recognizes that there may be occasions when a Contractor will need to submit encounters, or demographics, separate from the normal nightly submission. These submissions are considered Special Day Runs and can be utilized to test changes made to the Contractor's system or to isolate a specific group of encounters.

Request Process

Special Day Runs will only be performed by ADHS on Wednesdays. The Contractor must coordinate with the Office of Program Support to schedule a Special Day Run. The following are the procedures that must be adhered to:

- The Contractor must submit an electronic request, including encounter volumes and specific details of what is being submitted and why, by noon on Tuesday.
- The Office of Program Support will review the request.
- The Office of Program Support will notify the Contractor of the request approval or denial by COB that Tuesday, via e-mail.
- If the request is approved; the Office of Program Support will copy ADHS/ITS to alert them that a special day run will be submitted the next day.
- A Contractor can not submit production data to be processed via the development/test system in an effort to ensure 90% accuracy.

Processing the Special Run Day

To successfully complete the special day run request the Contractor must:

- Ensure files are not placed on the FTP server prior to Wednesday morning (files placed on the server prior to Wednesday morning risk being picked up by the nightly processing)
- Ensure that the file provided contains the correct ADHS naming convention for a Special Day Run.
- Ensure the files are submitted to the FTP server by 10:00 a.m. on Wednesday.
- Once ADHS ITS has completed processing of the Special Day Run, the Office of Program Support will provide an electronic notification to the Contractor.

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Additional Required Reports

Monthly Claims Inventory Report

Contractors are required to submit the Monthly Claims Inventory Report listing total work in process comprised of unprocessed claims received from provider for adjudication. Unprocessed claims have not yet been paid, denied or pended. This report should be a snapshot at the end of the month. (Three monthly reports can be submitted each quarter.)

Monthly Pended Claims Report

Contractors are required to submit the Monthly Pended Claims Report listing the amount of claims received that are pended, the reason they are pended (e.g., internal claims review), and the length of time they have been in the Contractor's system as pended. This report should be a snapshot at the end of the month. (Three monthly reports can be submitted each quarter.)

Monthly Claim to Encounter Reconciliation

Contractors are required to submit the Monthly Claim to Encounter reconciliation containing elements as defined by ADHS (see below). (Three monthly reports can be submitted each quarter.) This format can be found at the following link

http://www.azdhs.gov/phs/ocshcn/crs/crs_policy_az.htm

Children's Rehabilitative Services													
[Site's Name]													
Paid Claims to Encounters Report													
[Month Reported]													
Form Type A	December 2005												
Service Month:	Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05	Jan-06	Feb-06	Mar-06	Apr-06	May-06	Jun-06	Year to Date
CRS Paid Claims	952	800	620	745	520								3737
Paid Claims Submitted to ADHS as Encounters	952	650	545	358	580								3085
Percent Claims/Encounters to ADHS	100.00%	81.25%	87.90%	48.05%	93.55%								82.55%
Paid Claims not Submitted to ADHS as Encounters	0	150	75	387	40	0	0	0	0	0	0	0	652
Accepted Encounters	932	600	495	333	580	0	0	0	0	0	0	0	2920
Unresolved Rejected Encounters	15	20	80	20	10	0	0	0	0	0	0	0	95
Resolved Rejected Encounters	5	30	20	7	10	0	0	0	0	0	0	0	70
Total Accepted Encounters	937	630	515	338	570	0	0	0	0	0	0	0	2990
Percent Total Accepted Encounters	98.42%	96.92%	94.50%	94.41%	98.28%								96.92%
January 2006													
Service Month:	Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05	Jan-06	Feb-06	Mar-06	Apr-06	May-06	Jun-06	Year to Date
CRS Paid Claims	952	800	620	745	520								3737
Paid Claims Submitted to ADHS as Encounters	952	650	545	358	580								3085
Percent Claims/Encounters to ADHS	100.00%	81.25%	87.90%	48.05%	93.55%								82.55%
Paid Claims not Submitted to ADHS as Encounters	0	150	75	387	40	0	0	0	0	0	0	0	652
Accepted Encounters	932	600	495	333	580	0	0	0	0	0	0	0	2920
Unresolved Rejected Encounters	15	20	80	20	10	0	0	0	0	0	0	0	95
Resolved Rejected Encounters	5	30	20	7	10	0	0	0	0	0	0	0	70
Total Accepted Encounters	937	630	515	338	570	0	0	0	0	0	0	0	2990
Percent Total Accepted Encounters	98.42%	96.92%	94.50%	94.41%	98.28%								96.92%
February 2006													
Service Month:	Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05	Jan-06	Feb-06	Mar-06	Apr-06	May-06	Jun-06	Year to Date
CRS Paid Claims	952	800	620	745	520								3737
Paid Claims Submitted to ADHS as Encounters	952	650	545	358	580								3085
Percent Claims/Encounters to ADHS	100.00%	81.25%	87.90%	48.05%	93.55%								82.55%
Paid Claims not Submitted to ADHS as Encounters	0	150	75	387	40	0	0	0	0	0	0	0	652
Accepted Encounters	932	600	495	333	580	0	0	0	0	0	0	0	2920
Unresolved Rejected Encounters	15	20	80	20	10	0	0	0	0	0	0	0	95
Resolved Rejected Encounters	5	30	20	7	10	0	0	0	0	0	0	0	70
Total Accepted Encounters	937	630	515	338	570	0	0	0	0	0	0	0	2990
Percent Total Accepted Encounters	98.42%	96.92%	94.50%	94.41%	98.28%								96.92%
Definitions	Accepted Encounters = Encounters accepted on the first submission to ADHS Unresolved Rejected Encounters = Encounters rejected by ADHS and still unresolved Resolved Rejected Encounters = Encounters previously rejected by ADHS, but since resolved and accepted Total Accepted Encounters = Sum of Accepted and Resolved Rejected Encounters Percent Total Accepted Encounters = Percentage of Paid Claims Submitted to ADHS as Encounters that are Accepted by ADHS												

Admin Review Scoring

The Submission of Required Reports is monitored as part of the Contractor's yearly Administrative Review.

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Coordination of Benefits

Introduction

Contractors are required to take reasonable measures to determine the legal liability of third parties who are liable to pay for covered services.

Policy

Contractors shall cost-avoid a claim if it establishes the probable existence of a third party or has information that establishes that third party liability exists. However, if the probable existence of third party liability cannot be established or third party liability benefits are not available to pay the claim at the time the claim is filed, the Contractor must process the claim. If a Contractor knows that the third party insurer will not pay the claim for a covered services due to untimely claim filing or as the result of the underlying insurance coverage (e.g., the service is not a covered benefit), the Contractor shall not deny the service, deny payment of the claim based on third party liability, or require a written denial letter if the service is medically necessary. The Contractor is required to reimburse providers for previously recouped monies if the provider was subsequently denied payment by the primary insurer based on untimely filing limits or lack of prior authorization and the member failed to disclose additional insurance coverage other than AHCCCS.

Admin Review Scoring

The Coordination of Benefits process is monitored as part of the Contractor's yearly Administrative Review.

Claim Audit Process

Contractors must have a procedure to identify and timely recoup erroneously paid claims. The contractor must implement systems at the Clinic level to audit claims processing prior to payment i.e. the contractor audits 5% or high dollar claims prior to check issuance.

The contractor will submit evidence of this process with the quarterly deliverables.

Admin Review Scoring

The Claim Audit process is monitored as part of the Contractor's yearly Administrative Review.

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Edit Alerts (EA)

Introduction

An Edit Alert is the method used by the Office of Program Support to notify the Contractors of system changes that may impact the Contractor.

Notifying Contractors of System Changes

Whenever possible the Office of Program Support will notify the Contractor 90-days prior to the implementation of system modifications. There may be instances when the 90-day notification is not possible i.e. legislative requirements or emergency production corrections. If one of these situations occurs, the Contractor will be notified as soon as possible. These notifications will be communicated thru Edit Alerts, and reiterated in the monthly “Tidbits” newsletter.

Create and Distribute the Edit Alert

Once an SSR is written for a system modification, and the originator has obtained all of the required signatures, the original yellow SSR will be delivered to the IT Department and a copy will be delivered to the Testing Coordinator.

It is the responsibility of the Testing Coordinator to draft an Edit Alert. The Edit Alert will contain the following:

- The system change
- Scenarios (if applicable)
- The SSR number
- The expected implementation date

The completed Edit Alert is e-mailed to the Contractors and distributed to the Office of Program Support and ITS staff. A second Edit Alert will be e-mailed to advise the Contractors that testing of the change has been completed and the exact date production will be updated.

Edit Alert Database

To view and/or modify an Edit Alert in the database (EA Attachment 1), take the following steps.

1. Open the “Edit Alert” database by double-clicking on the desktop shortcut. If the shortcut is not available, go to the following target location: M:\Program Support Staff\Edit Alert Database\Edit_Alert_db, then double-click on the Edit_Alert_db.mdb file.
2. Select “New/Changed Edit Alert” from the Main menu.

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3. To review an Edit Alert, you can either scroll through the Edit Alerts, which are tracked by number, or do a search with specific wording, creation date, or Edit Alert number.
4. To modify an Edit Alert, locate the Edit Alert that needs modification or revision and populate the Edit Alert with new text. No save option is available because the MS Access database immediately saves each entry.
5. To add an Edit Alert, go to the record beyond the last Edit Alert for a blank form. Populate all Edit Alert database fields, keeping in mind that the Edit Alert will be distributed to all Contractors and Office of Program Support staff. Information entered should be specific and match the SSR.
6. A copy of each Edit alert that is distributed can be found in the M:\Program Support Staff\Edit Alert Database\Edit Alert Snapshots folder.
7. To create a snapshot of any Edit Alert, click on the box with the “camera and document”. A snapshot of the Edit Alert will be created in the F:\ drive.
8. Anytime an Edit Alert is sent, whether internally for Office of Program Support/IT staff or out to the Contractors, it must be in the form of a snapshot (EA Attachment 2)

Implementation

Once implementation takes place, an Edit Alert will be e-mailed to advise the Contractor of the exact date production will be updated.

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EA Attachment 1

Edit Alerts Database

Microsoft Access - [Edit_Alert_FRM]

File Edit View Insert Format Records Tools Window Help

MS Sans Serif 8 B I U

Tracking Number: [] Reference Title: REVISED - Billing Limitation Override Capability

Notification Date: 10/13/2006 Implemented:

Expected Implementation Date: 10/6/2006

Change_Description

CIS has been updated to allow the use of an override to bypass billing limitations on procedure codes T1019, S5110, H2014, H2014 HQ and H2017 billed in conjunction with Foster Care codes S5140, S5145 as well as all accommodation revenue codes for dates of service after 6/30/06. A new valid value of "F" has been added to the override field for this function.

Scenarios (if Applicable):	Edit_Function
It is the expectation that therapeutic foster care services may be billed in conjunction with support services, based on behavioral health recipient needs. Persons who are in need of support services, for specific specialized needs that cannot be addressed through their therapeutic foster care, must have access to those identified services. In those circumstances override "F" should be used.	

Create Snapshot Print This Screen

Record: 14 of 59

Form View NUM

Sample Edit Alert

New/Changed Edit Alert

Tracking Number: 69

Implemented:

Reference Title Demographic - AXISIII Field Change

Notification Date: May 25, 2007

Expected Implementation Date: July 1, 2007

ADHS will provide the RBHA's with 90 days notice when possible

Change Description: Establish a field that stores behavioral health recipient's current medical diagnoses. (SSR 2178)

The current data set submitted by the T/RBHA to BHS utilizes five 2-byte fields, which indicate a generic category of the recipient's current medical condition(s). ADHS must identify whether the behavioral health recipient reports as having any of 36 AHCCCS-specified diagnoses.

The new field will identify specified conditions of behavioral health recipients for which coordination of care should be provided. The Coordination of Care performance measure and other potential analysis will be extrapolated through examination of this data.

The existing AXISIII field(s) will remain in the data set, but field-specific edits for records with an intake date of MM/DD/YYYY (system change date) or later will be ignored/modified. Data submissions with an intake date of MM/DD/YYYY (system change date) or later will not require completion of the existing AXISIII field(s).

The new field will store up to three 2-byte codes. A maximum of three unique codes may be stored per individual record. Either Not Applicable (N/A) or a valid code must be entered. If N/A is entered as the first of the 3 possible entries, then N/A must also be entered for subsequent entries. Exact codes, other than N/A, cannot be repeated in an individual record. If more than one field is completed with any valid value other than N/A the codes must be unique.

This change will enable ADHS/DBHS to be more in sync with AHCCCS' system and will decrease the number of encounters pending at AHCCCS.

Miscellaneous Encounter Clarifications

Correct Reporting of Ancillary Charges

Incorrect Billing

UBs submitted in this manner will fail ADHS pre-processor edit, N228 UB ancillary line with zero/blank units or dollars.

Line	Rev Cd	Units	Billed	NonCovChg	Paid	Description
01	134	5	2960.00	000.00		Psych/3&4 Bed
02	251	1	0.00	000.00		Drugs/Generic
03	301	32	0.00	000.00		Lab/Chemistry
04	302	1	0.00	000.00		Lab/Immunology
05	305	1	0.00	000.00		Lab/Hematology
Total			2960.00		2960.00	

Line	Rev Cd	Units	Billed	NonCov Chg	Paid	Description
01	134	5	3650.00			Psych/3&4 Bed
02	251	1	450.00			Drugs/Generic
03	301	32	400.00			Lab/Chemistry
04	302	1	150.00			Lab/Immunology
05	305	1	150.00			Lab/Hematology
Total			4800.00		2960.00	Total paid for entire claim

Correct Billing

The providers should bill UBs to the Contractor exactly as they would bill any private insurance carrier. Ancillary revenue codes, units, and amounts must be reported on all inpatient UBs. The rates reported should not be the contracted amount or expected to payment amount but the actual amount of the service.

Line	Rev Cd	Units	Billed	NonCov Chg	Paid	Description
01	134	5	3650.00	690.00		Psych/3&4 Bed
02	251	1	450.00	450.00		Drugs/Generic
03	301	32	400.00	400.00		Lab/Chemistry
04	302	1	150.00	150.00		Lab/Immunology
05	305	1	150.00	150.00		Lab/Hematology
Total			4800.00		2960.00	Total paid for entire claim

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Correct Reporting of Same Day Admit/Discharge Encounters

Inpatient encounters for clients who are admitted and discharged on the same date will be allowed for ancillary services only. These UB92/UB04 inpatient encounters with the same start and end date must be submitted as follows:

Line	Revenue Code	Units	Billed	NonCov Charge	Paid	Description
01	134	1	1200.00	1200.00	0.00	Psych/3&4 Bed
02	251	1	450.00	0.00	450.00	Drugs/Generic
03	301	32	400.00	0.00	400.00	Lab/Chemistry
04	302	1	150.00	0.00	150.00	Lab/Immunology
05	305	1	150.00	0.00	150.00	Lab/Hematology
		Total	2350.00		1150.00	Total paid for claim

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Duplicate Encounter Logic

Introduction

ADHS Office of Program Support has system edits in place to prevent exact duplicate encounters from being accepted into the system. In addition ADHS Office of Program Support has potential duplicate edits that require review and intervention on the part of the Contractor. Duplicate logic is applied to an encounter when another encounter exists in the database or on the file being submitted by the Contractor. The following are the logic used in these edits for each form type

Exact Duplicate Logic

UB92/UB04 will reject when the fields listed below are the same

- Client ID
- Provider ID
- Dates of service
- First 2 digits of bill type

1500 will reject when the fields listed below are the same

- Client ID
- Provider ID
- Service/Procedure Code
- Date of service
- Modifier
- Place of service

Pharmacy/NCPDP will reject when the fields listed below are the same

- Client ID
- Provider ID
- NDC
- Dispense date

Potential Duplicate Logic

Two additional edits exist that use similar logic to the duplicate logic and when failed will require review and intervention by the Contractor. There are no override capabilities available for these edits.

1500 will reject when the fields listed below are the same

- Client ID
- Provider ID
- Service/Procedure Code
- Modifier
- Place of service

However, dates of service are overlapping

- Fail N254-overlapping dupe in file
- Fail N255-overlapping dupe in database

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Pharmacy/NCPDP will reject when the fields listed below are the same

- Client ID
- NDC
- Dispense date

However, provider is different

- Fail N256-NDC/different provider in file for date of service
- Fail N257-NDC/different provider in database for date of service

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Resync Requests

Introduction

The Office of Program Support recognizes that there may be occasions when a Contractor will need to have a file of all data as reflected in the ADHS computer system. This type of request is called a “resync” and may be utilized by the Contractor for the purpose of performing a reconciliation or due to processing problems.

Request Process

The Contractor must coordinate with the Office of Program Support to schedule a “resync”. The Contractor will send an e-mail to the Office of Program Support and will copy the Encounter Manager with a request for a “resync”. The Request must contain the following information:

- Contractor name and GSA (if applicable)
- Type of resync(s) requested:
 - ✓ AHCCCS Eligibility
 - ✓ Closure
 - ✓ Demographic
 - ✓ Encounter
 - ✓ Intake
- Date range:
 - ✓ Fiscal year (July 1 – June 30)
 - ✓ Calendar year (January 1 – December 31)
 - ✓ Any other time increment (quarter, month, etc.)

The Office of Program Support will forward the e-mail notification to the identified IT contact and will copy ADHS/ITS Management.

The Office of Program Support will be notified by ADHS/ITS when the files are available on the FTP Server. The Office of Program Support will then notify the Contractor via e-mail with the file names.

Grievance and Appeals Research (GA)

Introduction

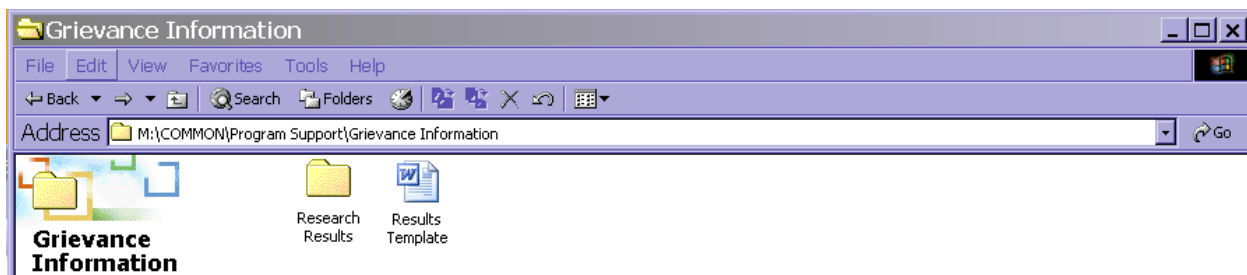
The Office of Program Support assists the Office of Grievance and Appeals in researching the AHCCCS claim processing of appeals filed by providers.

Referral Process

Providers submit appeals to the Office of Grievance and Appeals where they are reviewed to determine if ADHS or the Contractor is responsible. If it is determined that ADHS is responsible the appeal is assigned a docket number and a confirmation of receipt letter is sent to the Provider. When the appeal is regarding the incorrect processing or denial of a claim a *Provider Claim Dispute Research Request* (GA Attachment 1) form is completed. A copy of the information submitted by the provider and the *Provider Claim Dispute Research Request* form is delivered to the Office of Program Support for research.

Research Initiated

Upon receipt of the research request the Office of Program Support will utilize the AHCCCS PMMIS claim system to determine if the claim was processed correctly. Each claim submitted to AHCCCS by the provider for the service identified in the appeal must be addressed. An *Office of Program Support Grievance Research* form (GA Attachment 2) will be completed and screen prints from PMMIS will be attached to support findings. A template of the *Office of Program Support Grievance Research* form can be found at M:\COMMON\Program Support\Grievance Information\Results Template.



At a minimum the following PMMIS screen prints must be attached to the *Office of Program Support Grievance Research* form:

Denied Claims

- CL144 (XCLAM), Claim Browse Gateway
Enter recipient ID, provider ID, and dates of service then filter by typing either filter or "fil" in the CMD field to display only claims related to the grievance
- CL064 (SVTOP), Claim Service-Topics
Place cursor on the specific claim found on the Claim Browse Gateway screen and enter "V", this is the claim that will be displayed on CL064.

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- CL180, CL181 or CL182 (CLMFA, CLMFB, CLMFC), claim view screens
The claim view can also be accessed by placing a “V” on the Condensed Claim View line of the Claim Service Topics screen.
- CL108 (SCACT), Scorecard-work Actions
An explanation of the denial code can be displayed by placing the cursor on the reason code and pressing the F3 key. Each denial reason should be addressed.

The scorecard can also be accessed by placing a “V” on the Latest Work Action line of the Claim Service Topics screen.

- All PMMIS screens necessary to support the decision

Incorrectly Paid Claims

- CL144 (XCLAM), Claim Browse Gateway
Enter AHCCCS ID, provider ID, and dates of service then filter to display only claims related to the grievance
- CL064 (SVTOP), Claim Service-Topics
Place cursor on the specific claim found on the Claim Browse Gateway screen and enter “V”, this is the claim that will be displayed on CL064.
- CL180, CL181 or CL182 (CLMFA, CLMFB, CLMFC), claim view screens
The claim view can also be accessed by placing a “V” on the Condensed Claim View line of the Claim Service Topics screen.
- CL085 (ACACC), Claim Accounting Detail
This screen will display the actual payment and payment date.
- CL075 (ACPRC), Claim Pricing Detail
This screen will display how AHCCCS calculated the payment.
- All PMMIS screens necessary to support the decision

Additionally any PMMIS screen used to make a determination about the processing of the claim should be attached. These screens may include but are not limited to:

- CL233 (BCASE), Behavioral Health Case Browse
Enter the AHCCCS ID and dates of service then filter to display any prior authorizations issued. When the appropriate prior authorization is found enter an “E” on the line to see details.
- CL234 (BEVNT), BH Case-Event Browse
Displays all of the sequences authorized, enter an “E” to view a specific date range
- CL235 (BACTV), BH Event-Activity Browse
The Activity will display the actual diagnosis, dates and procedure authorized.

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Entering a “V” in the SEL field for the line will further identify who entered the authorization and the date issued.

Note: All prior authorization discrepancies should be thoroughly researched including reviewing ADHS internal files.

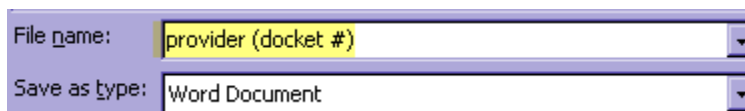
- **CM097, Client Contact Tracking System**
Screen is used to identify any phone call received by AHCCCS regarding the claim in question. Enter either “P” and the provider ID or “R” and the recipient (client) ID. The system will display 30 days at a time. Search back from the current date to the date of the first claim submission.
- **RP216/RP285, Inquire BHS/FYI Data**
Screen is used to verify client has behavioral health enrollment in a tribe on the date of service. RP285 is used to look up claims with dates of enrollment prior to 9/1/07.
- **Image of the Claim**
If there is a discrepancy between the keyed claim and the claim copy submitted by the provider in the grievance packet AHCCCS should be contacted to request a copy the claim submitted to AHCCCS.
- Any PMMIS screen, web-site or policy may be used to support a decision and should be included in the Office of Program Support response.

Response Due Date

Each referral from the Grievance and Appeals Unit will include a “Response is due no later than” date. The documented research must be completed by the Office of Program Support and returned to the Grievance and Appeals Unit on or before the indicated date.

Saving Research Results

Every *Office of Program Support Grievance Research* form when completed should be saved in the following folder M:\COMMON\Program Support\Grievance Information\Research Results. The document should be saved by listing the provider and docket number as the file name.



The image shows a file save dialog box with two fields. The first field is labeled 'File name:' and contains the text 'provider (docket #)'. The second field is labeled 'Save as type:' and contains the text 'Word Document'. Both fields have a small downward-pointing arrow on the right side, indicating they are dropdown menus.

Hearing

The Office of Grievance and Appeals will review the findings from the Office of Program Support and apply any legal statutes to determine the outcome of the Grievance. The provider will be advised of the final decision and may request a hearing if not pleased with the ruling. In the event the provider requests a hearing the Office of Program Support reviewer will be required to testify.



Division of Behavioral Health Services

Office of Grievance and Appeals

150 North 18th Avenue, Suite 230
Phoenix, Arizona 85007
(602) 364-4575
(602) 364-4591 FAX
Internet: www.azdhs.gov

IANET NAPOLITANO, GOVERNOR
JANUARY CONTRERAS, ACTING DIRECTOR

PROVIDER CLAIM DISPUTE RESEARCH REQUEST

TO: Office of Program Support
FROM: Grievance & Appeals Coordinator
DATE: _____
RE: PROVIDER: _____
DOCKET#: _____

Please research the following issue(s) and provide a recommended decision regarding payment of the claim(s) at issue. Anything used in formulating that decision (prior authorization screens, denial letters, policies, rules, etc.) should be referenced, and the documentation needs to be copied for the appeal record.

ISSUE(S):

Non-Payment of Claims

A response is needed by no later than: _____.

Thank you

Office of Program Support Grievance Research

Provider:
Provider ID:
Docket #:
OPS Analyst:
Phone #:

The Office of Program Support has completed reviewing the referred grievance and the following are the results of that research. All resolutions are based solely on claims processing guidelines and do not supersede a denial of the claim for other legal issues.

Client Name:
AHCCCS ID:

Date(s) of Service:

AHCCCS CRN:

Denial Reasons:

Last Denial Date:

Resolution:

\$ Owed: \$

Data Validation

Office of Program Support/Contractor Ride-Along (RA)

Introduction

The purpose of the data validation ride-along is to evaluate the process of the Contractor to ensure they are accurately and thoroughly performing their data validation studies. Additionally, it is an opportunity for the Office of Program Support to perform provider data validation studies with the Contractors similar to the yearly AHCCCS study.

The Office of Program Support will accompany each Contractor on a minimum of two provider data validation studies and at least one follow-up review per GSA per quarter. It is the Data Validation Specialist's responsibility to schedule the quarterly ride-along with the Contractor and to ensure that each GSA is reviewed.

Sample Selection Process

The Contractor is required to perform a data validation review in accordance with:

- Behavioral Health - *Data validation Procedure Code Review Schedule (RA Attachment 1)*
- Children's Rehabilitative Services - established sample criteria (APIPA to submit)

A minimum of 10% of the providers per GSA must be reviewed each quarter. Mandatory follow-up reviews are not included in the 10% requirement. Provider refers to all providers under contract with a Contractor or a Contractor network that deliver services to clients (any provider that the Contractor will receive a claim/encounter from). The Contractor is responsible for establishing the sample size, randomly selecting the medical records to be reviewed and notifying the provider of the upcoming data validation study. Sample size should be reflective of the number of encounters submitted by the provider during the review quarter. For example, if a provider only submitted 10 encounters during the quarter all 10 should be reviewed. However, if the provider submitted 1,000 encounters the Contractor should review a percentage that would reflect a reasonable sample. The Data Validation Specialist will review all services in the medical record for the review quarter not just the services identified in the sample selection process.

Quarterly Data Validation Review Schedule

<u>Review Quarter</u>	<u>Dates of Service Reviewed</u>
Ending March 31	July, August & September of previous year
Ending June 30	October, November & December of previous year
Ending September 30	January, February & March of current year
Ending December 31	April, May & June of current year

Example: In June 2008 the quarterly review will be for services provided in October, November and December of 2007.

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- Client name and ID, enter from the medical records or from the Contractor's printout of services found in the Contractor's system.
- Date of Birth (DOB), enter from the medical records or from the Contractor's printout of services found in the Contractor's system.
- Provider ID, enter from the medical records or from the Contractor's printout of services found in the Contractor's system.
- Assessment Date, review medical records and indicate the date of the most recent assessment and/or the date of the assessment appropriate for the services reviewed.
- Date of Service (DOS), review medical records and indicate the dates of the services within the review period.
- Service Code, review medical records and list the appropriate service code for the description provided.
- Modifier, review medical records and list the appropriate modifier for the description provided.
- Place of Service, review medical records and list the appropriate place of service code for the description provided.
- Units, review medical records and list the appropriate units for the service description provided.
- Diagnosis Code, review medical records and list the appropriate diagnosis code for the description provided.

Contractor's System-can be completed on site or when you return to ADHS. This information will be used to determine if the Contractor received the encounter correctly and it was not sent to CIS correctly or if the provider submitted the information incorrectly to the Contractor.

- Date of Service (DOS), review Contractor's system file and indicate the dates of the services within the review period.
- Service Code, review Contractor's system file and list the service code billed to the Contractor.
- Modifier, review Contractor's system file and list the modifier billed to the Contractor.
- Place of Service, review Contractor's system file and list the place of service code billed to the Contractor.
- Units, review Contractor's system file and list the units billed to the Contractor
- Diagnosis Code, review Contractor's system file and list the diagnosis code billed to the Contractor.

Per CIS/CRS- using the ADHS Encounter Information System the Data Validation Specialist will complete after returning to ADHS. Entering the client, provider and date of service information the Specialist will see a list of all the services received as encounters.

- ICN, list the internal control number assigned to the located encounter
- DOS, list the date of service as it was submitted to CIS on the encounter.
- Service Code, list the service code as it was submitted to CIS on the encounter.
- Modifier, list the modifier as it was submitted to CIS on the encounter.
- Place of Service, list the place of service as it was submitted to CIS on the encounter.
- Units, list the units of service as it was submitted to CIS on the encounter.
- Diagnosis Code, list the diagnosis code as it was submitted to CIS on the encounter.
- Rec'd Date, list the received date of the appropriate encounter as it was submitted to CIS.

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Contract Review- using the a copy of the providers contract and the Client Information system the Data Validation Specialist will complete after returning to ADHS. Entering the contracted amount for the services provided and the amount billed on the encounter.

- Rate identified in contract, list the contracted amount per service provided
- Rate on encounter, list the billed amount on each encounter found

Error Found-this section will be used to indicate any error found when the Per Audit section is compared to the Per ADHS Encounter Information System section.

- Omission, an omission error will be called when a service is identified in the medical record but is not found in CIS.
- Timeliness, a timeliness error will be called when the received date in CIS is greater than 210 days from the end date of service.
- Correctness/Service Code, a service code correctness error will be called when the service code from the medical record does not match the service code in CIS. A correctness error on the service code includes the modifier and place of service.
- Correctness/Diagnosis, a diagnosis code correctness error will be called when the diagnosis code does not match the diagnosis code in CIS.
- Correctness/Units, a units error will be called when the do not match the units in CIS.
- Non-billable, a non-billable error will be called when documentation is found in the chart that does not substantiate a billable service or when an encounter is found in CIS but documentation was not found in the chart.
- Comments, the comments section will be used to further explain any errors or additional findings from the review. The comments will also indicate if the error is also in the Contractor's system.

Exit Interview

The Contractors are required to perform an exit interview with each provider at the time of the review. The Data Validation Specialist(s) at the ride-along will attend the exit interview and will be available to assist with provider questions.

After the Ride-Along

Within five business days after the ride-along, the Data Validation Unit will prepare and issue a summary of the ride-along, which will include the number of records reviewed, the number of errors found, the review score, any training issues identified, and if required, requests for corrective action. DBHS will give the Contractor a date by which the omission errors must be submitted. The Contractor will also be required to correct and resubmit the correctness errors by that same date.

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Type of Error	Number Reviewed	Number of Errors	Error Rate
Correctness: Service Code			%
Correctness: Modifier			%
Correctness: Place of Service			%
Correctness: Units			%
Correctness: Diagnosis Code			%
A single encounter may have more than one correctness error, however the encounter will only be counted once in the total calculation and as a result these columns will not total.			
Timeliness			%
Omission			%
Subtotal of ALL Errors Found			%
	Encounter Total	Encounters w/Errors	
Total			%

The Contractor has two weeks to review the response and either challenge the findings or provide information on when DBHS can expect all corrections to be completed. The Data Validation unit will review the response submitted by the Contractor who will then be notified, within 2 business days, if the plan is accepted. If the response is a challenge, the Data Validation Specialist reviewing the challenge must provide a response to the Contractor within 5 business days.

The Contractor will be responsible for including the ADHS/DBHS site-visit in their final reports for the quarterly data validation studies.

In the event any one provider has an error rate greater than 10%, the Contractor is required to submit an implementation plan for that provider and perform a second data validation study for that provider within six months. The Contractor will include the date of the follow-up review in the implementation plan. After completion of the follow-up study, the Contractor will provide DBHS with documentation of the findings.

If fraud is suspected at any time during the ride-along, the suspected fraud will be reported to the Corporate Compliance Officer at ADHS.

Data Validation Review Code Schedule

Code	Description	Mod.	Place of Service	Code	Description	Mod.	Place of Service
Codes to be Reviewed for July, August & September Dates of Service				Codes to be Reviewed for January, February & March Dates of Service			
Inpatient Services				Rehabilitation Services			
114	Psychiatric room and board, private			H0020	Alcohol and/or drug services; methadone administration and/or service	HG	11, 22, 50, 53, 71, 72, 99
116	Detox, private			H0025	Behavioral health prevention/promotion education service (services to target population to affect knowledge, attitude and/or behavior)		11, 12, 50, 53, 71, 72, 99
124	Psychiatric room and board, semi private two beds			H0034	(Health promotion) medication training and support, per 15 minutes		11, 12, 50, 53, 71, 72, 99
126	Detox, semi private			H2010	Comprehensive medication services, per 15 minutes	HG	04, 11, 20, 50, 53, 72, 99
134	Psychiatric room and board, semi private three bed and four beds			H2014	Skills training and development, per 15 minutes		11, 12, 50, 53, 71, 72, 99
136	Detox, 3&4 bed			H2014	Group skills training and development, per 15 minutes per person	HQ	11, 12, 50, 53, 71, 72, 99
154	Room/board Ward Psychiatric			H2017	Psychosocial rehabilitation living skills training services, per 15 minutes		11, 12, 50, 53, 71, 72, 99
156	Detox, ward			H2025	Ongoing support to maintain employment, per 15 minutes		11, 12, 50, 53, 71, 72, 99
183	Home pass			H2026	Ongoing support to maintain employment, per diem		11, 12, 50, 53, 71, 72, 99
189	Bed hold			H2027	Psychoeducational service (pre-job training and development), per 15 minutes		11, 12, 50, 53, 71, 72, 99
Residential Services				Codes to be Reviewed for April, May & June Dates of Service			
S5140	Foster care adult, per diem		12, 99	Support Services			
S5145	Foster care child, per diem		12, 99	H0038	Self-help/peer services (peer support), per 15 minutes		11, 12, 50, 53, 71, 72, 99
H0018	Behavioral health short-term residential, without room and board		99	H0038	Self-help/peer services group, per 15 minutes	HQ	11, 12, 50, 53, 71, 72, 99
H0019	Behavioral health long-term residential (non-medical, Non-acute), without room and board		99	H2016	Comprehensive community support services(peer support), per diem		11, 12, 50, 53, 71, 72, 99
Day Programs				S5110	Home care training, family (family support), per 15 minutes		11, 12, 50, 53, 71, 72, 99
H2012	Supervised behavioral health day treatment, per hour up to 5 hours		53, 71, 72, 99	S5150	Unskilled respite care, not hospice, per 15 minutes		12, 99
H2015	Comprehensive community support services, supervised day program per 15 minutes, 6-10 hours		53, 71, 72, 99	S5151	Unskilled respite care, not hospice, per diem		12, 99
H2019	Therapeutic behavioral services day program, per 15 minutes up to 5 3/4 hours		53, 71, 72, 99	T1016	Office case management by behavioral health professional, each 15 minutes	HO	11, 50, 53, 71, 72
H2019	Therapeutic behavioral services day program, per 15 minutes up to 5 3/4 hours	TF	53, 71, 72, 99	T1016	Out of office case management by behavioral health professional, each 15 minutes	HO	12, 22, 99
H2019	Home therapeutic behavioral services day program, per 15 minutes up to 5 3/4 hours	TF	12	T1016	Office case management, each 15 minutes	HN	11, 50, 53, 71, 72
H2020	Therapeutic behavioral services, per diem		53, 71, 72, 99	T1016	Out of office case management by BHT, each 15 minutes	HN	12, 22, 99
H2020	Home therapeutic behavioral health day services, per diem		12				
H0036	Community psychiatric supportive treatment day program, face-to-face, per 15 minutes		53, 72, 99				

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Data Validation Review Code Schedule

Codes to be Reviewed for July, August & September Dates of Service				Codes to be Reviewed for April, May & June Dates of Service			
Day Programs (continued)				Support Services (continued)			
H0036	Community psychiatric supportive treatment medical day program, face-to-face, per 15 minutes	TF	53, 72, 99	T1019	Personal care services, per 15 minutes (not for inpatient or residential care facilities)		04, 11, 12, 20, 50, 53, 71, 72, 99
H0036	Home community psychiatric supportive medical treatment face-to-face, per 15 minutes		12	T1020	Personal care services, per diem (not for inpatient or residential care)		11, 12, 50, 53, 71, 72, 99
H0036	Home community psychiatric supportive medical treatment face-to-face, per 15 minutes	TF	12	Crisis			
H0037	Community psychiatric supportive treatment medical day program, per diem		53, 72, 99	S9484	Crisis intervention mental health service, per hour		21, 51, 99
H0037	Home community psychiatric supportive medical treatment program, per diem		12	S9485	Crisis intervention mental health services, per diem		21, 51, 99
Codes to be Reviewed for October, November & December Dates of Service				H2011	Crisis intervention service, per 15 minutes		04, 11, 12, 20, 23, 50, 53, 71, 72, 99
Treatment Services				H2011	Crisis intervention service via 2 person team, per 15 minutes	HT	04, 11, 12, 20, 23, 50, 53, 71, 72, 99
H0001	Alcohol and/or drug assessment		99				
H0031	Mental health assessment, by non-physician 30 minute increments		04, 11, 12, 20, 22, 23, 50, 53, 71, 72, 99				
H0002	Behavioral health screening to determine eligibility for admission		11, 12, 22, 50, 53, 71, 72, 99				
H0004	Home, individual behavioral health counseling and therapy, per 15 minutes		12, 31, 32, 33, 99				
H0004	Out of office, family behavioral health counseling and therapy with client present, per 15 minutes	HR	12, 99				
H0004	Out of office, family behavioral health counseling and therapy without client present, per 15 minutes	HS	12, 99				
H0004	Office, individual behavioral health counseling and therapy, per 15 minutes		11, 22, 50, 53, 72				
H0004	Office, family behavioral health counseling and therapy with client present, per 15 minutes	HR	11, 22, 50, 53, 72				
H0004	Office, family behavioral health counseling and therapy without client present, per 15 minutes	HS	11, 22, 50, 53, 72				
H0004	Office, group behavioral health counseling and therapy, per 15 minutes	HQ	11, 22, 31, 32, 33, 50, 53, 72, 99				

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Ride-Along Follow Up (Technical Assistance) (TA)

Introduction

In an effort to improve the accuracy of medical records the Office of Program Support will utilize the outcome of completed Ride-Alongs to identify providers that would benefit from additional technical assistance.

Identifying Providers

- Multiple Ride-along reviews without evidence of significant improvement
- Provider expressing interest in additional technical assistance during a review
- A provider with a specific type of error identified in repeat reviews

Contacting the Provider

At the ride-along the Data Validation Specialist or the Contractor will advise the Provider that technical assistance is available. The Data Validation Specialist will obtain contact information from the Provider.

The Office of Program Support will:

- Schedule the visit which will include time to review a of sample medical records.
- Advise the Provider to pull a small sample of charts with current services and any charts the provider would like the Office of Program Support to review.
- Communicate to the provider that the technical assistance is intended for the staff that are documenting in the chart, staff that are billing services and/or the office manager

Training Material Development

- Standard package which will consist of:

- Important Web Links
- Common Documenting Mistakes
- Sample Progress Note Formats
- FAQs

- Provider/issue specific documents

Materials deemed appropriate after review of ride-along findings

Process at Site

- Review sample medical records
- Compare current medical records to problems noted during ride-along
- Provide sample based technical assistance include sign-in sheet for each session

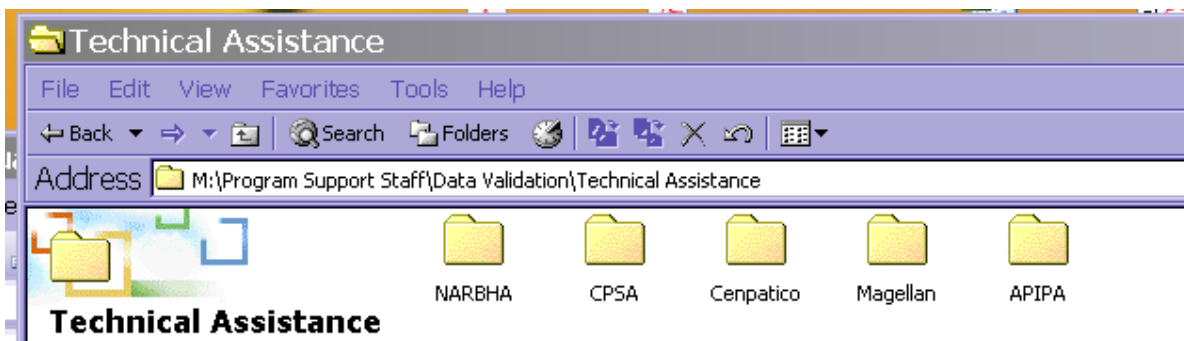
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- Allow time for questions

Document of Visit

Within 10 days of the technical assistance the completed Technical Assistance Documentation form (TA Attachment 1) will be sent to the provider and the Contractor.

In addition electronic documentation will be maintained in the Office of Program Support shared folder at M:\Program Support Staff\Data Validation\Technical Assistance in the appropriate Contractor's folder.



ADHS/Office of Program Support

Technical Assistance Documentation

Provider: _____
Address: _____

Contractor: _____
Contractor Contact: _____

Contact Person: _____
Contact Number: _____

Date of Initial Contact: _____

Date Scheduled: _____

Time: _____

In Attendance:

_____	_____
_____	_____
_____	_____
_____	_____

Materials Provided:

- | | |
|---|--|
| <input type="checkbox"/> Important Web Links | <input type="checkbox"/> Common Documentation Mistakes |
| <input type="checkbox"/> Sample Progress Note Formats | <input type="checkbox"/> FAQs |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Specific Issues Addressed:

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Error Rate Monitoring (ER)

Introduction

The purpose of the data validation ride-along is to evaluate the process of the Contractor to ensure they are accurately and thoroughly performing their data validation studies. The error rate monitoring reports will be scored as part of the Contractor’s yearly Administrative Review.

After the Ride-Along

Within five business days after the ride-along, the Data Validation Unit will prepare and issue a summary of the ride-along, which will include the number of records reviewed, the number of errors found, the review score, any training issues identified, and if required, requests for corrective action. The Office of Program Support will give the Contractor a date by which the omission errors must be submitted. The Contractor will also be required to correct and resubmit the correctness errors by that same date. Correctness errors include diagnosis code errors.

Type of Error	Number Reviewed	Number of Errors	Error Rate
Correctness: Service Code			
Correctness: Modifier			
Correctness: Place of Service			
Correctness: Units			
Correctness: Diagnosis Code			
A single encounter may have more than one correctness error, however the encounter will only be counted once in the total calculation			
Timeliness			
Omission			
	Encounter Total	Encounters w/Errors	Error Rate
Total			

In the event any one provider has an error rate greater than 10%, the Contractor is required to submit an implementation plan for that provider and perform a second data validation study for that provider within six months. After completion of the follow-up study, the Contractor will provide the Office of Program Support with documentation of the findings.

Implementation Plan

The Contractor is required to respond to the Office of Program Support within 10 business days from the date of the Ride-along letter with an implementation plan on any review with an error rate greater than 10%. The implementation plan must include the following:

- o The date the follow-up Data Validation study will be performed

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- The date error correction will be completed-the Contractor will provide the Office of Program Support with ICNs when the errors have been corrected
- The date omissions will be submitted-the Contractor will provide the Office of Program Support with the ICNs of the submitted encounters
- The date non-billable/non-documented services will be voided from the Contractor's system and the ADHS data system-the Contractor will provide the Office of Program Support with ICNs of the voided encounters
- The date training will be provided-the Contractor will provide the Office of Program Support with a copy of the sign-in sheet and a brief summary of the training content.

Monitoring

After the letter is sent to the Contractor the Data Validation Specialist will enter the following information in the *Completed Data Validation Ride-Alongs* log found at M:\Program Support Staff\Data Validation.

- Name of provider reviewed
- RBHA
- Review Date
- Contract Year
- Review Quarter
- Date of Service Span Reviewed
- Initial (I) or Follow-up (F)
- Date of Initial or Previous Follow-up Review if Applicable
- Error Rate
- Date the Implementation Plan is due from the Contractor
- Implementation Plan Status
- Implementation Plan Received Date
- Date Implementation Plan Response Letter Sent
- Date Corrections Expected
- Encounters Corrected in CIS?
- Date Encounters Corrected in CIS
- Date of Follow-up Audit
- Follow-up Audit Error Rate
- Comments

Implementation Plan Received

After the Implementation Plan is received from the Contractor the Data Validation Specialist will validate the following:

- Did the Contractor identify the date the follow-up Data Validation study will be performed?
- Did the Contractor identify the date error correction will be completed?
- Did the Contractor identify the date omissions will be submitted?

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- Did the Contractor identify the date non-billable/non-documented services will be voided from the Contractor's system and CIS?
- Did the Contractor identify the date training will be provided?
- Are the dates provided within 30 days from the date of the original letter?

Implementation Plan Complete/Accepted

If the information provided is complete the Data Validation Specialist will notify the Contractor within 5 business days of acceptance (ER Attachment 1). The Data Validation Specialist will update the *Completed Data Validation Ride-Alongs* log with the Implementation Plan status and the date corrections are expected.

Implementation Plan Received/Incomplete

If the information provided is incomplete or not specific the Data Validation Specialist will notify the Contractor within 5 business days that a revision is required (ER Attachment 2). The Contractor will have 10 business days from the date of the second letter to submit a revised implementation plan. The Data Validation Specialist will update the *Completed Data Validation Ride-Alongs* log with the Implementation Plan status and the new expected receipt date for the plan. When the revised plan is received and accepted the Data Validation Specialist will follow the guidelines listed above for an accepted implementation plan.

Implementation Plan Not Received

If the Office of Program Support has not received the Contractor's implementation plan by COB on the due date the Data Validation Specialist will send the Contractor an e-mail the next business day requesting a status. If there is no response to the e-mail or the implementation plan is not received by the promised date the Data Validation Specialist will send a letter to the Contractor requesting the plan (ER Attachment 3). The Contractor will be given 5 days to submit the requested implementation plan or further action will be taken. In addition, the Data Validation Specialist will update the *Completed Data Validation Ride-Alongs* log with the Implementation Plan status and the new expected receipt date for the plan.

Correction of Errors

The Office of Program Support will give the Contractor a date by which all errors discovered during the ride-along must be corrected. The Data Validation Specialist is responsible for monitoring the ADHS data system to ensure all corrections have been submitted by the identified date. If corrections have not been received the Data Validation Specialist will send the Contractor a letter (ER Attachment 4) advising that corrections must be submitted.

Maintaining Completed Data Validation Ride-along log

It is the Office of Program Support Data Validation Specialist's responsibility to update and maintain the *Completed Data Validation Ride-Along* log.

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Administrative Review Scoring

Contractor Quarterly reports and follow-up after ride-alongs are monitored as part of the Contractor's yearly administrative review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review Section of this manual.

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ER Attachment 1

[Date]

[Recipient/Title]
[Contractor]
[Street Address]
[City, State Zip]

Dear [Mr./Ms.] [Recipient]:

The Arizona Department of Health Services, Office of Program Support (ADHS/OPS) has received and reviewed [Contractor's] Implementation Plan regarding the Ride-Along for [Provider] that took place on [Month Day Year].

Your Implementation Plan for [Provider] has been accepted. The corrections addressed must be submitted to ADHS/OPS by [the date provided by the Contractor].

[Contractor] will be responsible for informing ADHS/OPS when the encounters have been submitted either via e-mail or letter. [Contractor] will also submit the corrected ICN's for the encounters to ADHS/OPS.

ADHS/OPS may attend the follow-up Data Validation Audit for [Provider]. If ADHS/OPS attends the follow-up Data Validation Audit, the ADHS Data Validation Specialist will notify [Contractor] via telephone call or e-mail.

Should you have any questions regarding this matter or need assistance, please contact [Name and phone number of Data Validation Specialist].

Sincerely,

[Name]
[Data Validation Specialist]

c: [Contractor CFO and/or other identified Contractor Staff], [Contractor]
Contract Compliance File

Office of Program Support
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ER Attachment 2

[Date]

[Recipient/Title]
[Contractor]
[Street Address]
[City, State Zip]

Dear [Mr./Ms.] [Recipient]:

The Arizona Department of Health Services, Office of Program Support (ADHS/OPS) has received [Contractor's] Implementation Plan regarding the Ride-Along for [Provider] that took place on [Month Day Year].

Your Implementation Plan for [Provider] has been reviewed and found to be unsatisfactory.

ADHS/OPS requests that [Contractor] submit a revised Implementation Plan for [Provider]

within 10 business days of receiving this letter. The revised Implementation Plan must include

the following points:

[Enter specific bullets as required]

- Date when the correction of billing errors will be complete
- Date when the submission of omissions will be complete
- Date when the voiding of non-billable services from Contractor's system and CIS will occur
- Date when the services not documented in the chart will be voided from RBHA's system and CIS or submission of proof of service
- Date the follow-up Data Validation Study for the [Provider] will occur

Should you have any questions regarding this matter or need additional assistance, please contact [Name and phone number of Data Validation Specialist]

Sincerely,

[Name]
Data Validation Specialist

C: [Contractor CFO and/or other identified Contractor Staff], [Contractor]
Contract Compliance File

Office of Program Support
Operations and Procedures Manual

ER Attachment 3

[Date]

[Recipient/Title]
[Contractor]
[Street Address]
[City, State Zip]

Dear [Mr./Ms.] [Recipient]:

The Arizona Department of Health Services, Office of Program Support (ADHS/OPS) has not yet received the Implementation Plan for the Ride-Along that took place on [Month Day Year] for the [Provider].

[Contractor] is required to submit to ADHS/OPS an Implementation Plan for the Ride-Along that took place on [Month Day Year] for the [Provider] by [Exact Date 5 business days] upon receiving this letter. If the aforementioned letter is not received by ADHS/OPS by the due date it is within the realm of ADHS/OPS to seek action against [Contractor].

[Contractor] Implementation Plan must contain the following:

- Correction of billing errors
- Submission of omissions
- Voiding of non-billable services from Contractor's system and CIS
- Voiding of services not documented in the chart from RBHA's system and CIS or submission of proof of service
- Date of follow-up Data Validation Study for [Provider]

It is imperative [Contractor] submit the outline and Implementation Plan as it is stated in the guidelines set by ADHS/OPS for the Data Validation Ride-Along process.

Should you have any questions regarding this matter or need additional assistance, please contact [Name and phone number of Data Validation Specialist]

Sincerely,

[Name]
Data Validation Specialist

c: [Contractor CFO and/or other identified Contractor Staff], [Contractor]
Contract Compliance File

Office of Program Support
Operations and Procedures Manual

ER Attachment 4

[Date]

[Recipient/Title]

[Contractor]

[Street Address]

[City, State Zip]

Dear [Mr./Ms.] [Recipient]:

The Arizona Department of Health Services, Office of Program Support (ADHS/OPS) has not yet received the Corrections for the Ride-Along that took place on [Month Day Year] for the [Provider].

[Contractor] is required to submit to ADHS/OPS the corrected ICN's for all errors found during the Ride-Along that took place on [Month Day Year] for the [Provider] by [Date]. If the aforementioned corrections are not received by ADHS/OPS by the due date it is within the realm of ADHS/OPS to sanction [Contractor].

It is imperative [Contractor] submit the corrections as it is stated in the guidelines of the Office of Program Support Operations and Procedures Manual.

Should you have any questions regarding this matter or need additional assistance, please contact [Name and phone number of Data Validation Specialist]

Sincerely,

[Name]

Data Validation Specialist

c: [Contractor CFO and/or other identified Contractor Staff], [Contractor]
Contract Compliance File

Office of Program Support Operations and Procedures Manual

Quarterly Report (QR)

Introduction

The Contractors are required to perform data validation studies quarterly on their providers in accordance with the established schedules. Each record must be reviewed for omission, correctness and timeliness errors. In addition the Quarterly Data Validation reports will be scored as part of the Contractor's yearly Administrative Review.

Reporting Findings

The Contractor is required to report the findings of the data validation studies to the Office of Program Support no later than the 15th of the month following the end of the quarter. For example, for quarter ending September 30, 2007, the reports are due by October 15, 2007. If the reports aren't received by the 15th the Data Validation Specialist will contact each Contractor for a status. Findings should be reported using the Contractor *Data Validation Study Results* form (QR Attachment 1). A separate form should be completed for each provider reviewed. Action to be taken by the Contractor needs to be specific; the following are examples of acceptable and unacceptable entries.

Example:

Contractor Quarterly Data Validation Study Results

Review Period: _____

Contractor: _____ GSA: _____ Date of Review: _____

Provider Name & ID: _____ Date of Exit Interview: _____

Provider's Score: _____ Date Final Report Sent: _____

	Client Name & ID	# of Services Reviewed	Number of Errors by Type			Action taken by RBHA	Provider Follow-up	Did DBHS Attend Y/N
			Omission	Correctness	Timeliness			
Unacceptable	M. Mouse	20	3	14	not reviewed	will provide training. Provider to correct claims		blank
Acceptable	Minnie Mouse A123456789	20	3	14	5	Provider to be trained 9/13/07 on proper use of diagnosis codes. Provider advised that omissions and errors must be corrected by 9/30/07	Training provided 9/13/07, sign-in sheets and a brief summary of training content attached. 10/1/07 verified that all omissions and errors have been corrected.	Y or N

Definitions of required fields:

- Contractor -Name and GSA
- Provider Name and ID (list one provider per sheet)
- Provider's Score-This is the number of errors identified divided by the number of services reviewed.
- Review Period-This is the quarter reviewed for example quarter ending March 31.
- Date of Exit Interview-the exit interview must be performed at the close of the review
- Date of Final Report-must be within 10 business days from the date of the review

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- Client Name-List all clients reviewed for the provider
- # Of Services-Total number of services reviewed per client
- Number of Errors by Type
 1. Omission-The service was documented in the provider’s medical record but was not in the Contractor s system.
 2. Correctness-The service documented in the medical record does not match the service in the Contractor’s system.
 3. Timeliness-The Contractor must review the submission of the claim in accordance with their established submission time frames.
- Action Taken by Contractor -This information need to be specific and should include the date training will be provided, date omissions will be submitted, date errors will be corrected and any other corrective action required of the provider.
- Provider Follow-up
 1. Training- Contractor will provide the date of training and will attach a copy of the sign-in sheet and brief summary of the training content.
 2. Omission/Correctness Error- Contractor will provide the date of error(s) correction and will provide the ICN of the corrected encounter.

The Contractor will be responsible for including the ADHS/DBHS site-visit in their final reports for the quarterly data validation studies.

Report Received

After the report is received from the Contractors the Data Validation Specialist will validate that the information provided is complete and will notify the Contractor via e-mail of acceptance or rejection within 2 business days of receipt. The Contractor will have 2 business days to complete and resubmit the report. The Data Validation Specialist will then review each report and will provide feedback to the Contractor within in 10 business days after the acceptance of the report. The Data Validation Specialist will review each report for the following:

Did Contractor Meet Quarterly Requirement		Yes/No
Contractor submitted Quarterly Report by 15 th		
Contractor submitted the report in the proper format with all required fields		
Contractor Reviewed 10% of provider network		
Contractor reviewed records for omissions		
Contractor reviewed records for timeliness		
Contractor reviewed records for correctness		
Contractor’s actions are specific		
Contractor performed exit interview with provider at end of every review		
Contractor sent provider report of review findings within 10 days of review		
Divide total yes answers by total possible (9) to get score.	Score:	

Did the Contractor submit/correct encounters in error in a timely manner (30 days):

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A percentage will be determined by dividing the total number of errors corrected by the total number of errors. The two percentages will be added together and divided by two to acquire the final percentage, which will be scored against the standard Administrative Review scale (see below):

Score Rating	
90-100%	Full Compliance
75-89%	Substantial Compliance
50-74%	Partial Compliance
0-49%	Non Compliance

The feedback provided to the Contractor (QR Attachment 2) will include the findings of each of the above monitored items and may require the Contractor to make corrections to their process if issues are discovered. Additionally, the Data Validation Specialist may perform a follow-up study on passing as well as failing providers reported by the Contractor.

Administrative Review Scoring

The Quarterly report is monitored as part of the Contractor's yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review Section of this manual.

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QR Attachment 2

Arizona Department of Health Services
Office of Program Support

150 N. 18th Avenue, Suite 200
Phoenix, Arizona 85007-3228
(602) 364-4558
(602) 364-4736 FAX

JANET NAPOLITANO, Governor
JANUARY CONTRERAS, Director, Acting

[Date]

[Recipient/Title]
[Contractor]
[Street Address]
[City, State Zip]

Dear [Mr./Ms.] [Recipient]:

The Arizona Department of Health Services, Office of Program Support (ADHS/OPS) has received and reviewed [Contractor's] Data Validation Quarterly report for the quarter ending [Month Day, Year]. [Contractor] has received a score of [Percentage] which represents a rating of [score] compliance.

For the quarter ending [Month Day, Year] [Contractor] was responsible for correcting [enter total number of errors expected to be corrected] encounters. To date [Contractor] has corrected [enter total number of errors that have been corrected] encounters. [if all encounters have not been corrected enter language that missing need to be corrected]

[Identify any changes/corrections required of the Contractor i.e. ADHS/OPS requires that the submission of future Quarterly Reports contain a copy of the sign in sheet and a brief summary of the training content. In addition the Contractor should include provider follow-up omission/correctness errors that contain the date the errors were corrected and the ICN of the corrected encounters].

Should you have any questions regarding this matter or need additional assistance, please contact [Name and phone number of Data Validation Specialist]

Sincerely,

Kayla Caisse
Data Validation Manager

c: [Contractor CFO and/or other identified Contractor Staff], [Contractor]
Contract Compliance File

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AHCCCS Study (AS)

Introduction

The Centers for Medicare and Medicaid Services (CMS) requires AHCCCS to oversee and submit progress reports on the encounter data collection process. AHCCCS performs yearly data validation studies to meet this requirement. All AHCCCS contractors and subcontractors are contractually required to participate in this process. In addition to meeting the CMS requirement, the data validation studies enable AHCCCS to monitor and improve the quality of encounter data.

Sample Selection Process

The sample size for each contractor is re-calculated each year. The size is determined using the detailed “Random Sample Calculation” methodology documented in the *AHCCCS Encounter Data Validation Technical Document*. The sample size indicates the number of encounters/services AHCCCS intends to review for the data validation study.

Medical Record Collection Process

AHCCCS creates a report for each Contractor identifying the clients selected for review. The Data Validation Specialist will send the Contractor the appropriate portion of the report and a computer disk that identifies the clients that are included in the data validation study. The Contractor is responsible for identifying which provider/facility provided the services to the client and where the medical records are housed. The Contractor must forward the list of providers/facilities to AHCCCS by the date specified. AHCCCS will prepare a letter to notify the provider about the data validation process and its requirements. The provider/facility must locate the medical records for each of the clients requested and must forward the medical records to AHCCCS by the date specified.

Type of Errors Examined

AHCCCS will review the medical records to determine what services the clients received. The services received will be compared to the encounters submitted to determine what types of errors, if any, exist. To comply with CMS requirements three types of errors are examined.

- Correctness-an error is assessed when the dates of service, procedure code and or diagnosis code in the encounter were incorrectly coded according to the medical documentation
- Timeliness- an error is assessed when the encounter is received by AHCCCS more than 240 days from the end of the month in which the service was rendered, or the effective date of the enrollment
- Omission- an error is assessed when provider documentation indicates that medical services were rendered, but an encounter was never received at AHCCCS

Preliminary Report Distribution, Review and Challenge

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A preliminary report will be prepared and will be distributed to each Contractor. This is the only opportunity that the Contractor /provider has to challenge the errors identified by AHCCCS. The Contractor is responsible for identifying any errors that they want to challenge in the AHCCCS preliminary report. The Contractor should review the preliminary error report and perform a comparison to data from the client's medical records and/or the Contractor's system. Each challenge must be supported by additional documentation. Types of additional documentation include, but are not limited to:

- PMMIS screen prints
- CIS screen prints
- Screen prints from the Contractor's internal system

All documentation required to support the challenge including the *Data Validation Challenge Form* (Attachment 1) must be submitted to the Office of Program Support by the date specified. If the documentation does not support the challenge, the challenge will not be processed and forwarded to AHCCCS.

Methods for Challenging Errors

The type of evidence that is required to successfully challenge an error is dependent on the type of error identified. This section describes some the techniques that may be useful in challenging data validation errors.

Remember: This is the ONLY opportunity for the Contractor to challenge the errors identified by AHCCCS.

Correctness Errors-The Contractor or the provider must:

- Submit documentation outside of the medical record supporting that the code or date on the encounter is the clinically correct code or date
- Show that the ICD9 diagnosis code in question did not require a 4th or 5th digit at the time the service was provided

Timeliness Errors-The Contractor or the provider must:

- Document that the encounter could not be submitted in a timely fashion at AHCCCS because of system problems at AHCCCS during the relevant timeframe.
- Show that the encounter referenced is an adjustment and that the original encounter and the adjustment were both submitted in the correct time frame.

Omission Errors-The Contractor or the provider must document that the encounter should never have been sent to AHCCCS because:

- The client was not eligible for Title XIX or XXI services
- The service was not covered by AHCCCS
- The provider was not eligible to bill for Title XIX or XXI services

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Challenge Received

The Data Validation Unit will review the preliminary report and the challenges submitted by the Contractors. The Data Validation Unit will create one unified challenge response containing all documented challenges noted by the Contractor. This along with all the supporting documentation submitted by the Contractors, will be forwarded to AHCCCS.

Final Report

AHCCCS will review the challenges and documentation submitted. This review will result in a final report that is distributed to the appropriate Contractor. Included with the final report is the sanction assessed by AHCCCS. The AHCCCS sanction calculation process is a complex, multi-step process. Details regarding the AHCCCS sanction calculation process can be found in the *AHCCCS Encounter Data Validation Technical Document*. The ADHS/DBHS process for passing the AHCCCS Sanction on to the Contractor is as follow, ADHS/DBHS takes the total sanction dollar amount and divides it by the total number of errors from AHCCCS, which results in a sanction amount per error. The sanction amount per error is then multiplied by the number of errors for each Contractor resulting in a final sanction amount per Contractor. This process is valid for both the “A” and “B” Study.

Collection of Sanction

ADHS/DBHS will withhold the final sanction amount from the capitation paid to the Contractor each month.



Arizona Department of Health Services
Office of Program Support Services
150 N. 18th Avenue, Suite 200
Phoenix, Arizona 85007

DBHS Received Date

Data Validation Challenge

Preliminary Results are the Contractor's Only Opportunity to Challenge the AHCCCS Data Validation Findings

Contractor: Cenpatico2 Cenpatico4 NARBHA Magellan CPSA3 CPSA5 APIPA

Contractor Representative: _____ **Phone:** _____

Client Information:

Client Name: _____

CIS Client ID: _____ AHCCCS Client ID: _____

Challenged Error:

Omission Correctness Timeliness

AHCCCS Tracking #: _____

ADHS ICN: _____ AHCCCS CRN: _____

Explanation of Challenge: _____

Please note: Without proper and legible documentation attached the challenge will not be forwarded to AHCCCS and the challenge will be considered unsubstantiated.

Required Documentation:

ADHS IT Screen Print PMMIS Screen Print Contractor Internal Screen Print Other Information as Needed to Support Claim

For ADHS Use Only: _____ ADHS Reviewer: _____

Challenge Referred to AHCCCS _____ Date: _____

Challenge Determined to be ADHS Responsibility

Challenge Determined to be Contractor Responsibility

Comment: _____

Office of Program Support

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Testing

Introduction

The Office of Program Support performs tests on system changes that affect the encounter, demographic or enrollment data systems at the Arizona Department of Health Services. The Office of program support will work closely with the IT department to ensure that changes perform as expected.

Test Case Preparation

A System Service Request (SSR) is initiated to request any type of data system change. After the SSR is written the originator will obtain all of the required signatures and a copy will be distributed to the Test Team to create a testing folder.

Test Folder

The Test Folder will contain the following:

- A copy of the signed System Service Request
- Copies of Edit Alerts
- Documentation
- Test Scenarios
- Data System screen prints
- Test results

Testing

The IT department will notify the Test Unit when a change/enhancement is ready to be tested. The Test Unit will enter all applicable scenarios to ensure the change/enhancement works as expected. Additional non-change related scenarios will be entered to ensure the change did not affect previously working programs. The expected outcomes are listed on the test scenarios worksheet (Testing Attachment 1). Test results are documented in the SSR data base. The Test Unit will work closely with the IT department until the change/enhancement is approved and the SSR is “signed-off”.

Contractor Notification

The Contractor will be notified via Edit Alert of changes/enhancements that are ready to be moved into production.

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Testing Attachment 1

SSR -	Test# 1 -	Date
-------	-----------	------

Scenario:	
Expected results:	
Results as Expected?	
Errors:	

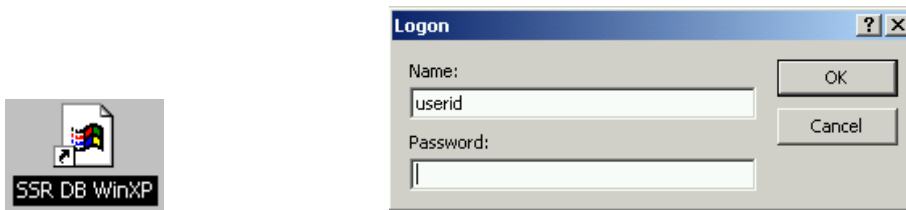
System Service Requests

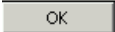
Introduction

A System Service Request (SSR) is the method used by the Office of Program Support to notify DBHS/ITS of system changes/modifications needed in the Client Information System (CIS). In addition an SSR can be used to request research of encounter issues or to request reports.

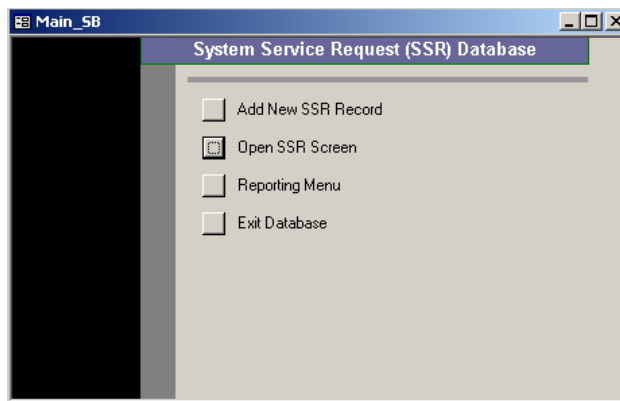
Create an SSR

The Office of Program Support staff can access the SSR database using the following icon found on their desktop. The user ID and Password will then be entered.



- 1) Type in your **User ID** and **Password**. (*Note: User IDs and passwords are case sensitive*)
- 2) Press the **OK** button. 

SSR Main Menu



- **Add New SSR Record** – Open SSR Input Screen to enter a new SSR
- **Open SSR Screen** – Open SSR Input Screen to view all existing SSRs
- **Reporting Menu** – Go to Report Menu
- **Exit Database** – Exit system

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Adding a New SSR Record

The following information is to be completed to add a new or change an existing SSR.

SSR INFO TAB

SSR FORM TABLE2 : Form

SYSTEM SERVICE REQUEST (SSR) INPUT FORM
* Required fields in yellow *

SSR ID: 0003 SSR TITLE: UB-92 Unit Validation Edit

SSR INFO | INFO2/REVISIONS | ITS | BHS/TESTING | SIGNATURES

REQUESTED BY: Ruth Bateman REQ DATE: 2/9/2002
CONTACT:

DIVISION REQUESTED BY: OPS CLASSIFICATION: Production Fix
COMPLETION BY: PRIORITY: High
REQUESTED IMPLEMENT: PRIORITY ORDER:
RBHAS NOTIFIED: STATUS: Completed - Implemented
DOCUMENTATION ATTACHED: Yes COMPLETED: 5/20/2002

SSR DESCRIPTION:
Add revenue-codes starting with 15 to edit. Add acceptable bill-types that go with patient-status 20 to edit.

Record: 3 of 810

Note: Required fields are in yellow.

- **SSR ID** – Number automatically generated by SSR database
- **SSR TITLE** – Brief description of request
- **REQUESTED BY** - Name of requester + **DATE** - Date request was created
- **CONTACT** – Contact for questions regarding the request, if different from the Requester
- **DIVISION REQUESTED BY** - Requester's Division (pull down list)
- **COMPLETION BY** - If applicable, date the request needs to be completed
- **REQUESTED IMPLEMENTATION** - If applicable, requested date for implementation
- **RBHAS NOTIFIED** - If applicable, date Contractors were notified of change
- **DOCUMENTATION ATTACHED** - Yes/No (default = "No")
- **CLASSIFICATION** - Type of request (pull down list, default = "Enhancement")
- **PRIORITY** - Requester's priority for request (pull down list, default = "Normal")
 - ❖ *Emergency*: Agency services immediately negatively affected
 - ❖ *High*: Important to Agency/Division - Complete after any emergencies
 - ❖ *Normal*: Change request will increase production - Complete as scheduled
- **PRIORITY ORDER** - Order in which requests will be prioritized and worked
- **STATUS** - Status of request (read-only, see ITS Tab to edit this field)
- **COMPLETED** - Date request was completed (read-only, see ITS Tab to edit this field)
- **SSR DESCRIPTION** - Detailed description of request

Office of Program Support Operations and Procedures Manual

INFO2/REVISIONS TAB

SSR FORM TABLE2 : Form

SYSTEM SERVICE REQUEST (SSR) INPUT FORM

* Required fields in yellow *

HELP! SAVE PRINT Print UA Signoff

SSR ID: 0003 SSR TITLE: UB-92 Unit Validation Edit

SSR INFO INFO2/REVISIONS ITS BHS/TESTING SIGNATURES

SCENARIO:

BENEFITS:
It will include revenue codes starting with 15 in the edit check. It will ensure that discharge bill-types are used with patient status 20 (client deceased).

REVISION DATE: 6/6/2002

SSR REVISION:
If revenue code starts with 11, 12, 13 or 15, then
if it the last day of the month (all Ubs) or
If it is a provider type 78, B1 B2 or B3 and it is the first day of the month or
If it is a provider type 78, B1, B2 or B3 and the revenue code is 18x, or
if ((patient-status = 30 AND
bill-type = '112' or '113' or '122' or '123') OR
(patient-status = 20 AND
bill-type = '111' or '114' or '121' or '124') OR
(patient-status is '02' thru '06' AND
bill-type = 111))

Record: 3 of 810

- **SCENARIO** - A descriptive example of the problem or change
- **BENEFITS** - A description of any/all benefits of the request
- **REVISION DATE** - Date of revision (*Note: If there are multiple revisions, note the revision date for each one in the SSR Revision description field*).
- **SSR REVISION** - If applicable, a description of change to original request

After the SSR form has been completed it must be signed by the Office of Program Support Manager or the DBHS CFO.

Distribution of an SSR

After an SSR is written and the originator has obtained all of the required signatures the SSR is placed in the designated Administrative Staff's In-Basket. The Administrative Staff will then:

- Make 2 copies of the SSR including any attached documentation
- Hand deliver the original SSR including all attached documentation to the IT department
- Deliver one copy including documentation to the SSR Originator
- The remaining copy will be used to create a testing folder which will be delivered to the Testing Unit.

It is the responsibility of the SSR Originator to follow-up on the progress/completion of the SSR request

Training Requirements

Introduction

Contractors are required to provide on-going training to their providers for submission of claim/encounter/demographic data.

Encounter Related Training

The Office of Program Support Encounter Unit requires the Contactor to provide evidence of on-going training that has been provided to their providers. The following evidence will be submitted as a monthly deliverable:

- Sign-in sheets for any training that took place in the previous month
- A brief description of the training provided

Data Validation Related Training:

The Office of Program Support Data Validation Unit requires the Contractor to provide training to any provider with a data validation review error rate greater than 10%. The following evidence will be submitted with each Quarterly Data Validation Report:

- Sign-in sheets for any training that took place in the previous quarter
- A brief description of the training provided

Office of Program Support Training Available

The Office of Program Support has a Trainer available to provide training at the Contractor Sites. Any Site that would like to arrange training should contact the Office of Program Support.

Administrative Review

Introduction

Annually the ADHS conducts an Administrative review of each Contractor. Monitoring and Scoring of the Administrative Review Standards is performed throughout the review year based on the following established policies/procedures.

Standard

The Contractor has a Data Validation Review process to ensure that all providers are submitting accurate, complete and timely claims for all services performed and corrects errors identified in the Data Validation process in a timely manner.

Scoring

Did Contractor Meet On-site Requirement		Yes/No
Contractor submitted Quarterly Report by 15 th		
Contractor submitted the report in the proper format with all required fields		
Contractor Reviewed 10% of provider network		
Contractor reviewed records for omissions		
Contractor reviewed records for timeliness		
Contractor reviewed records for correctness		
Contractor's actions are specific		
Contractor performed exit interview with provider at the end of every review		
Contractor sent provider report of review findings within 10 days of review		
Divide total yes answers by total possible (9) to get score.	Score:	

Contractor submitted/corrected encounters in error in a timely manner (30 days):

For the Administrative Review period, each Ride-along worksheet will be reviewed to determine the number of errors/omissions that have been corrected. A percentage will be determined by dividing the total number of errors corrected by the total number of errors. The two percentages will be added together and divided by two to acquire the final percentage, which will be scored against the standard Administrative Review scale (see below):

Score Rating	
90-100%	Full Compliance
75-89%	Substantial Compliance
50-74%	Partial Compliance
0-49%	Non Compliance

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Standard

The Contractor ensures that FFS claims are accurately encountered to ADHS.

Scoring

The score for this standard reflects the score from the Office of Program Support's FFS Check Register Reviews for the average of all quarters reviewed and scored during FY 07.

For the Administrative Review period, each Contractor should have completed four separate FFS Check Register Reviews with four separate percentages. All four of the percentages will be added together and divided by four to acquire the final percentage, which will be scored against the standard Administrative Review scale:

Score Rating	
90-100%	Full Compliance
75-89%	Substantial Compliance
50-74%	Partial Compliance
0-49%	Non Compliance

Standard

The Contractor submits complete, accurate and timely intake and demographic information

Scoring

There are two elements that apply when evaluating the final score for meeting demographic data processing requirements defined by ADHS: the percentage of timely demographic submissions and the percentage of complete/accurate demographics during the review period. Here is how each element is rated:

- **90% Accuracy /Completeness**

The total of all demographics accepted / the total amount of all demographics submitted = percentage

- If the percentage is 90% or above Score = 100%
- If the percentage is below 90% Score = 0%

- **Timeliness**

(This element's scoring will be based on the 7 Report [Initial Demographic] provided by Quality Management.)

The total number of demographics > 55 days / the total number of demographics = percentage

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The percentages from both elements will be added together and then divided by two, resulting in the final percentage that will be scored against the standard Admin Review scale:

Score Rating	
90-100%	Full Compliance
75-89%	Substantial Compliance
50-74%	Partial Compliance
0-49%	Non Compliance

Standard

The Contractor has developed and maintained a system that meets claims/encounter data processing requirements defined by ADHS/DBHS.

Scoring

There are four elements that apply when evaluating the final score for meeting claims/encounter data processing requirements defined by ADHS: Meeting a 90% Acceptance Rate, meeting performance measured by the 210 Report, meeting the Contractor's submission schedule and meeting performance measured by the Aged Pends Report. Here is how each element is rated:

- **90% Acceptance**

The total number of all encounters accepted / the total amount of all encounters submitted = passing/failing percentage

- If the final percentage is 90% or above Score = 100%
- If the final percentage is below 90% Score = 0%

- **210 Report**

The total amount 210 PD / the total amount of encounters accepted = percentage

Take the percentage and subtract by 100 to receive the final score

- **Submission Schedule**

Each Contractor should have 12 months worth of submission data to review for the Admin Review period (7/1/06 – 6/30/07). If a Contractor does not meet its predetermined submission schedule, for any one of the three form types, within a month, it will be determined that the Contractor has not met the requirements of its submission schedule.

There are 12 possible points a Contractor can obtain. Each month the Contractor meets its submission schedule requirements; 1 point will be awarded. Each month the Contractor fails to meet its submission schedule requirements; 0 points will be awarded.

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The total points awarded / total months = percentage

(12/12) =	100%
(11/12) =	92%
(10/12) =	83%
(9/12) =	75%
(8/12) =	67%
(7/12) =	58%
(6/12) =	50%
(5/12) =	42%
(4/12) =	33%
(3/12) =	25%
(2/12) =	17%
(1/12) =	8%
(0/12) =	0%

- **Aged Pends**

The total number of pends > 120 days / the total number of pends = percentage

Take the percentage and subtract from 100 to receive the final percentage for this element

Each element should now have its own percentage. Add all acquired percentages together and then divide by 4 (the sum of all the elements). This will result in the final percentage, for this standard, which should be scored against the standard Admin Review scale:

Score Rating	
90-100%	Full Compliance
75-89%	Substantial Compliance
50-74%	Partial Compliance
0-49%	Non Compliance

Standard

The Contractor submits an accurate and timely Encounter Reconciliation log from providers to the Contractor and for encounters from the Contractor to ADHS in accordance with the Office of Program Support submission schedule.

There are two elements applied to the evaluation of the final scoring of the Administrative Review standard: timeliness and accuracy. The Contractor must submit the encounter reconciliation log by the Office of Program Support requested deadline and the file must be formatted according to specifications of the file layout. Each Contractor should have submitted four encounter reconciliation logs during the review period.

- The Contractor submitted all four Encounter Reconciliation logs timely and accurately – 100% (Full Compliance)

Office of Program Support Operations and Procedures Manual

- The Contractor submitted three out of the four Encounter Reconciliation logs timely and accurately – 89% (Substantial Compliance)
- The Contractor submitted two out of the four Encounter Reconciliation logs timely and accurately – 74% (Partial Compliance)
- The Contractor submitted one out of the four Encounter Reconciliation logs timely and accurately – 49% (Non-Compliance)
- None of the Encounter Reconciliation logs submitted by the Contractor were timely and accurate – 0% (Non-Compliance)

AHCCCS Operational and Financial Review

Annually, AHCCCS will conduct an Operational and Financial Review (OFR) of DBHS in order to determine if there are organization, management and administrative systems in place capable of fulfilling all contract requirements including those areas related to encounter submission and data validation.

System Access Requests

Introduction

Some Contractor employees will need access to the ADHS-CIS/CRS and AHCCCS-PMMIS claim systems to perform their job duties. The procedures to obtain a CIS/CRS and/or PMMIS ID are as follows:

CIS/CRS

Three forms must be completed to request a CIS/CRS user ID. The employee requesting the login ID must complete and sign both forms. To obtain copies of the CIS/CRS forms the Contractor should contact the ADHS Compliance Division, Contracts Development.

- ADHS Computer User Registration Request Form (SA Attachment 1)
- ADHS User Affirmation Statement (SA Attachment 2)
- ADHS Confidentiality Agreement (SA Attachment 3)

The Contractor should fax all signed forms to the ADHS Compliance Division, Contract Development at fax number (602) 364-4762. The Data Owner will review the forms to ensure they are complete and will forward the request to the IT department. ADHS/ITS will assign an appropriate login ID and password for the new user.

PMMIS

Two forms must be completed to request a PMMIS user ID. The employee requesting the login ID must complete and sign both forms. The Contractor may obtain copies of the AHCCCS security forms at the following website:

<http://www.ahcccs.state.az.us/Publications/Forms/PlansProviders/02-001F.doc>
http://www.ahcccs.state.az.us/publications/forms/plansproviders/useraffirmation2008_external.pdf

- AHCCCS User Access Request Form (SA Attachment 4)
- AHCCCS User Affirmation Statement (SA Attachment 5)

The Contractor should fax both signed forms to the ADHS Compliance Division, Contracts Development at fax number (602) 364-4762. The Data Owner will review the forms to ensure they are complete and will forward the request to AHCCCS. AHCCCS will assign an appropriate login ID and password for the new user.

ADHS COMPUTER USER REGISTRATION REQUEST FORM

MAIL TO: Data Security, ITS, 1740 W. Adams, Suite 407, Phoenix, 85007
FAX #: (602) 542-3250 **E-MAIL:** DataSecurity **PHONE #:** (602) 542-2810

*** TO BE COMPLETED BY AUTHORIZED REQUESTOR ***			
Please	<input type="checkbox"/> Add	<input type="checkbox"/> Employee	Request Date: _____
	<input type="checkbox"/> Change	<input type="checkbox"/> Contractor	
	<input type="checkbox"/> Remove	<input type="checkbox"/> Temp	Effective Date: _____
	Company Name _____		
Transfer	<input type="checkbox"/> To: _____		
	<input type="checkbox"/> From: _____ Temp or Intern		

Last Name	First Name	MI	Working Title
Office/Section	Physical Location		Employee Phone

On the following systems/applications:

LAN =	<input type="checkbox"/> ACPTC	<input type="checkbox"/> DHS	<input type="checkbox"/> FLG	<input type="checkbox"/> LAB	<input type="checkbox"/> OVR
	<input type="checkbox"/> ALS	<input type="checkbox"/> EDC	<input type="checkbox"/> HSP	<input type="checkbox"/> PHS	
	<input type="checkbox"/> BHS	<input type="checkbox"/> FHS	<input type="checkbox"/> ITS	<input type="checkbox"/> TUC	
	<input type="checkbox"/> Internet	<input type="checkbox"/> Outlook			
DLS =	<input type="checkbox"/> AMS	<input type="checkbox"/> TAE	<input type="checkbox"/> CTS	Ad hoc Query	
BEMS =	<input type="checkbox"/> AMB	<input type="checkbox"/> EMP	<input type="checkbox"/> EMT	<input type="checkbox"/> IRS	<input type="checkbox"/> HR
BHS =	<input type="checkbox"/> CIS	<input type="checkbox"/> OGA	<input type="checkbox"/> OHR	<input type="checkbox"/> CIS	<input type="checkbox"/> OGA <input type="checkbox"/> CRSG
	<input type="checkbox"/> IRS	<input type="checkbox"/> DWH	<input type="checkbox"/> FTP(CIS)	<input type="checkbox"/> CRSG	
CFHS =	<input type="checkbox"/> CRS	<input type="checkbox"/> CATS	<input type="checkbox"/> Sensory	<input type="checkbox"/> CFR	
EDC =	<input type="checkbox"/> ASIIS	<input type="checkbox"/> BDR	<input type="checkbox"/> STD		
FIN SVCS =	<input type="checkbox"/> AEDW	<input type="checkbox"/> EPR	<input type="checkbox"/> POTSY	<input type="checkbox"/> PPTS	<input type="checkbox"/> Supply <input type="checkbox"/> PWO
{DOA}	<input type="checkbox"/> USAS	<input type="checkbox"/> HRIS	<input type="checkbox"/> Fix asset		
HSP =	<input type="checkbox"/> IRD				
HSS =	<input type="checkbox"/> HDD				
PHS =	<input type="checkbox"/> Birth	<input type="checkbox"/> Death	<input type="checkbox"/> ATS	<input type="checkbox"/> VitalChek	
SLS =	<input type="checkbox"/> CLAS	<input type="checkbox"/> RLIMS	<input type="checkbox"/> ELBIS	<input type="checkbox"/> LITS	<input type="checkbox"/> CLIA <input type="checkbox"/> STARLIMS
ITS =	<input type="checkbox"/> Unix	<input type="checkbox"/> AppWorx			
ORACLE:	<input type="checkbox"/> asit	<input type="checkbox"/> tw	<input type="checkbox"/> cist	<input type="checkbox"/> crst	<input type="checkbox"/> natt <input type="checkbox"/> vrst <input type="checkbox"/> azht <input type="checkbox"/> limsp
	<input type="checkbox"/> asip	<input type="checkbox"/> pw	<input type="checkbox"/> cisp	<input type="checkbox"/> crsp	<input type="checkbox"/> natp <input type="checkbox"/> vrsp <input type="checkbox"/> azhp

Other Instructions: _____

If User removal please choose:

Move F: drive contents to specific user;

Delete F: drive (Contents not needed)

Supervisor (PRINT): _____

Supervisor Signature: _____ **Phone:** _____

Data Owner Signature: _____ **Phone:** _____

***TO BE COMPLETED BY THE DATA SECURITY ANALYST** Completed Date: ___/___/___

Login ID	LAN	ENTITY CODE
Comments: _____		
Signed: _____		Form Rev. 3/04/2008
Data Security Analyst		

**ARIZONA DEPARTMENT OF HEALTH SERVICES
 USER AFFIRMATION STATEMENT**

I have been made aware and understand that all personnel who have access to the Arizona Department of Health Services (DHS) data are bound by applicable laws, rules and DHS directives and are responsible for DHS data.

I agree to abide by all applicable laws, rules and DHS directives, and I pledge to refrain from any and all of the following:

1. Revealing DHS data to any person or persons outside or within DHS who have not been specifically authorized to receive such data.
2. Attempting or achieving access to DHS data not germane to my mandated job duties.
3. Entering/altering/erasing DHS data for direct or indirect personal gain or advantage.
4. Entering/altering/erasing DHS data maliciously or in retribution for real or imagined abuse, or for personal amusement.
5. Using DHS workstations, printers, and/or other equipment for other than work related purposes.
6. Using another person(s) personal logon ID and password.
7. Revealing my personal logon ID and password to another person.
8. Asking another person to reveal his/her personal DHS logon ID and password.

In relation to my responsibilities regarding the proprietary rights of the authors of computer software utilized by DHS, I recognize that:

1. DHS licenses the use of computer software from a variety of outside companies. DHS does not own this software or its related documentation and, unless authorized by the software developer, does not have the right to reproduce it.
2. When used on a local area network or on multiple machines, employees/contractors shall use the software in accordance with the license agreement.
3. Employees/contractors who know of any misuse of software or related documentation within the agency shall notify their manager/supervisor, or the department security administrator.
4. Employees/contractors making, acquiring or using unauthorized copies of computer software, or using personal non-DHS software are subject to punitive action in accordance with agency guidelines as appropriate to the circumstances.
5. According to U. S. Copyright Law, 17 USC Sections 101 and 506, illegal reproduction of software can be subject to criminal damages up to \$250,000 and/or up to 5 years imprisonment.
6. In the event that an employee is sued or prosecuted for the illegal reproduction of software, he/she will not be represented by the Department of the Attorney General.

Appropriate action will be taken to ensure that applicable federal and state laws, regulations, and directives governing confidentiality and security are enforced. A breach of procedures occurring pursuant to this policy or misuse of department property including computer programs, equipment, and/or data, may result in disciplinary action including dismissal, and/or prosecution in accordance with any applicable provision of law including Arizona Revised Statutes, Section 13-2316.

My signature below confirms that I have read this form and accept responsibility for adhering to all applicable laws, rules, and DHS directives. Failure to sign this statement will mean that I will be denied access to DHS data, computer equipment, and software.

NAME (Last, First, M.I.) PRINT OR TYPE	SIGNATURE	PHONE	DATE
NAME OF SUPERVISOR (Last, First, M.I.)	SIGNATURE	PHONE	DATE

**ARIZONA DEPARTMENT OF HEALTH SERVICES
Confidentiality Agreement Form**

PLEDGE TO PROTECT CONFIDENTIALITY INFORMATION

I, _____, understand and agree to abide by the following statements addressing
(Please Print Name)

the creation, use and disclosure of confidential information, including information designated as protected health information ("PHI"), and all other sensitive information:

1. I understand that as a user of information at the Arizona Department of Health Services, I may develop, use, or maintain information relating to public health and welfare, direct or indirect health care, quality improvement, peer review, audit functions, education, billing, reimbursement, administration, research or other approved purposes. This information, from any source and in any form, including, but not limited to paper records, oral communications, audio recordings and electronic display, is considered confidential. Access to confidential information is permitted only on a need-to-know basis and limited to the minimum amount of confidential information necessary to accomplish the intended purpose of the use, disclosure or request.
2. I understand that it is the policy of the Arizona Department of Health Services that users (i.e. employees, medical staff, students, volunteers, contractors, vendors and others who may function in an affiliated capacity) shall respect and preserve the privacy, confidentiality, and security of confidential information.
3. I understand that persons who have access to information that contains confidential information are ethically and legally responsible for observing the federal and state statutes and rules governing confidential records. I will not alter, misuse, disclose without proper authority or the individual's authorization any confidential information.
4. I understand that confidential information may include oral communications, paper or electronic documents, databases, audio/visual tapes, and other items identified as "confidential" or "sensitive" information.
5. I understand that Arizona State Law prohibits me from using confidential information for personal gain.
6. I understand that confidential information in my control must be maintained and protected from inappropriate disclosure at all times (i.e. hard copy information when not in use will not be accessible to others, including stored or locked or other secure compartments, computer files must be password protected and closed, working documents turned face down on desk, electronic transmission of information will be encrypted according to Department policy, etc.)

**ARIZONA DEPARTMENT OF HEALTH SERVICES
Confidentiality Agreement Form**

7. I understand that it is the user's responsibility to protect highly sensitive Department information. As such, I am required to use good judgment in assessing what form of communication is appropriate for particular information. If I have any questions or concerns, I am to consult Department policies, my supervisor or the applicable Assistant Director for guidance.
8. I understand that confidential information may only be accessed when I am specifically authorized to do so by the appropriate program manager and I will use only the amount of information necessary within the scope of my duties. When confidential information is no longer needed, I will dispose of it in an appropriate manner to prevent inappropriate access to that information.
9. I understand that confidential information, including paper and electronic records, correspondence, documents and other forms of such information, cannot be released to or discussed with anyone other than authorized individuals. I will also violate this provision if I intentionally or negligently mishandle or destroy confidential information.
10. I understand that I am not to contact the individual(s) or other related persons to whom confidential information pertains unless I am specifically authorized to do so by law and the appropriate program manager.
11. I understand that it is a violation of Department and State of Arizona policy for me to share my sign-on code and/or password for accessing electronic confidential information or for physical access to restricted areas. I further understand that I will not use another person's sign-on code and/or password or otherwise attempt to access electronic confidential information or to gain physical access to a restricted area that is not within the scope of my work or permitted by my supervisor.
12. I understand that it is my responsibility to know and abide by any additional confidentiality provisions required by my job that may be issued by the Department, Division, Bureau, program or other work unit to which I report. If I have questions about which confidentiality rules apply to my job, I understand that it is my responsibility to ask my supervisor prior to releasing any information, even if the information request is in the form of a subpoena or other legal document.
13. I understand that it is my responsibility to report any observed or suspected breach of confidentiality by any other Department employee to my supervisor.
14. I understand that if it is determined that I have violated the Pledge or any other confidentiality requirement, I may be subject to formal disciplinary action up to and including termination of employment, loss of privileges, contractual or other rights which may be granted as a result of an affiliation in accordance with Department and/or State of Arizona procedures. Unauthorized use or release of confidential information may also subject me to personal, civil, and/or criminal liability and legal penalties.

Service Designation:

Employee Contractor Volunteer Student Other

User Signature: _____ Title: Date:

Version 3, 06/09/05

EXTERNAL USER AFFIRMATION STATEMENT

I understand that all users who have access to the AHCCCS computer network and data are bound by applicable laws, rules and AHCCCS directives, including but not limited to, AHCCCS Administrative Policies and Procedures, AHCCCS Privacy and Security Policies (HIPAA), ARS 13-2316, ARS 41-770, and ARS 38-448.

Use of AHCCCS Data:

- I will share (i.e., verbal, hardcopy, electronic) AHCCCS data only with people who are authorized to receive the data.
- I will only access/add/change/copy/delete AHCCCS data related to my assigned job duties.
- I will never use AHCCCS data for non-work related purposes.

Logon IDs and Passwords:

- I will never use another person's AHCCCS Logon ID and password.
- I will never ask another person to reveal his/her AHCCCS Logon ID and password.
- I will never reveal my AHCCCS Logon ID and password to anyone, at any time.
- I understand that no one else may use my AHCCCS Logon ID and password and that I am responsible for all actions taken with my Logon ID.

Use of State Resources:

- I will use state equipment in a legal and ethical manner.
- I understand that the use of equipment provided by the agency is subject to monitoring.

Use of Software:

- I will not download or install computer software. Only ISD Network Services has the authority to install and license software.
- Unless authorized, I do not have the right to copy, change or distribute computer software or its related documentation.

Misuse of Equipment, Software or Data:

- I understand that if I become aware of any misuse of AHCCCS equipment, software or data I must promptly notify AHCCCS ISD Customer Support at 602-417-4451.
- I understand that AHCCCS will take appropriate action to ensure that applicable federal and state laws, regulations, and directives governing confidentiality and security are enforced.
- I understand that the misuse of AHCCCS equipment, software or data may result in prosecution, or disciplinary action if I am an employee of another state agency.

My signature below confirms that I have read and understood this form. I accept responsibility for adhering to all applicable laws, rules, and AHCCCS directives. Failure to sign this statement will mean that I will be denied access to AHCCCS data, computer equipment, and software.

Print Legal Name of User (Last, First, M.I.)	Signature	Date

Tidbits Newsletter

The Office of Program Support (OPS) produces a monthly newsletter called *Tidbits* that is posted on the ADHS/DBHS website at <http://www.azdhs.gov/bhs/tidbits.htm>. The purpose of the *Tidbits* is to keep the RBHAs and the CRS up to date with OPS changes, Edit Alerts, Encounter processing information and Covered Services Guide clarifications. As the Covered Services Guide is updated quarterly the *Tidbits* will be utilized as a more current process to notify RBHAs of changes. The following is an example of the first page of a *Tidbits* issue.



Special Day Runs and Testing

As discussed in the RBHA/IT and Encounter Workgroup meetings, DBHS will only be accepting special day runs every Wednesday. This is being done to ensure DBHS/IT can focus on other projects through the remainder of the week.

If a RBHA wishes to perform a special day run, they must coordinate it through their designated RBHA Representative by doing the following:

- ✓ Provide an electronic request, by Noon on Tuesday, including encounter volumes and specific details of what is being submitted and why. OPS will either approve or deny the request per an electronic response that will be sent out by COB on Tuesday.
- ✓ Ensure that files are submitted to the FTP server by 10:00am on Wednesday. Please do not post files to the server, for a day run, prior to Wednesday as they may be picked up in the nightly process.

NPI Testing

As you all know, DBHS officially started the NPI testing process on March 1, 2007. The May 1, 2007, CIS NPI implementation is now here. The Office of Program Support (OPS) would like to express appreciation to all the RBHAs for their dedication and hard work in making the NPI Testing process a success over the past two months!

OPS urges the RBHAs to ensure providers are obtaining NPIs and submitting them to AHCCCS in the proper fashion.

NPI Taxonomy codes

Confused about Taxonomy Codes? Go to:
http://www.wpc-edi.com/taxonomy/more_information

Need to see a list of Taxonomy Codes? Go to:
<http://www.wpc-edi.com/content/view/515/229>

Submission of Form CMS-1500 (08-05)

CMS is instructing contractors to reject Form CMS-1500 (12-90) claims received starting July 2, 2007. Providers will now be required to begin submitting the Form CMS-1500 (08-05) beginning July 2, 2007. For more information on this matter, please click on the following link:
<http://www.cms.hhs.gov/transmittals/downloads/R1274CP.pdf>

Coding Q & A

Q

Can a provider bill Individual counseling and Level I Residential on the same day?

A

Yes. Based on the B2 and B5 Matrixes, as well as the Covered Services Guide. There are no billing limitations, which would prevent those two codes being billed together on the same day. As always, documentation is key when billing any service.

Q

Where should one encounter the Diagnosis Code for a client?

A

The Diagnosis Code should be encountered from the most recent assessment. If however, during the course of an audit, the assessment falls after the date range in question the Diagnosis Code should then be taken from the most current assessment for the date range in question. Please note that if a Diagnosis Code is present, it must be signed and dated by an individual who meets the applicable requirements A.A.C. R9-20-209 (i.e. a Psychiatrist or a Behavioral Health Medical Practitioner).

Operations and Procedures Manual Updates and Revisions

The Office of Program Support Operations and Procedures Manual will be reviewed and updated as needed. The Office of Program Support Manager is responsible for maintaining this manual and should coordinate with all functional areas of the Arizona Department of Health Services when there are proposed changes. All functional areas of the Arizona Department of Health Services should coordinate with the Office of Program Support Manager regarding any changes in their policies, procedures, contracts or reference documents that may affect this manual.