



Encounter Data Validation

Technical Document

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Introduction

The Centers for Medicare and Medicaid Services (CMS) requires the Arizona Health Care Cost Containment System Administration (AHCCCSA) to oversee and report on the utilization of medical services of AHCCCS's prepaid capitated Contractors. Contractors report service utilization on an encounter. An encounter is a record of a service rendered by a provider who is registered with AHCCCS to a recipient who is enrolled with an AHCCCS Contractor. Contractors are required to submit encounters to AHCCCS for all services.

CMS requires AHCCCS to submit progress reports on the encounter data collection process. AHCCCS must take appropriate action to correct deficiencies identified in the collection of encounter data and enforce financial penalties on Contractors that are not in compliance with data collection requirements.

AHCCCS's encounter collection actions are based on the results of encounter data validation studies. Collecting accurate, timely and complete encounters is a high priority for AHCCCS. Encounter data is used to support programmatic budget assumptions and in actuarial analyses to set capitation rate ranges. In addition, this data is used for AHCCCS Contractor Performance Measures and Performance Improvement Projects.

This document provides the Contractor with the methodology and statistical formulae used in Encounter Data Validation. These processes may change year to year and this document will be updated accordingly.

Annual Encounter Data Validation Study

On an annual basis, the AHCCCS Division of Health Care Management (DHCM) conducts an Encounter Data Validation Study. The purpose of this study is to compare recorded utilization information from claim or other source with the Contractor's submitted encounter data. Any and all covered services may be validated as part of this study.

Errors resulting from this study may fall into several categories defined as:

- Omission Error - an encounter for a medically related service for which a Contractor incurred a financial liability not submitted to AHCCCS. Or, an encounter inappropriately voided from AHCCCS historical files and not resubmitted, but still appearing as a paid claim for the Contractor is an omission.
- Accuracy Error - an inconsistency between the claim documentation and an encounter submitted in respect to member ID, Provider ID/NPI, procedure, modifiers, diagnosis, date of service, billed charged, paid amount, units, coordination of benefits.
- Timeliness Error - an encounter received at AHCCCS beyond the allowable time period as defined in the contract.

Encounter Data Validation Study Steps

Approximately 9 months after the end of a contract year, encounter extract files are generated from AHCCCS Data Warehouse based on adjudicated encounter data for each Contractor.

AHCCCS will request an extract from the Contractor's claims system. Upon receipt of the requested claims file extract, AHCCCS will sort and prepare the file for matching through the data validation process. Random sample files will be created for each of the study measures. The review scope will include two sections: Acute study "A" for all professional services and the Acute study "B" for all facility services. The studies will measure:

- Claims included in the Contractor's claim submission and encountered in AHCCCS' Prepaid Medical Management Information System (PMMIS) (Match) – to be reviewed for accuracy and timeliness.
- Claims included in the Contractor's claim submission but not encountered in PMMIS (NotEnc InCIm) – to be reviewed for omission.
- Encounters reported in PMMIS but not included in the Contractor's claim submission (InEnc NotCIm) – to be reviewed for omission from claim submission file.

Once the samples have been determined, the Contractor will be notified. For each record identified on the samples, the Contractor will be required to submit a copy the claim (or EDI) submitted by the provider, along with any other pertinent information such as, primary insurance EOB, AHCCCS CRN, proof of timely encounter submission, explanation for omission from claim file extract, etc. The Contractor will return all documentation to the SFTP server.

Once the Contractor's response is received, AHCCCS will review the documentation against the encounter data in PMMIS. Preliminary findings will be reported back to the Contractor. The Contractor will have 30 days to challenge the preliminary findings. Once all challenges have been considered, a final report will be generated and sent to the Contractor. Sanctions are applied based on the final report.

Random Sample Calculation

The health plans should send DAR the Plan Data, datasets required in a fixed width text format according to the attachments to the preliminary letters, which contain N_p records. DAR analysts pull the Agency Data from AHCCCS Data Warehouse following exactly the same formats and time period as the Plan Data. Then following the below process the random samples are selected.

1. Assuming the health plans send the complete datasets to AHCCCS using SPSS or other software to do the data manipulation, match the plan data to the agency data and find the number of omission claims. This data matching includes three steps:

Step 1. Match the Plan Data to the Agency Data by 4 columns, Member ID Number, Date of Service, Service Provider Number, Procedure Code(Study A) or First Revenue Code(Study B). Most of plan data records can be found in agency data and some of the plan data are omissions. Part of the result of this step is also for internal use.

Step 2. Match the omission data from Step 1 to the Agency Data by 3 columns, Member ID Number, Date of Service, Service Provider Number. Some of omission records can be found in the agency data and some of them are still omissions. Part of the result of this step is also for internal use.

Step 3. Match the omission data from Step 2 to the Agency Data by 3 columns, Member ID Number, Month of Service, Service Provider Number. Some of omission records can be found in the agency data and some of them are still omissions, which result in the overall omission number N_o .

2. The overall omission rate is calculated as $i_o = N_o / N_p$, where N_o is from Step 3 and N_p is from the plan data.

3. Using statistical method by SPSS or Excel to select a random omission sample dataset of 500 records from the overall omissions. If the omissions are less than 500, select them all.
4. DAR analysts manually check each of these 500 records in AHCCCS Prepaid Medical Management Information System (PMMIS) to see whether those omissions are truly omissions and come up with a number N_r , (i.e. how many records are not found in PMMIS by any chance.) A random sample rate i_r is calculated as $i_r = N_r/500$, where the number of 500 can be substituted by the actual number if $N_o < 500$.
5. The final omission rate i_f is calculated as $i_f = i_r * i_o = (N_o / N_p) / (N_r / 500)$, where the number of 500 can be substituted by the actual number if $N_o < 500$.

Example of Random Sample Calculation

In this example, assume that Nearly Perfect Health Plan sends a complete Study A dataset to AHCCCS in a fixed width text format which contain $N_p = 3,283,651$ records. DAR analysts pull the agency data from AHCCCS Data Warehouse following exactly the same formats and time period as the Nearly Perfect Data. Then following the below process the random samples are selected.

1. Using SPSS or other software to do the data manipulation, match the Nearly Perfect Data to the Agency Data and find the number of omission claims. This data matching includes three steps:

Step 1. Match the Nearly Perfect Data to the Agency Data by 4 columns, Member ID Number, Date of Service, Service Provider Number, and Procedure Code. Most of the 3,283,651 records can be found in agency data and 705,382 records are omissions. This number is also for internal use.

Step 2. Match the 705,382 records from Step 1 to the Agency Data by 3 columns, Member ID Number, Date of Service, and Service Provider Number. Some of omission records can be found in the agency data and 683,176 are still omissions. This number is also for internal use.

Step 3. Match the 683,176 records from Step 2 to the Agency Data by 3 columns, Member ID Number, Month of Service, and Service Provider Number. Some of omission records can be found in agency data and 652,928 records are still omissions, i.e. the overall omission number $N_o = 652,928$.

2. The overall omission rate is calculated as $i_o = 19.9 \% (652,928 / 3,283,651)$.
3. Using the statistical methods by SPSS or Excel to select a random omission sample dataset of 500 records from the overall omissions since $N_o > 500$.

4. DAR analysts manually check each of these 500 records in the AHCCCS Prepaid Medical Management Information System (PMMIS) to see whether those omissions are truly omissions and come up with 16 records that are not found in PMMIS by any chance. The random sample rate i_r is calculated as $i_r = 3.2\%$ (16/500).
5. The final omission rate i_f is calculated as $i_f = 0.6\%$ (19.9% * 3.2%).

Sanctions

Sanction Calculation

The sanction amount by Contractor is calculated by applying the sanction formula:

$S = P \times ((L - A) \times NAdj)$, where:

S = sanction amount,

P = per-error sanction amount,

L = lower limit of the confidence interval,

A = allowable error rate of 5%, and

$NAdj$ = total number of encounters by form type adjusted for omissions by Contractor.

$NAdj = Ntot / (1 - LOm)$, where:

$Ntot$ = total number of encounters submitted by form type by Contractor, and

LOm = the lower limit of the omission error by Contractor.

The per-error base sanction amounts are:

ERROR TYPE	SANCTION AMOUNT
Omission	\$5.00
Accuracy	\$5.00
Untimely	\$2.00

Guidelines

Response Documentation Guidelines

In order to properly submit the claims file extract to AHCCCS, these guidelines must be followed:

Acceptable form submission files examples:

1. Number each file submission to match the Row on the excel spreadsheet.
2. One file numbered to match spreadsheet which holds all the documentation for that row.
Example (Use for all audit file submissions)
 01. AHCCCS ID # (Folder name)
 1. Add all documentation needed to support claim/encounter into one folder with the row number
 2. Make sure if using your own ID for members to add AHCCCS ID to your documentation.
3. Do this for each row on spreadsheet
4. Do not put all documentation all in one word document, pdf document, or insert into spreadsheet.
5. Zip all the individual files into one zip file and upload to AHCCCS server under "Other" and the particular health plan.

Focused Audits

Override/Void Logs

At its discretion AHCCCS may conduct focus audits.

The Contractor is required to maintain logs for all overridden or voided encounters. Those logs are submitted quarterly pursuant to the Encounter Manual. AHCCCS will conduct periodic focused audit of the logs. The purpose of the audit is to ensure the override/void was an appropriate action.

From the information provided on the logs, AHCCCS will select a file sample. The file sample will be forwarded to the Contractor with a request for the documentation used to override or void the encounter. The Contractor will follow the guidelines below to support each override or void. AHCCCS will review the documentation for appropriateness and return the findings to the Contractor.

Override Log Audit Guidelines

Provide all documentation that supports the reason for the override of the encounter – including any guidelines, Medical Director approval, policy, etc.

If replaced with another CRN, please include CRN information

Return spreadsheet in same format as sent to you – you may add an additional column at the end to provide additional comments.

See Response Documentation Guidelines above.

Upload all documentation and spreadsheet on SFTP server, placed in “Other” folder.

Void Log Audit Guidelines

Provide all documentation that supports the reason the encounter was voided.

Return spreadsheet in same format as sent to you – you may add an additional column at the end to provide additional comments.

See Response Documentation Guidelines above.

Upload all documentation and spreadsheet on SFTP server, placed in “Other” folder.