Encounter Data Validation

Nathan Burgess

1. Purpose
2. Audit Approach
3. Findings
4. Discussion

NC SB 371

Requires that each LME/MCO submit encounter data for payments made to providers for Medicaid and State-funded

- mental health
- intellectual and developmental disabilities
- substance abuse disorder services

Purpose

- Assess and improve quality
- Monitor program integrity
- Determine capitation payments
- Provide program transparency

Approach

ISCA Response Review

Information Systems Capability Assessment

- Focused on section V. Encounter Data Submission
- Review of information flow from the MCO to DMA
- Compare YoY submission and acceptance (Inst vs Prof)
- Denial and Resubmission process

Encounter Analysis

Data Accuracy and Completeness

- General magnitude of missing encounter data
- Types of missing encounter data
- Overall data quality issues
- PIHP data submission issues

Data Quality Standards for Evaluation of Submitted Encounter Data Fields

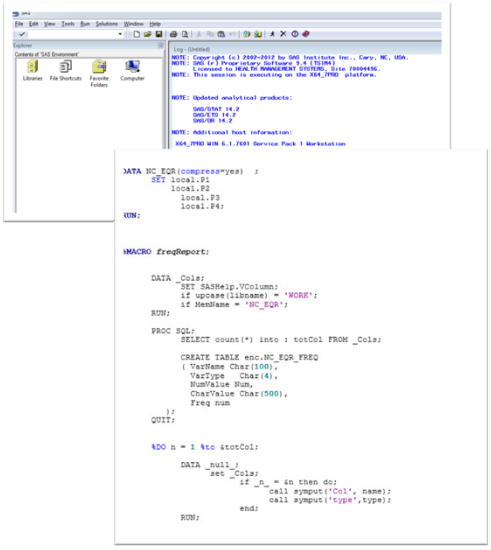
Adapted and Revised from CMS Encounter Validation Protocol

Data Element	Expectation	Validity Criteria
Recipient ID	Should be valid ID as found in the State's eligibility file. Can use State's ID unless State also accepts Social Security Number.	100% valid
Recipient Name	Should be captured in such a way that makes separating pieces of name easy. Expect data to be present and of good quality	85% present. Lengths should vary, but there should be at least some last names of >8 digits and some first names of < 8 digits, validating that fields have not been truncated. Also, a high percentage of names should have at least a middle initial.
Recipient Date of Birth	Should not be missing and should be a valid date.	< 2% missing or invalid
MCO/PIHP ID	Critical Data Element	100% valid
Provider ID	Should be an enrolled provider listed in the provider enrollment file.	95% valid
Attending Provider ID	Should be an enrolled provider listed in the provider enrollment file (will accept the MD license number if it is listed in the provider enrollment file).	> 85% match with provider file using either provider ID or MD license number
Provider Location	Minimal requirement is county code, but zip code is strongly advised.	> 95% with valid county code > 95% with valid zip code (if available)
Place of Service	Should be routinely coded, especially for physicians.	➢ 95% valid for physicians ➢ 80% valid across all providers
Specialty Code	Coded mostly on physician and other practitioner providers, optional on other types of providers.	Expect > 80% nonmissing and valid on physician or other applicable provider type claims (e.g., other practitioners)

Data Quality Standards for Evaluation of Submitted Encounter Data Fields Adapted and Revised from CMS Encounter Validation Protocol		
Data Element	**Expectation**	**Validity Criteria**
Principal Diagnosis	Well-coded except by ancillary type providers.	> 90% non-missing and valid codes (using International Statistical Classifications of Diseases, Ninth Revision, Clinical Modification [ICD-9-CM] lookup tables) for practitioner providers (not including transportation, lab, and other ancillary providers)
Other Diagnosis	This is not expected to be coded on all claims even with applicable provider types, but should be coded with a fairly high frequency.	90% valid when present
Dates of Service	Dates should be evenly distributed across time.	If looking at a full year of data, 5%–7% of the records should be distributed across each month.
Unit of Service (Quantity)	The number should be routinely coded.	98% nonzero <70% should have one if Current Procedural Terminology (CPT) code is in 99200–99215 or 99241–99291 range.
Procedure Code	Critical Data Element	99% present (not zero, blank, or 8- or 9-filled). 100% should be valid, State-approved codes. There should be a wide range of procedures with the same frequency as previously encountered.
Procedure Code Modifier	Important to separate out surgical procedures/ anesthesia/assistant surgeon, not applicable for all procedure codes.	> 20% non-missing. Expect a variety of modifiers both numeric (CPT) and Alpha (Healthcare Common Procedure Coding System [HCPCS]).
Patient Discharge Status Code (Hospital)	Should be valid codes for inpatient claims, with the most common code being "Discharged to Home." For outpatient claims, the code can be "not applicable."	For inpatient claims, expect >90% "Discharged to Home." Expect 1%–5% for all other values (except "not applicable" or "unknown").
Revenue Code	If the facility uses a UB04 claim form, this should always be present	100% valid

Data Validation

- Encounter data imported into SAS
- Data is analyzed and categorized by service/record type (per DMA direction)
- Each category of encounters is analyzed using a variety of redundant data analysis routines configured by our data analysts to reflect each MCO's data format and DMA's specifications
- Comprehensively review 100% of submitted encounter data from a variety of perspectives and will address the following questions, among others:
  1. Is the data complete?
  2. Does the data contain required data elements, and appropriate values?
  3. Does the data meet general quality and reasonability expectations?

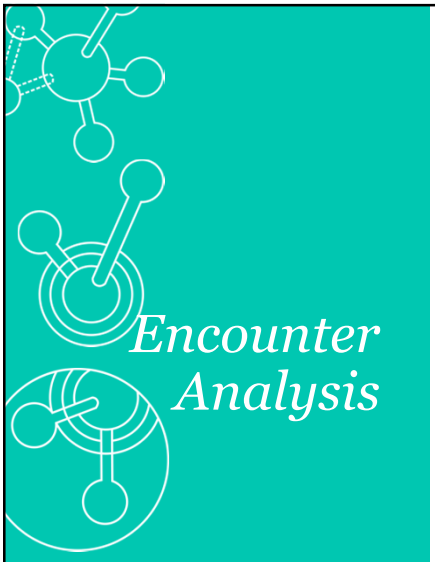


```
DATA NC_EQR(compress=yes)  ;
      SET local.P1
          local.P2
          local.P3
          local.P4;
RUN;

%MACRO freqReport;

      DATA _Cols;
            SET SASHelp.VColumn;
            if upcase(libname) = 'WORK';
            if MemName = 'NC_EQR';
      RUN;

      PROC SQL;
            SELECT count(*) into : totCol FROM _Cols;

            CREATE TABLE enc.NC_EQR_FREQ
            ( VarName Char(100),
              VarType  Char(4),
              NumValue Num,
              CharValue Char(500),
              Freq num
      );
      QUIT;

      %DO n = 1 %to &totCol;

            DATA _null_;
                  set _Cols;
                        if _n_ = &n then do;
                              call symput('Col', name);
                              call symput('type',type);
                        end;
            RUN;
```

Evaluation of key fields

- Document results
- Compared back to data quality thresholds
- Identify issues / data gaps
- Identify potential resolutions

Required Field	Information present		Correct type of information		Correct size of information		Presence of valid value?	
	#	%	#	%	#	%	#	%
Recipient ID	2,011,062	100.00%	2,011,062	100.00%	2,011,061	100.00%	2,011,061	100.00%
Recipient Name	2,011,062	100.00%	2,011,062	100.00%	2,011,062	100.00%	2,011,062	100.00%
Recipient Date of Birth	2,011,076	100.00%	2,011,062	100.00%	2,011,062	100.00%	2,011,062	100.00%
MCO/PIHP ID	2,011,076	100.00%	2,011,076	100.00%	2,011,076	100.00%	2,011,076	100.00%
Provider ID	2,011,076	100.00%	2,011,076	100.00%	2,011,076	100.00%	2,011,076	100.00%
Attending Provider ID (Inst Only)	353,370	100.00%	353,370	100.00%	353,370	100.00%	353,370	100.00%
Provider Location	2,011,076	100.00%	2,011,076	100.00%	2,011,076	100.00%	2,011,076	100.00%
Place of Service	2,011,076	100.00%	2,011,062	100.00%	2,011,062	100.00%	2,011,062	100.00%
Specialty Code / Taxonomy - Billing	1,657,706	82.43%	1,656,454	82.37%	1,656,454	82.37%	1,656,454	82.37%
Specialty Code / Taxonomy - Rendering	851,427	42.34%	803,742	39.97%	803,742	39.97%	803,742	39.97%
Principal Diagnosis	2,011,062	100.00%	2,011,062	100.00%	2,011,062	100.00%	2,011,062	100.00%
Other Diagnosis	463,274	23.04%	463,274	23.04%	463,274	23.04%	463,274	23.04%
Dates of Service	2,011,062	100.00%	2,011,062	100.00%	2,011,062	100.00%	2,011,062	100.00%
Unit of Service (Quantity)	2,010,768	100.00%	2,010,768	100.00%	2,010,768	100.00%	2,010,768	99.98%
Procedure Code - Inst	353,370	100.00%	44,343	12.55%	44,343	12.55%	44,343	12.55%
Procedure Code - Prof	1,657,692	100.00%	1,657,254	99.97%	1,657,254	99.97%	1,657,254	99.97%
Procedure Code Modifier	233,450	13.72%	233,450	100.00%	233,450	100.00%	233,450	100.00%
Patient Discharge Status Code Inpatient	-	0.00%	-	0.00%	-	0.00%	-	0.00%
Revenue Code	353,370	100.00%	353,370	100.00%	353,370	100.00%	353,370	100.00%



DMA Acceptance Report

- Report maintained weekly by DMA
- Reflects all encounters submitted, accepted, and denied for each MCO
- Identify Top 5 denials
- Tie denials back to data accuracy and completeness

HMS Findings

- Taxonomy code for Billing and Rendering providers
- Missing/Invalid Admission Date
- Invalid HCPCS
- Missing Institutional Claims

DMA Denials – 2016 Check write

Denial Reason	$Paid Amount
BILLING PROVIDER MUST BE ENROLLED FOR BILLING TAXONOMY CODE	$ 1,482,336,860.31
HISTORY RECORD NOT FOUND FOR ADJUSTMENT/VOID	$ 236,867,579.39
RENDERING PROVIDER MUST BE ENROLLED FOR RENDERING TAXONOMY CODE	$ 224,131,744.66
TOTAL DAYS ON CLAIM GREATER THAN BILLING PERIOD	$ 221,452,156.12
ADMISSION DATE INVALID	$ 153,825,177.31
PROCEDURE CODE INVALID FOR BILLING PROVIDER TAXONOMY	$ 136,265,271.69
PROCEDURE CODE\REVENUE CODE INVALID FOR PLACE OF SERVICE	$ 124,159,808.83
TAXONOMY CODE FOR ATTENDING OR RENDERING PROVIDER MISSING	$ 118,696,854.71
RENDERING PROVIDER NUMBER CHECK	$ 110,008,301.27
PROCEDURE IS INVALID FOR THE DIAGNOSIS	$ 105,900,308.38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