FY 2018–2019
412 Independent Audit Report
for Rocky Mountain Health Plans Medicaid Prime

June 2019

Contents

Background

In fiscal year (FY) 2018–2019, the Colorado Department of Health Care Policy and Financing (the Department) contracted Health Services Advisory Group, Inc. (HSAG), to conduct encounter data validation among the Department's contracted Medicaid managed care organizations (MCOs) as an optional External Quality Review (EQR) task under the Centers for Medicare & Medicaid Services (CMS) Medicaid Guidelines.[1]

The study assesses the MCOs' data validation capacity among encounters submitted to the Department by each MCO. The study aims to evaluate each MCO's compliance with State standards regarding encounter data submission as well as the consistency and accuracy with which the MCO audits encounter data through the use of medical record review.

This report addresses findings for the **Rocky Mountain Health Plans Medicaid Prime** (**RMHP Prime**) managed care plan. Since FY 2015–2016, HSAG has conducted this study annually with a different Colorado Medicaid MCO. However, this **RMHP Prime**'s first year participating in the study.

To facilitate this assessment, the Department randomly selected 103 final, adjudicated physical health encounters from four distinct service categories (i.e., a total of 412 encounters) to be audited by **RMHP Prime**. These service categories included encounters with services rendered in federally qualified health centers (FQHCs), as well as in inpatient, outpatient, and professional settings. **RMHP Prime** submitted the internal audit results and an encounter data quality report to HSAG and the Department.

To further improve the quality of encounter data submitted by **RMHP Prime**, the Department developed and implemented the MCO Encounter Data Quality Review Guidelines (guidelines). The guidelines include file format and reporting requirements as well as a specific timeline to guide **RMHP Prime** in conducting its internal audit and using the audit results to prepare the Encounter Data Submission Quality Report and Service Coding Accuracy Report.

The Department contracted HSAG to evaluate each MCO's capacity to internally audit encounters through an independent assessment of the MCO's service coding accuracy results. Specifically, the Department requested HSAG to complete the following tasks during FY 2018–2019:

1. Conduct a desk review of each MCO's audit process, including any audit documentation submitted by the MCO.
2. Conduct a review of medical records for cases randomly selected from each service category's 103 sample list, which was generated by the Department.

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[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 4: Validation of Encounter Data Reports by the MCO: A Voluntary Protocol for External Quality Review (EQR)*. Version 2.0. September 2012. Available at https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: March 28, 2019.

3. Produce an MCO-specific report with findings specific to each service category, including a statement regarding HSAG's assessment of the accuracy of each MCO's internal audit results.

Methodology

HSAG's independent audit consisted primarily of an assessment of **RMHP Prime**'s internal audit results through an over-read of medical records for a sample of randomly selected encounters. HSAG recommended a sampling strategy to the Department to ensure that audit cases were generated randomly from a representative base of encounters eligible for inclusion in this study. HSAG's review of the Department's sampling protocol was limited to an assessment of sampling methodology documentation provided by the Department.

The second component of HSAG's independent audit was to evaluate whether **RMHP Prime**'s internal audit of the sampled encounters against members' medical records was accurate and consistent with standard coding manuals. HSAG received a response file containing **RMHP Prime**'s internal audit results for the 412 cases sampled by the Department. Prior to receiving **RMHP Prime**'s internal audit results, HSAG generated an over-read sample of 20 cases for each of the four service categories (80 cases overall). The evaluation process included the following steps:

1. Generation of Over-Read Samples

The Department developed a 412-case sample of final adjudicated **RMHP Prime** encounters paid between October 1, 2017, and September 30, 2018, for four physical health service categories.[2,3] The Department submitted the sample lists to **RMHP Prime** and HSAG in January 2019; **RMHP Prime** then conducted its internal audit on the sampled encounters.

HSAG used the sample lists from the Department to generate an over-read sample using a two-stage sampling approach. Under this sampling approach, HSAG randomly selected 20 identification numbers for unique individuals from each service category and then selected a single encounter line for each of the 20 individuals, resulting in a list of 20 randomly selected encounter lines per service category and 80 cases overall. A single health event could result in a member having encounters for both the Inpatient Services and the Professional Services categories; therefore, HSAG assessed the service category lists to ensure that no members were included in multiple service categories.

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[2] Service categories were identified using the audit_typ field assigned to each encounter by the Department. Audit_typ values of "PROF" identified Professional Services, "IP" identified Inpatient Services, "FQ/RHC" identified services rendered at an FQHC, and "OP" identified Outpatient Services. The Department assigns claims to service categories according to a hierarchy, and each claim may be assigned to only a single category.

[3] The Department's data layout for **RMHP Prime** encounter data flat files is presented for reference in Appendix A.

2. Audit Tool Development

RMHP Prime submitted its response file containing internal audit results for the 412 sampled cases to HSAG in March 2019. HSAG designed a web-based data collection tool and tool instructions based on the guidelines and on standard national coding manuals. As a result of the unique data fields and coding standards required for inpatient encounters, HSAG's web-based tool included separate data collection screens for inpatient encounters versus those used for ambulatory-type encounters (i.e., FQHC, outpatient, and professional). A control file containing select fields from the Department's encounter data flat file as well as **RMHP Prime**'s corresponding internal audit values for sampled cases was uploaded into the tool, permitting pre-population of encounter and audit information for each case. Pre-populated information could not be altered, and HSAG's coders were required to actively select an over-read response for each data element. Corresponding medical records procured by **RMHP Prime** were linked to cases within the tool. The web-based tool allowed the HSAG analyst to extract MS Excel files containing encounter data, **RMHP Prime** audit responses, and HSAG coder responses specific to each encounter type (i.e., service category).

3. HSAG's Over-Read Process

HSAG evaluated the accuracy of **RMHP Prime**'s audit findings in April 2019. More specifically, the HSAG reviewers validated **RMHP Prime**'s accuracy in auditing the providers' submitted encounter data in accordance with the national code sets: International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM); International Classification of Diseases, Procedural Modification (ICD-10-PM); Current Procedural Terminology (CPT); Healthcare Common Procedure Coding System (HCPCS); and the 1995 Evaluation and Management (E&M) documentation guidelines. HSAG's over-read did not evaluate the quality of the medical record documentation or the provider's accuracy in submitting encounter data, only whether **RMHP Prime**'s audit responses were accurate based on the review of the supporting medical record documentation submitted by **RMHP Prime**. All over-read results were entered into the HSAG audit tool.

HSAG trained five certified coders to conduct the over-read. During the over-read of the outpatient claim types, the coders located the selected date of service in the submitted medical records to determine whether the ICD-10-CM and CPT or HCPCS codes pre-populated in the audit tool from the encounter data flat file were supported by the submitted medical record documentation and in alignment with the criteria outlined in the review and code set guidelines. During the over-read of the inpatient claim types the coders located the selected date of service in the submitted medical records to determine whether or not the ICD-10-PM and the ICD-10-CM codes pre-populated in the audit tool from the encounter data flat file were supported by the submitted medical record documentation and in alignment with the criteria outlined in the review and code set guidelines. The HSAG coders then determined whether **RMHP Prime** agreed or disagreed with the accuracy of the codes submitted by the provider. If the HSAG coder agreed with **RMHP Prime**'s response, an agreement response was recorded in the tool. If the HSAG coder disagreed with **RMHP Prime**'s response, a disagreement response was recorded in the tool. The findings of this over-read were based on HSAG's percent of agreement or disagreement with **RMHP Prime**'s responses.

Prior to beginning abstraction, coders participated in an interrater reliability (IRR) assessment using training cases. To proceed with abstraction on study cases, coders were required to score 95 percent or higher on the post-training IRR. If this threshold was not met, the nurse manager provided re-training, including abstraction of additional test cases.

During the over-read period, HSAG conducted an ongoing IRR assessment by randomly selecting a minimum of 10 percent of cases per coder and comparing the over-read results to those from a second coder. For cases in which over-read discrepancies were identified between the first and second coders, a third "Gold Standard" review was conducted that provided a final determination regarding the appropriate over-read result. Any IRR result that fell below 95 percent required further evaluation by the nurse manager and possible re-training of the coder(s).

4. Analysis Process

Following completion of the over-read, the HSAG analyst exported results from the over-read tool for each service category. Because data elements varied by claim type, results were not aggregated across the service categories. The analyst reviewed the coders' over-read notes, and notes requiring further information were addressed with the nurse manager.

The HSAG analyst assessed the over-read results to determine the percentage of records per service category for which the HSAG coder agreed with **RMHP Prime**'s internal audit response. Results were displayed by service category for data elements that were audited by **RMHP Prime** and overread by HSAG. Over-read analysis results were independently verified by a second HSAG analyst.

Results

Desk Review

Sampling Methodology

The Department provided HSAG with a brief description of the process used to generate a random sample of **RMHP Prime**'s encounters. The Department's documentation listed the criteria by which encounters were assigned to service categories and noted that the sample was restricted to final adjudicated encounters paid within the study period. The Department selected the first 3,000 observations meeting the study criteria, deleted excess observations with duplicate Medicaid IDs, and randomly selected 103 observations per service category. Encounters were defined using the Medicaid ID data field.

HSAG reviewed the sample list provided by the Department, the sampling process description, and the portion of sampling code that the Department reported using to generate the sample. Sample selection used the SQL SAMPLE() function to obtain a random sample of observations within each service category. The Department's sampling documentation included no details regarding validation or reasonability checks for the sampled encounters (e.g., verifying that the distribution of providers in the

sample aligned with the distribution of providers in **RMHP Prime**'s encounters). Based on the sampling documentation provided, HSAG was unable to determine whether or not the Department ensured that the sample represented the underlying data.

RMHP Prime's Internal Audit Methodology

To help provide context for **RMHP Prime**'s Encounter Data Submission Quality Report and Service Coding Accuracy Report, the Department requested **RMHP Prime**'s internal audit methodology documentation as a component of the Service Coding Accuracy Report. HSAG's review of **RMHP Prime**'s internal audit methodology documentation verified the presence of:

- A limited example of the coding guidelines referenced for **RMHP Prime**'s auditing process.
- A brief description of the record procurement process.
- A brief description of the audit tool, and a description of the training provided by a lead nurse reviewer to **RMHP Prime**'s reviewers.
- The credentials, training, and experience of all reviewers.
- The rater reliability testing process for audit validation.

Over-Read of Sample Cases by Service Category

The audit response file submitted by **RMHP Prime** contained all required audit fields. However, **RMHP Prime**'s initial audit response file submission did not align with the file layout specified in the guidelines. HSAG then provided technical support to **RMHP Prime** to ensure that an adequate file was submitted. The audit response data layout is presented in Appendix B.

RMHP Prime was unable to procure medical records for four over-read inpatient cases and three over-read professional cases; however, HSAG's coders agreed with **RMHP Prime'**s audit responses for these cases. In nine additional over-read cases, **RMHP Prime** determined that the available medical records were insufficient for its audit; HSAG's coders disagreed with this determination.

During the over-read, HSAG's coders noted that **RMHP Prime** used the T1015 HCPCS code in the FQHC encounters. The T1015 code is defined as a temporary code for Medicaid programs, typically with state-specific coding uses. The Department noted that it did not require the use of T1015 codes to document State plan services rendered at FQHCs during the study measurement period but had provided no specific guidance to **RMHP Prime** regarding the use of this code in lieu of or addition to an E&M code. As such, the Department confirmed that HSAG's reviewers would not consider use of the T1015 code as the sole reason to disagree with a case's procedure code; HSAG's reviewers would agree with **RMHP Prime'**s audit response and note whether or not a more appropriate E&M code was supported by the medical record documentation.

The remainder of this section details HSAG's over-read findings by service category. For reference, Appendix C presents, by service category, **RMHP Prime**'s internal audit results found in its Service Coding Accuracy Report.

In addition to the results presented in this report, HSAG has provided the Department with supplemental spreadsheets detailing, by claim type, the nature of the disagreement for any data element about which HSAG's coder disagreed with **RMHP Prime**'s audit determination. This MS Excel workbook is referenced in the remainder of the report as the Case-Level Disagreement List.

Inpatient Cases

Figure 1 presents the aggregate results from HSAG's over-read of the 20 inpatient cases. Agreement values range from 90.0 percent to 100 percent for individual elements, where 100 percent represents complete agreement between **RMHP Prime**'s internal audit results and HSAG's over-read results, and 0 percent represents complete disagreement.

Figure 1—Aggregated Percent of Agreement Between HSAG's Over-Read and RMHP Prime's Internal Audit Findings, by Data Element Inpatient Services
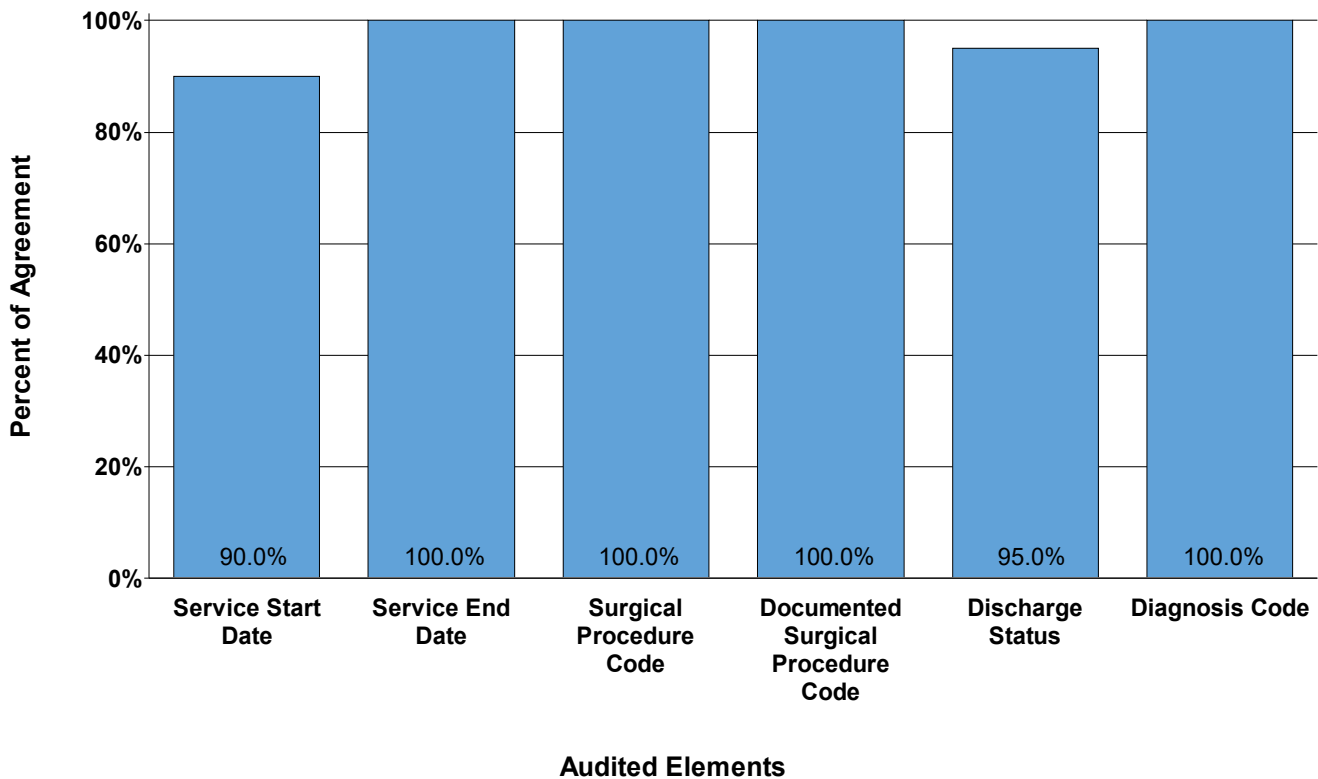
Complete agreement for a sampled inpatient encounter occurred when HSAG's over-read results indicated agreement with **RMHP Prime**'s audit response for each of the six assessed data elements. Of the 20 sampled inpatient encounters, over-read results demonstrated complete agreement for 17 cases, producing an 85.0 percent aggregate agreement rate. HSAG's over-read results agreed with **RMHP Prime**'s audit responses for all cases (i.e., complete agreement) for the *Service End Date*, *Surgical Procedure Code*, *Documented Surgical Procedure Code*, and *Diagnosis Code* data elements. The lowest agreement rate (90.0 percent) was observed for the *Service Start Date* data elements.

HSAG's reviewers determined that medical record documentation did not align with the encounter data for the three audited data elements for which **RMHP Prime**'s audit results were inconsistent with HSAG's over-read results. The three data elements in disagreement represented three sampled over-read cases.

Outpatient Cases

Figure 2 presents the aggregate results from HSAG's over-read of the 20 outpatient cases. Agreement values range from 90.0 percent to 95.0 percent for individual elements, where 100 percent represents complete agreement between **RMHP Prime**'s internal audit results and HSAG's over-read results, and 0 percent represents complete disagreement.

**Figure 2—Aggregated Percent of Agreement Between
HSAG's Over-Read and RMHP Prime's Internal Audit Findings, by Data Element
Outpatient Services**
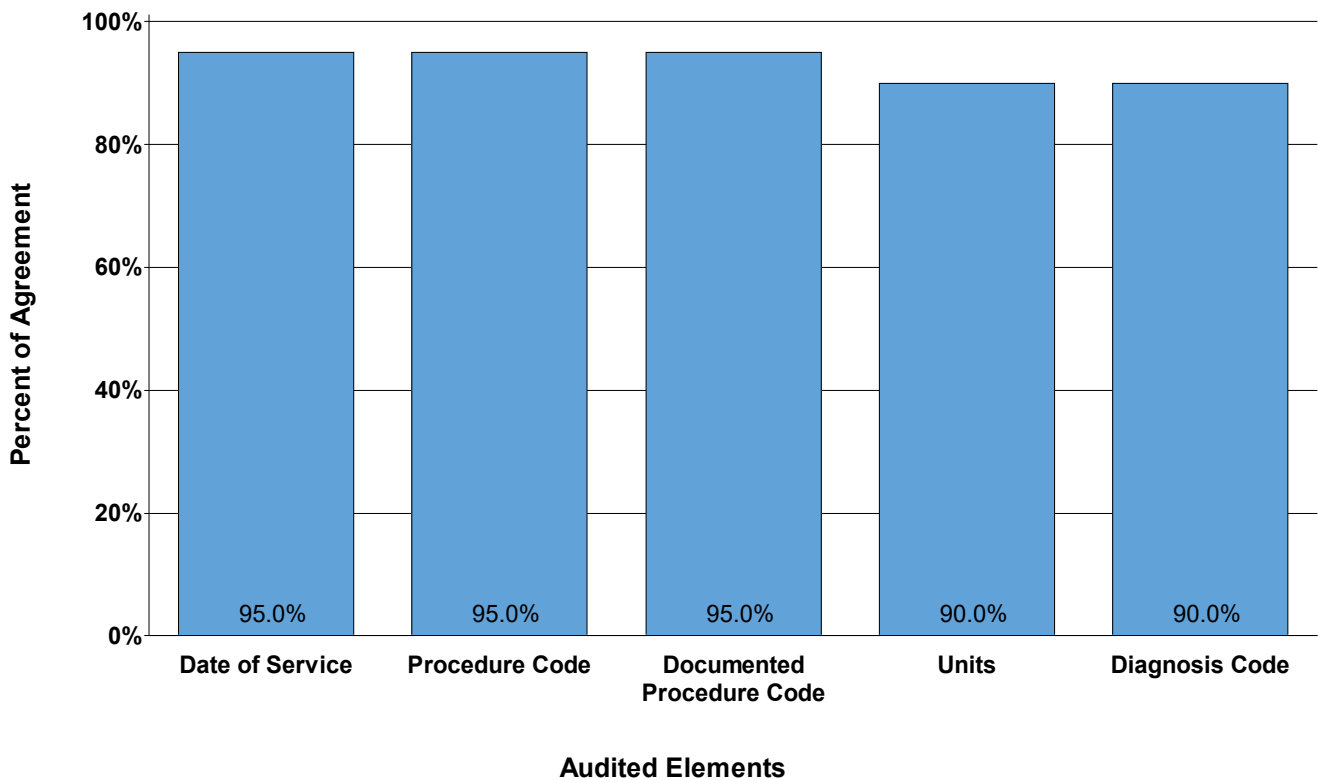
Complete agreement occurred when HSAG's over-read results indicated agreement with **RMHP Prime**'s audit response for each of the five individual data elements assessed for a sampled outpatient encounter. Of the 20 sampled outpatient encounters, over-read results demonstrated complete agreement for 17 cases, producing an 85.0 percent aggregate agreement rate. The highest agreement rates (each 95.0 percent) were observed for the *Date of Service*, *Procedure Code*, and *Documented Procedure Code* data elements. The lowest agreement rates (each 90.0 percent) were observed for the *Units* and *Diagnosis Code* data elements.

HSAG's reviewers determined that medical record documentation did not align with the encounter data or **RMHP Prime**'s documented information for two of the seven audited data elements for which **RMHP Prime**'s audit results were inconsistent with HSAG's over-read results. For the remaining five data elements, **RMHP Prime**'s auditors reported no documentation or insufficient documentation to record an audit response value; HSAG's reviewers disagreed with this assessment. The seven data elements in disagreement represented three sampled over-read cases.

Professional Cases

Figure 3 presents the aggregate results from HSAG's over-read of the 20 professional cases. Agreement values range from 85.0 percent to 100 percent for individual elements, where 100 percent represents complete agreement between **RMHP Prime**'s internal audit results and HSAG's over-read results, and 0 percent represents complete disagreement.

**Figure 3—Aggregated Percent of Agreement Between
HSAG's Over-Read and RMHP Prime's Internal Audit Findings, by Data Element
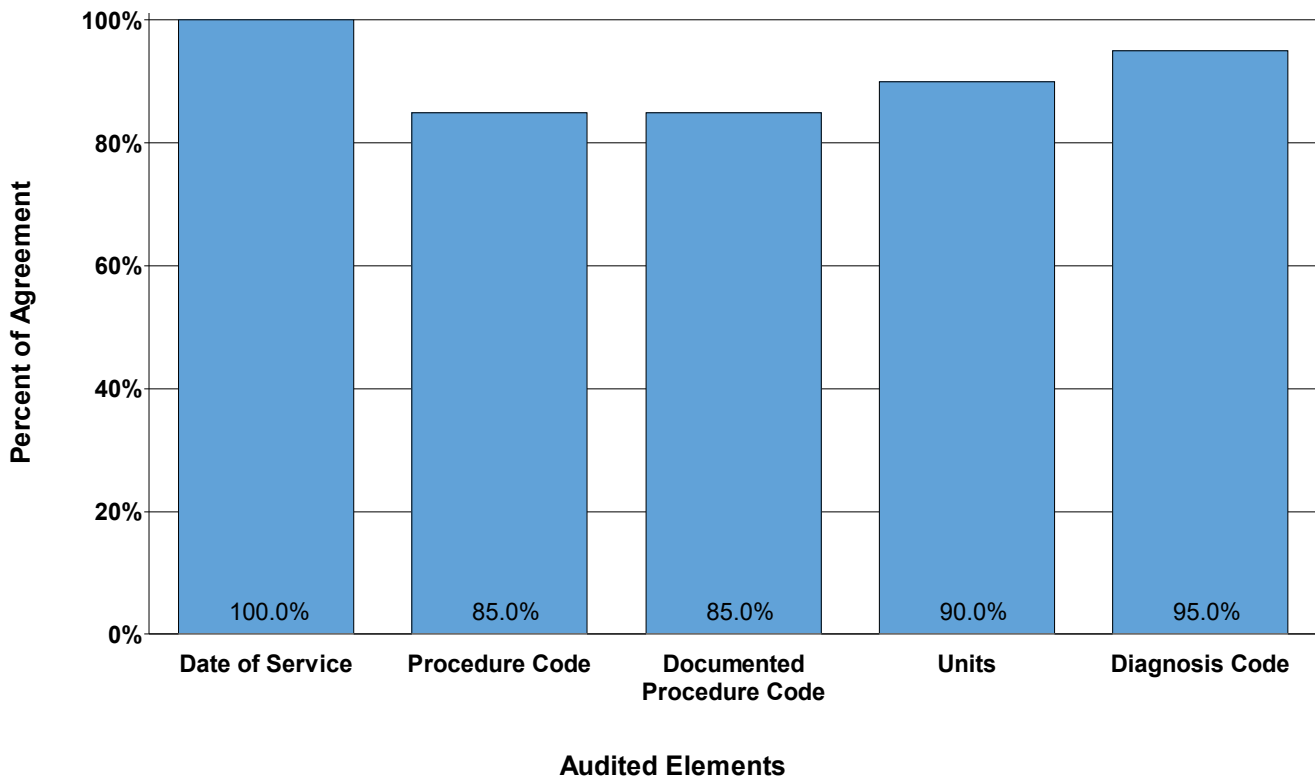Professional Services**

Complete agreement occurred when HSAG's over-read results indicated agreement with **RMHP Prime**'s audit response for each of the five individual data elements assessed for a sampled professional encounter. Of the 20 sampled professional encounters, over-read results demonstrated complete agreement for 14 cases, producing a 70.0 percent aggregate agreement rate. HSAG's over-read results agreed with **RMHP Prime**'s audit responses for all cases (i.e., complete agreement) for the *Date of*

Service data element. The lowest agreement rates (each 85.0 percent) were observed for the *Procedure Code* and *Documented Procedure Code* data elements.

HSAG's reviewers determined that medical record documentation did not align with the encounter data or **RMHP Prime** documented information for six of the nine audited data elements for which **RMHP Prime**'s audit results were inconsistent with HSAG's over-read results. The nine data elements in disagreement represented six sampled over-read cases.

FQHC Cases

Figure 4 presents the aggregate results from HSAG's over-read of the 20 FQHC cases. Agreement values range from 60.0 percent to 75.0 percent for individual elements, where 100 percent represents complete agreement between **RMHP Prime**'s internal audit results and HSAG's over-read results, and 0 percent represents complete disagreement.

**Figure 4—Aggregated Percent of Agreement Between
HSAG's Over-Read and RMHP Prime's Internal Audit Findings, by Data Element
FQHC Services**

Complete agreement occurred when HSAG's over-read results indicated agreement with **RMHP Prime**'s audit response for each of the five individual data elements assessed for a sampled FQHC encounter. Of the 20 sampled FQHC encounters, over-read results demonstrated complete agreement for 10 cases, producing a 50.0 percent aggregate agreement rate. The highest agreement rates (each 75.0
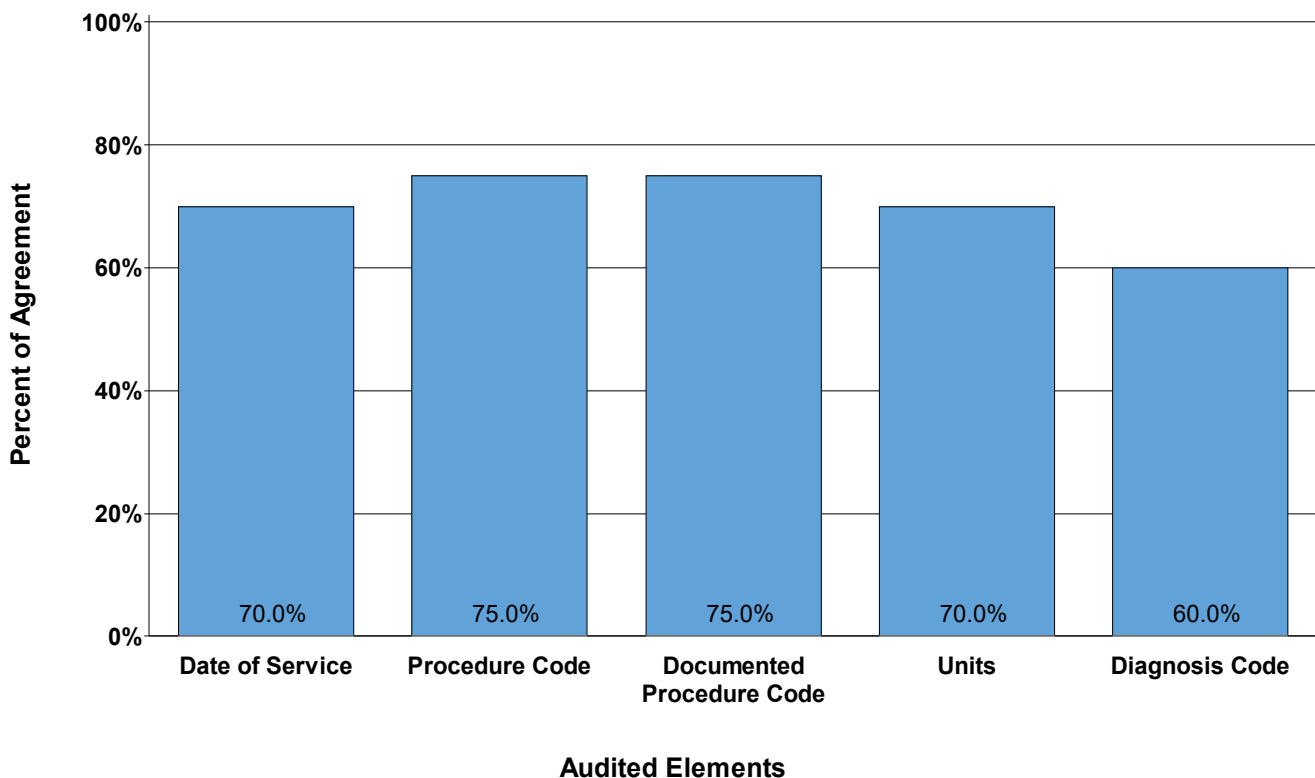
percent) were observed for the *Procedure Code* and *Documented Procedure Code* data elements. The lowest agreement rate (60.0 percent) was observed for the *Diagnosis Code* data element.

HSAG's reviewers determined that medical record documentation did not align with the encounter data or **RMHP Prime**'s documented information for five of the 30 audited data elements for which **RMHP Prime**'s audit results were inconsistent with HSAG's over-read results. For the remaining 25 data elements, **RMHP Prime**'s auditors reported no documentation or insufficient documentation to record an audit response value; HSAG's reviewers disagreed with this assessment. The 30 data elements in disagreement represented 10 sampled over-read cases.

Conclusions

HSAG performed a desk review of the Department's sampling methodology, assessing documentation that outlined key steps in the Department's generation of the 412-case sample. **RMHP Prime** conducted its internal audit of the 412 cases sampled by the Department; however, the Department's sampling methodology may not have resulted in a representative sample of the encounter data eligible for study inclusion. For example, the Department reported to HSAG that it selected the first 3,000 data rows meeting the study criteria, rather than generating a random sample from all study-eligible encounters. Had the input data set been sorted by date of service, encounters with a date of service at the end of the measurement period may have been inadvertently excluded from the sample, resulting in a sample not representative of the complete encounter data file. The Department's sampling methodology documentation did not include information on the preparation of the input data that would have allowed HSAG to determine if the 412-case sample list was representative of all relevant encounter data. Additionally, the Department provided no details regarding a runout interval between the study measurement period and the date on which the encounters were compiled for sample generation. Depending on the Department's data collection and storage processes, the length of a run-out interval prior to sampling could limit the encounters included in the study, biasing the sample toward encounters for services occurring earlier in the study period.

HSAG's over-read results indicated complete agreement with **RMHP Prime**'s internal audit results for 58 of the 80 sampled encounters, resulting in a 72.5 percent agreement rate. Table 1 shows case-level and element-level accuracy rates by service category.

Table 1—Percent of Cases in Total Agreement and Percent of Element Accuracy by Service Category

Service Category	Case-Level Accuracy		Element-Level Accuracy	
	Total Number of Cases	Percent With Complete Agreement	Total Number of Elements	Percent With Complete Agreement
Inpatient	20	85.0	120	97.5
Outpatient	20	85.0	100	93.0
Professional	20	70.0	100	91.0
FQHC	20	50.0	100	70.0
Total	**80**	**72.5**	**420**	**88.3**

Cases in which HSAG's reviewers disagreed with **RMHP Prime**'s audit results are divided into the following general categories:

- Cases in which HSAG's reviewers and **RMHP Prime**'s reviewers disagreed on the encounter data elements supported by the medical record.
- Cases that contained the **RMHP Prime** reviewer's comments stating that the medical record was insufficiently authenticated, though HSAG's reviewers disagreed. Most of these instances involved FQHC cases.

RMHP Prime provided medical record documentation for 73 of the 80 sampled over-read cases, and HSAG's over-read results were not impacted by **RMHP Prime**'s medical record procurement for this study.

Results from HSAG's FY 2018–2019 MCO over-read suggest opportunities for **RMHP Prime** to improve its audit processes and encounter data quality. Overall, results from HSAG's FY 2018–2019 MCO over-read showed that HSAG's coders agreed with **RMHP Prime**'s reviewers for 88.3 percent of individual audited data elements. Agreement rates among the different service categories were highest for inpatient cases (97.5 percent) and lowest among FQHC cases (70.0 percent). As reported in **RMHP Prime**'s Service Coding Accuracy Report, **RMHP Prime**'s reviewers consistently recorded low agreement rates for *Procedure Code* and *Procedure Code Modifier* as well as no agreement rate greater than 90 percent, suggesting opportunities for root cause analyses to determine barriers to encounter data quality.

Recommendations

The Department designed this study to assess the accuracy with which **RMHP Prime** audits physical health encounters in support of the Department's overall encounter data quality efforts. Therefore, HSAG recommends that findings associated with this independent audit be used for the Department's information and not for performance measurement or compliance monitoring purposes.

The Department continues to transition its encounter data process to a new Medicaid Management Information System (MMIS), interChange; and **RMHP Prime** will submit encounter data directly into the MMIS. For validation purposes, **RMHP Prime** will continue to submit encounter data flat files to the Department in parallel with MMIS submissions for a period of time determined by the Department. This change to the encounter data process will require enhanced data monitoring by the Department and **RMHP Prime** to ensure encounter data timeliness and accuracy as well as comparability between encounter data provided by **RMHP Prime** under the new and legacy systems.

FY 2018–2019 is **RMHP Prime**'s first year participating in the independent MCO audit. However, HSAG requested feedback from the Department regarding quality improvement actions resulting from prior years' independent MCO audit recommendations. In its response, the Department noted ongoing work with its encounter data system vendor to improve the encounter data documentation guiding the MCOs' data submissions.

Based on HSAG's document review, **RMHP Prime**'s service coding accuracy results, and the over-read results described in this report, HSAG offers the following recommendations to improve the quality of **RMHP Prime**'s encounter data.

- The Department's sampling methodology was limited to SQL code and a bulleted summary of the SQL code steps; therefore, HSAG recommends that the Department thoroughly document the sampling methodology to ensure that the sample is representative of all encounters eligible for study inclusion.
  - For example, HSAG recommends that the Department's Rates Section update the sampling documentation to define the terms used in the documentation, include an excerpt of sampling code, and describe any limitations on the sample frame (e.g., how to limit the universe of encounters or the code values for the different claim types).
  - As a final step in the sampling process, HSAG recommends that the Department's Rates Section perform validity checks on the 412 sample lists to verify that the sample is representative of the encounter data from which it was selected (e.g., compare distribution of the submission dates and/or providers among the sampled encounters and the sample frame).

- **RMHP Prime**'s FQHC encounters included the T1015 HCPCS code, and the Department confirmed that no specific guidance was provided to **RMHP Prime** regarding the use of this code in lieu of or addition to an E&M code. The T1015 code is not required to identify specific State plan services; therefore, HSAG recommends that the Department's Rates Section collaborate with the Department's contract administrator for **RMHP Prime** to provide formal guidance to **RMHP Prime** regarding the expected use of the T1015 code in encounter data submissions to the Department.

- **RMHP Prime**'s initial audit response file contained responses that did not align with the guidelines, and its service coding accuracy documentation regarding its audit tool was limited. To maintain audit data integrity, HSAG recommends that **RMHP Prime** consider the following enhancements for independent audits:
  - Thoroughly document audit tool(s), including a written description of the tool development and testing processes.
  - Add built-in logic to the data collection tool to limit reviewers' responses to acceptable response values (e.g., reviewers can only enter "0" or "1" in the tool for a specified data element).
  - Thoroughly document auditor training materials and procedures, including examples of written training and oversight materials and/or decision documents.

- **RMHP Prime**'s auditors determined that selected medical records were insufficient to meet auditing standards (e.g., missing key documentation elements such as the provider's signature). However, HSAG's reviewers disagreed with this assessment, noting that the medical records supported the encounter data. HSAG recommends that **RMHP Prime** assess internal auditing processes and document what is expected of MCO 412 auditors. HSAG also recommends that **RMHP Prime** follow up with the FQHCs during future medical record procurement activities to ensure that medical records are submitted in a standardized format and contain the information needed to authenticate an encounter.

- **RMHP Prime**'s service coding accuracy results showed a significant number of cases with procedure code data values not supported by medical record documentation, as well as variation in disagreement rates between service categories. To ensure that **RMHP Prime** has implemented quality improvement actions to address these encounter data deficiencies, HSAG recommends that the Department's contract administrator for **RMHP Prime**:

  – Request copies of **RMHP Prime**'s provider training and/or corrective action documentation.

  – Request copies of **RMHP Prime**'s policies and procedures for monitoring providers' data submissions.

  – Collaborate with the Department's Rates Section to review **RMHP Prime**'s encounter data quality documents and verify that **RMHP Prime** is monitoring encounter data quality and ensuring that providers are trained to submit encounters that accurately reflect the medical record documentation.

This table was copied from the *FY 2018–2019 Annual MCO Encounter Data Quality Review Guidelines Appendix II, Rocky Mountain Health Plan Flat File Encounter Data Specification*.

	Data Field Name	Format	General Description
1	INT_ENC_ID	VARCHAR (25)	MCO Assigned Claim Identifier
2	MCAID_ID	VARCHAR (9)	State Assigned Client Medicaid ID
3	CLNT_FST_NM	VARCHAR (255)	Client First Name
4	CLNT_MID_NM	VARCHAR (255)	Client Middle Name
5	CLNT_LST_NM	VARCHAR (255)	Client Last Name
6	CLNT_DOB	DATE	Client Date of Birth
7	PROV_MCAID_ID	VARCHAR (10)	State Assigned MCO Provider ID
8	PROV_NPI	VARCHAR (10)	CMS Assigned MCO Provider NPI
9	BILL_PROV_ID	VARCHAR (10)	Billing Provider Medicaid ID
10	BILL_PROV_NM	VARCHAR (255)	Billing Provider Name
11	BILL_PROV_ZIP	VARCHAR (10)	Billing Provider Zip Code
12	BILL_PROV_TYP	VARCHAR (255)	Billing Provider Type
13	BILL_PROV_SPCLTY_CD	VARCHAR (25)	Billing Provider Specialty Code
14	BILL_PROV_SPCLTY_DESC	VARCHAR (255)	Billing Provider Specialty Code Description
15	REND_PROV_ID	VARCHAR (25)	Rendering Provider Medicaid ID
16	REND_PROV_NM	VARCHAR (255)	Rendering Provider Name
17	REND_PROV_ZIP	VARCHAR (10)	Rendering Provider Zip Code
18	REND_PROV_TYP	VARCHAR (255)	Rendering Provider Type
19	REND_PROV_SPCLTY_CD	VARCHAR (25)	Rendering Provider Specialty Code
20	REND_PROV_SPCLTY_DESC	VARCHAR (255)	Rendering Provider Specialty Code Description
21	ATND_PROV_ID	VARCHAR (25)	Attending Provider Medicaid ID
22	ATND_PROV_NM	VARCHAR (255)	Attending Provider Name
23	ATND_PROV_ZIP	VARCHAR (10)	Attending Provider Zip Code
24	ATND_PROV_TYP	VARCHAR (50)	Attending Provider Type
25	ATND_PROV_SPCLTY_CD	VARCHAR (25)	Attending Provider Specialty Code
26	ATND_PROV_SPCLTY_DESC	VARCHAR (255)	Attending Provider Specialty Code Description
27	VENDOR_TYP	VARCHAR (25)	Vendor Type Assignment
28	CLM_CTG_CD	VARCHAR (25)	Claim Category Code
29	CLM_NUM	VARCHAR (50)	Claim Number
30	CLM_LNE_NUM	VARCHAR (50)	Claim Line Number
31	SRV_SRT_DT	DATE	Service Start Date
32	SRV_LST_DT	DATE	Service End Date
33	PD_DT	DATE	Paid Date
34	CLM_STS	VARCHAR (25)	Claim Payment Status
35	CLM_LNE_STS	VARCHAR (25)	Claim Line Payment Status

	Data Field Name	Format	General Description
36	REV_CD	VARCHAR (25)	Revenue Code
37	REV_DESC	VARCHAR (255)	Revenue Code Description
38	FQHC_IND	VARCHAR (25)	FQHC/RHC Indicator
39	PROC_CD	VARCHAR (25)	Procedure Code (CPT/HCPCS)
40	PROC_CD_MOD_1	VARCHAR (25)	Procedure Code Modifier 1
41	PROC_CD_MOD_2	VARCHAR (25)	Procedure Code Modifier 2
42	PROC_CD_MOD_3	VARCHAR (25)	Procedure Code Modifier 3
43	PROC_CD_MOD_4	VARCHAR (25)	Procedure Code Modifier 4
44	PROC_CD_MOD_5	VARCHAR (25)	Procedure Code Modifier 5
45	SRG_PROC_CD_1	VARCHAR (25)	Surgical Procedure Code 1
46	SRG_PROC_CD_2	VARCHAR (25)	Surgical Procedure Code 2
47	SRG_PROC_CD_3	VARCHAR (25)	Surgical Procedure Code 3
48	SRG_PROC_CD_4	VARCHAR (25)	Surgical Procedure Code 4
49	SRG_PROC_CD_5	VARCHAR (25)	Surgical Procedure Code 5
50	SRG_PROC_CD_1_DESC	VARCHAR (255)	Surgical Procedure Code 1 Description
51	SRG_PROC_CD_2_DESC	VARCHAR (255)	Surgical Procedure Code 2 Description
52	SRG_PROC_CD_3_DESC	VARCHAR (255)	Surgical Procedure Code 3 Description
53	SRG_PROC_CD_4_DESC	VARCHAR (255)	Surgical Procedure Code 4 Description
54	SRG_PROC_CD_5_DESC	VARCHAR (255)	Surgical Procedure Code 5 Description
55	ICD_VER	VARCHAR (25)	ICD Version
56	DIAG_CD_1	VARCHAR (25)	Diagnosis Code 1
57	DIAG_CD_2	VARCHAR (25)	Diagnosis Code 2
58	DIAG_CD_3	VARCHAR (25)	Diagnosis Code 3
59	DIAG_CD_4	VARCHAR (25)	Diagnosis Code 4
60	DIAG_CD_5	VARCHAR (25)	Diagnosis Code 5
61	DIAG_CD_6	VARCHAR (25)	Diagnosis Code 6
62	DIAG_CD_7	VARCHAR (25)	Diagnosis Code 7
63	DIAG_CD_8	VARCHAR (25)	Diagnosis Code 8
64	DIAG_CD_9	VARCHAR (25)	Diagnosis Code 9
65	DIAG_CD_1_DESC	VARCHAR (255)	Diagnosis Code 1 Description
66	DIAG_CD_2_DESC	VARCHAR (255)	Diagnosis Code 2 Description
67	DIAG_CD_3_DESC	VARCHAR (255)	Diagnosis Code 3 Description
68	DIAG_CD_4_DESC	VARCHAR (255)	Diagnosis Code 4 Description
69	DIAG_CD_5_DESC	VARCHAR (255)	Diagnosis Code 5 Description
70	DIAG_CD_6_DESC	VARCHAR (255)	Diagnosis Code 6 Description
71	DIAG_CD_7_DESC	VARCHAR (255)	Diagnosis Code 7 Description
72	DIAG_CD_8_DESC	VARCHAR (255)	Diagnosis Code 8 Description
73	DIAG_CD_9_DESC	VARCHAR (255)	Diagnosis Code 9 Description
74	NDC	VARCHAR (25)	National Drug Code
75	DSCHRG_STS	VARCHAR (25)	Discharge Status
76	POS_CD	VARCHAR (25)	Place of Service Code

	Data Field Name	Format	General Description
77	POS_CD_DESC	VARCHAR (255)	Place of Service Code Description
78	QTY	NUMBER (25,2)	Quantity
79	BILLED_AMT	NUMBER (25,2)	Billed Amount
80	ALLOWED_AMT	NUMBER (25,2)	Allowed Amount
81	TPL_AMT	NUMBER (25,2)	TPL Amount
82	COPAY_AMT	NUMBER (25,2)	Copayment Amount
83	OTHER_AMT	NUMBER (25,2)	Other Amount
84	NET_AMT	NUMBER (25,2)	Net Amount
85	PD_NET_AMT	NUMBER (25,2)	Paid Net Amount
86	BILL_TYP_CD	VARCHAR (25)	Bill Type Code
87	BILL_TYP_CD_DESC	VARCHAR (255)	Bill Type Code Description

This table was copied from the *FY 2018–2019 Annual MCO Encounter Data Quality Review Guidelines Appendix III, Response Data Layout for MCOs' Encounter Data Quality Audit.* Please note that HSAG made minimal edits to the table for readability.

	Data Element (Field)	Data Description	Format	Length
0	Record_No	Sequential number for each of 412 records	X	Integer
1	Encounter_Procedure_Code	0 = No or insufficient documentation, incorrect code utilized for procedure performed 1 = Correct code 9 = If data element does not pertain to encounter service type *Required for Professional, Outpatient, and FQHC Encounters* *See further details in Appendix III following this table**	X	1
2	Encounter_Procedure_Code_ Modifier	0 = No or insufficient documentation, incorrect code modifier utilized for procedure performed 1 = Correct code modifier 9 = If data element does not pertain to encounter service type *Required for Professional, Outpatient, and FQHC Encounters*	X	1
3	Encounter_Surgical_Procedure_ Code	0 = No or insufficient documentation, incorrect code utilized for surgical procedure performed 1 = Correct code 9 = If data element does not pertain to encounter service type *Required for Inpatient Encounters*	X	1
4	Encounter_Primary_Diagnosis_ Code	0 = No or insufficient documentation, assignment of incorrect primary diagnosis code, diagnosis not treated during encounter 1 = Correct code *Required for Inpatient, Professional, Outpatient, and FQHC Encounters*	X	1
5	Encounter_Units	0 = No or insufficient documentation, incorrect units 1 = Correct units 9 = Data element does not pertain to encounter service type *Required for Professional, Outpatient, and FQHC Encounters*	X	1
6	Encounter_Service_Date	0 = No or insufficient documentation, incorrect service start date 1 = Correct service start date 9 = If data element does not pertain to encounter service type *Required for Inpatient, Professional, Outpatient, and FQHC Encounters*	X	1

	Data Element (Field)	Data Description	Format	Length
7	Encounter_Thru_Date	0 = No or insufficient documentation, incorrect service end date 1 = Correct service end date 9 = If data element does not pertain to encounter service type *Required for Inpatient Encounters*	X	1
8	Encounter_Discharge_Status	0 = No or insufficient documentation, incorrect discharge status 1 = Correct discharge status 9 = If data element does not pertain to encounter service type *Required for Inpatient Encounters*	X	1
9	Doc_Procedure_Code	Enter correct procedure code if present in the supporting documentation. Enter 'No Doc' if no or insufficient documentation of correct procedure code. Enter 'NA' if data element does not pertain to encounter service type. *Required for Professional, Outpatient, and FQHC Encounters*	X	7
10	Doc_Procedure_Code_Modifier	Enter correct procedure code modifier if present in the supporting documentation. Enter 'No Doc' if no or insufficient documentation of correct procedure code modifier. Enter 'NA' if data element does not pertain to encounter service type. *Required for Professional, Outpatient, and FQHC Encounters*	X	7
11	Doc_Surgical_Code	Enter correct surgical procedure code if present in supporting documentation. Enter 'No Doc' if no or insufficient documentation of correct surgical procedure code. Enter 'NA' if data element does not pertain to encounter service type. *Required for Inpatient Encounters*	X	7
12	Doc_Diag	Enter correct primary diagnosis code if present in the supporting documentation. Enter 'No Doc' if no or insufficient documentation of correct diagnosis code. *Required for Inpatient, Professional, Outpatient, and FQHC Encounters*	X	7
13	Doc_Units	Enter correct units if present in the supporting documentation. Enter 'No Doc' if no or insufficient documentation of correct units. *Required for Professional, Outpatient, and FQHC Encounters*	X	Integer

	Data Element (Field)	Data Description	Format	Length
14	Doc_Service_Date	Enter correct start date if present in supporting documentation. Enter 'No Doc' if no or insufficient documentation of correct start date. *Required for Inpatient, Professional, Outpatient, and FQHC Encounters*	X	8
15	Doc_Thru_Date	Enter correct end date if present in supporting documentation. Enter 'No Doc' if no or insufficient documentation of correct end date. Enter 'NA' if data element does not pertain to encounter service type. *Required for Inpatient Encounters*	X	8
16	Doc_Encounter_Discharge_ Status	Enter correct discharge status if present in supporting documentation. Enter 'No Doc' if no or insufficient documentation of correct discharge status. Enter 'NA' if data element does not pertain to encounter service type. *Required for Inpatient Encounters*	X	8
17	E&M Guidelines Version	1 = 1995 version of Evaluation and Management Services Documentation Guidelines 2 = 1997 version of Evaluation and Management Services Documentation Guidelines 9 = Does Not Apply	X	1
18	Comments (optional)	Any comments, for example 'no documentation received from provider' or 'refer to leveling tool'	X	Flexible

* To assess encounter data quality, data elements are contingent on corresponding medical record documentation. Medical records correspond to the encounter data when the member information (i.e., name, date of birth, and/or Medicaid ID), provider information, and date of service are in agreement. If the medical records match the member and provider information but the date of service is incorrect, the Encounter_Service_Date will be scored as "0" and the remaining data elements will be scored as "0". The Comments field should be used to indicate that subsequent data elements were in disagreement due to the invalid date of service.

For Inpatient records or other records with services occurring over a date range, the encounter date of service is acceptable if it falls within the date range.

In the event medical record documentation is unavailable to support the encounter, all elements will be scored as "0" or "No Doc."

In the event that medical record documentation could support more than one procedure code, auditors should note agreement with the encounter procedure code, if applicable, and use the Comments field to indicate other applicable procedure codes identified in the medical record.

To ensure consistency between each MCO's audit and the independent auditor's over-read, MCOs should provide the independent auditor with all medical records and supporting documentation used by the MCO during its 412 audit. Examples of such documentation include internal leveling tools, crosswalks, or any other such supporting materials used by the MCO in the completion of the 412 audit.

Appendix C. RMHP Prime Service Coding Accuracy Results

Data from these tables have been copied from the Service Coding Accuracy Report submitted to the Department and HSAG by **RMHP Prime**. Data tables were created following the specifications listed in Section 6 of the *FY 2018–2019 Annual MCO Encounter Data Quality Review Guidelines*.

Table C-1—Inpatient Encounters Service Coding Accuracy Summary

Requirement	MCO Name	Numerator	Excluded/ Does Not Apply	Total Denominator	Modified Denominator	Overall Percent	Modified Percent
Date of Service (Service_Date)	RMHP Prime	91	—	103	103	88%	88.%
Through Date (Thru_Date)	RMHP Prime	91	—	103	103	88%	88%
Diagnosis Code (Diag_Code_1)	RMHP Prime	93	—	103	103	90%	90%
Surgical Procedure Code (SurgicalProcedure1)	RMHP Prime	47	38	103	65	46%	72%
Discharge Status (Discharge_Status)	RMHP Prime	74	—	103	103	72%	72%

The (—) symbol indicates that RMHP Prime did not report a data value.

Table C-2—Outpatient Encounters Service Coding Accuracy Summary

Requirement	MCO Name	Numerator	Excluded/ Does Not Apply	Total Denominator	Modified Denominator	Overall Percent	Modified Percent
Date of Service (Service_Date)	RMHP Prime	65	—	103	103	63%	63%
Diagnosis Code (Diag_Code_1)	RMHP Prime	61	—	103	103	59%	59%
Procedure Code (Proc_Code)	RMHP Prime	61	—	103	103	59%	59%
Procedure Code Modifier (Procedure_Code_Modifier)	RMHP Prime	11	61	103	42	11%	26%
Units (Quantity)	RMHP Prime	60	—	103	103	58%	58%

The (—) symbol indicates that RMHP Prime did not report a data value.

Table C-3—Professional Encounters Service Coding Accuracy Summary

Requirement	MCO Name	Numerator	Excluded/ Does Not Apply	Total Denominator	Modified Denominator	Overall Percent	Modified Percent
Date of Service (Service_Date)	RMHP Prime	80	—	103	103	78%	78%
Diagnosis Code (Diag_Code_1)	RMHP Prime	72	—	103	103	70%	70%
Procedure Code (Proc_Code)	RMHP Prime	61	—	103	103	59%	59%
Procedure Code Modifier (Procedure_Code_Modifier)	RMHP Prime	12	66	103	37	12%	32%
Units (Quantity)	RMHP Prime	76	—	103	103	74%	74%

The (—) symbol indicates that RMHP Prime did not report a data value.

Table C-4—FQHC Encounters Service Coding Accuracy Summary

Requirement	MCO Name	Numerator	Excluded/ Does Not Apply	Total Denominator	Modified Denominator	Overall Percent	Modified Percent
Date of Service (Service_Date)	RMHP Prime	75	—	103	103	73%	73%
Diagnosis Code (Diag_Code_1)	RMHP Prime	74	—	103	103	72%	72%
Procedure Code (Proc_Code)	RMHP Prime	63	—	103	103	61%	61%
Procedure Code Modifier (Procedure_Code_Modifier)	RMHP Prime	5	88	103	15	5%	33%
Units (Quantity)	RMHP Prime	75	—	103	103	73%	73%

The (—) symbol indicates that RMHP Prime did not report a data value.