Appendix 4

DM Roadmap

APPENDIX 4

DM ROADMAP

Introduction

Welcome to the NCQA HEDIS Compliance Audit™ tool, the *Disease Management Record of Administration, Data Management and Processes* (Roadmap). The DM Roadmap collects information about how your organization’s information management practices affect measure reporting; it is not meant to evaluate the effectiveness of your organization’s information systems.

The DM Roadmap

Yearly completion of the Roadmap is a required component of the NCQA HEDIS Compliance Audit process. The Roadmap’s tables provide auditors with the preliminary information they need to conduct the audit. All information requested in the Roadmap is essential to the audit process, and auditors require the organization to answer or update each question accurately and completely. Keep the following in mind.

* Each organization that participates in the audit process must complete or update a Roadmap every year.
* Auditors may not prepare the Roadmap for an organization.
* When a single organization reports for multiple programs (e.g., *Heart Failure, IVD, Asthma, Diabetes, COPD*), it may complete one Roadmap, but it must provide separate responses for each program when necessary.
* Provide answers only for programs under review (i.e., subject to audit).
* All questions relate to the measurement year systems and processes, unless otherwise indicated.

The following table provides instructions for completing the Roadmap sections for each organization.

|  |  |
| --- | --- |
| Section | Completing the HEDIS Roadmap |
| General Information. | *Complete or update:*  One for the organization. |
| 1. Medical Services. | *Complete or update:*  One for the organization.  One for each medical services vendor. |
| 1A–C. Ancillary Services. | *Complete or update:*  One for each ancillary services vendor. |
| 2. Enrollment. | *Complete or update:*  One for the organization.  One for each enrollment vendor. |
| 3. Registry Data. | *Complete or update:*  One for the organization. |
| 4. Supplemental Data. | *Complete or update:*   * One for each supplemental database. |
| 5. Data Integration. | *Complete or update:*  One for the organization.  One for each software vendor. |

If your organization’s data systems, processes or measure production are centralized and serve several organizations, you may only need to submit one copy of a section or attachment. Work with your auditor to ensure accurate completion of the Roadmap.

Each section lists the corresponding standard to help you link the information provided in the Roadmap to individual HEDIS Audit standards. You are encouraged to refer to the relevant standards as you prepare the Roadmap.

* Use ***Sections 1A-1C*** for standard claim-type data from ancillary providers.
* Use ***Section 5*** for nonstandard supplemental data.

Requested Documents

The Requested Documents table at the end of each section lists workflow diagrams, reports and other documents you should attach. Label the attachments as directed. If you cannot provide the requested documents when you submit the Roadmap, indicate this in the table and tell your auditor when you will be able to provide them.

If you determine a separate document might provide a more complete or accurate response, you may include it as an attachment. You may also include documents previously requested by your auditor. Add the attachment name, description and label to the applicable Requested Documents table. You are not limited to providing only the requested documents; you are encouraged to provide additional information that helps clarify an answer or eliminates the need for a lengthy response.

Successfully Completing the DM Roadmap

An organization that gives clear and complete responses has better onsite visits and receives fewer requests for follow-up documents. As you complete the DM Roadmap, keep the following in mind.

* Ensure that all persons completing the DM Roadmap know which programs are subject to review and that they provide responses for *only* those programs.
* Distribute a copy of the instructions to everyone involved in completing the DM Roadmap.
* Provide electronic copies of completed DM Roadmap sections and attachments where possible.
* Label all electronic documents clearly, indicating section or attachment number and description.
* Add additional columns to tables or additional copies of tables to ensure accurate completion for each program under review.
* Label all attachments accurately and add additional attachments to the applicable Requested Documents table.

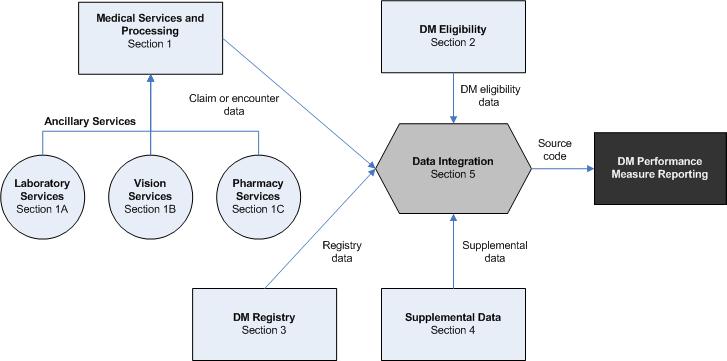
Auditors hold the Roadmap and attached documents in strict confidence; however, NCQA uses the DM Roadmap and attached documents to assess auditor performance.

DM Roadmap Data Workflow Diagrams

The Roadmap was changed to help organizations of all types give auditors information about data they use for DM Measure Reporting—where data come from, how data are organized. The Roadmap also helps you send the right set of questions to the right people.

Below are visual representations of the data sources and variations possible for organizations completing the Roadmap.

### For DM Measure Reporting



General Information

Introduction

The *DM* *Roadmap Appendix 1* is an Excel file that includes: General Information, Instructions, and Measure Reporting tabs. Complete the spreadsheet for each program under review.

DM Roadmap Appendix 1

* General Information:
* About your organization.
* Contact information.
* Programs undergoing an audit for the measurement year.
* Measure Reporting Instructions.
* What DM measures are you reporting?
* *Heart Failure* measures.
* *IVD* measures.
* *COPD* measures.
* *Asthma* measures.
* *Diabetes* measures.

Requested Documents

Provide the documents listed below and label them as instructed in the table. Use “NA” if the document is not applicable.

|  |  |  |
| --- | --- | --- |
| Document | Details | Label |
| **Previous DM audit reports (if applicable)** | If your organization is using a new audit firm for the measurement year, attach the final report from the previous year’s DM Audit. | **GI.1** |
| **Program overview and description** | Provide a detailed overview of all DM programs undergoing accreditation and the audit, including program structure, design and staffing. | **GI.2** |

Section Contact

***Who is responsible for completing this section of the DM Roadmap?***

|  |  |  |
| --- | --- | --- |
|  | Contact |  |
| Name |  |  |
| Title |  |  |
| Company |  |  |
| Address |  |  |
| City, state, zip |  |  |
| Telephone |  |  |
| Fax |  |  |
| E-mail address |  |  |
|  |  |  |

Attestation\*

**Organization name:**

I declare that the information provided in this DM Roadmap is accurate and complete, to the best of my knowledge.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature |  | Date |
|  |  |  |
|  |  |  |
| Name *(print or type)* |  | Title |

*\* This form must be completed by the staff member responsible for the completeness and accuracy of the entire DM Roadmap. The signature may be actual or an electronic version (e.g., a JPEG file) of an actual signature.*

Section 1: Medical Services and Processing *(IS 9.1)*

Introduction

***Claim or encounter data system and processes used during the measurement year.***

|  |  |
| --- | --- |
| Organization information | **Organization name:** |
| **Completion date:** |
| Definitions |  |
| *Claim* | A submission for reimbursement (e.g., from fee-for-service providers). |
| *Encounter* | A submission that is not linked to payment (e.g., from capitated providers). |
| *Claim or encounter processing vendor* | Includes any external entity with which the organization has contracted to perform the following tasks.   * Provide a particular type of medical service. * Perform claim or encounter data processing functions. |
| *Product* | An organized health care system that is accountable for financing and delivering a broad range of comprehensive health services to an enrolled population (HMO, POS, combined HMO/POS, PPO). |
| *Product line* | The programs offered to distinct populations brought forward by an organization for evaluation (e.g., commercial, Medicare, Medicaid). |
| *Vendor* | May include, but is not limited to, ancillary providers, third-party administrators, traditional data capture (TDC) vendors, provider groups and intermediary organizations (e.g., IPAs, MSOs, PHOs). |
| *Significant change* | A change of (+/–)10% in volume of data processed, or a conversion, consolidation or upgrade to the data processing system. |
| Instructions | * Complete Section 1 for each claim or encounter data processing system produced in-house. * If the DM contracts with multiple plans, each plan must complete a separate Section 1. * If vendors are used to collect ancillary services: * Complete***Section 1.A*** for laboratory data. * Complete ***Section 1.B*** for vision data. * Complete ***Section 1.C*** for pharmacy data. * Where there are differences by product line or product, provide a separate response for each product line or product subject to audit. |

Claim or Encounter System General Information

### Table 1.1: *Claim or encounter data system described in this section.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Question | | Product Line A | Product Line B | Product Line C |
| ***1.1A*** | Name of claim or encounter system. |  |  |  |
| ***1.1B*** | Type of data processed. |  |  |  |
| ***1.1C*** | Location (city, state). |  |  |  |
| ***1.1D*** | Average monthly volume. |  |  |  |
| ***1.1E*** | Percentage of facility claims or encounters submitted: | | | |
| * On paper. |  |  |  |
| * Electronically. |  |  |  |
| ***1.1F*** | Percentage of professional claims or encounters submitted: | | | |
| * On paper. |  |  |  |
| * Electronically. |  |  |  |

Claim or Encounter Policy Questions

|  |  |
| --- | --- |
| ***1.1-1*** | ***Q.*** Regarding claim or encounter policies in place during the measurement year, what was the time limit for practitioner submissions?  ***A.*** |
| ***1.1-2*** | ***Q.*** How did your organization handle claims submitted past the deadline?  ***A.*** |

Complete Tables 1.2–1.6 only if your organization processes claims or encounters  
from providers.

Coding Software

**Table 1.2: *Automated coding software used for the claim or encounter data system described in this section.***

| Question | | Description |
| --- | --- | --- |
| ***1.2A*** | Name of automated coding software. |  |
| ***1.2B*** | How often are codes updated? |  |
| ***1.2C*** | Does your organization verify procedure or diagnosis codes? |  |
| ***1.2D*** | Does your organization group or ungroup procedure or diagnosis codes? |  |
| ***1.2E*** | Does your organization use its own grouper? |  |
| ***1.2F*** | Which grouper does your organization use? Does the grouper retain codes for reporting? |  |
| ***1.2G*** | Does your organization ensure accurate assignment of DRGs? |  |

Coding Schemes

**Table 1.3: *Coding schemes.*** Consider all nonstandard coding methods, including state-specific codes (e.g., Medicaid), internally-developed codes and case and per diem rates.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Coding Scheme | | Type of Service | | | |
| Inpatient Diagnosis | Inpatient Procedure | Ambulatory Diagnosis | Ambulatory Procedure |
| ***1.3A*** | Standard codes (e.g., ICD-9, CPT, UB Revenue, HCPCS, CPT II, SNOMED-CT). |  |  |  |  |
| ***1.3B*** | Nonstandard codes: | | | | |
| State-specific (e.g., Medicaid). |  |  |  |  |
| Internally developed. |  |  |  |  |

**Table 1.4: *Complete this table for each coding scheme if state-specific codes or internally developed codes were used for any service type in Table 1.3.*** List each code type on a separate row in the table.

|  | | Descriptions | | |
| --- | --- | --- | --- | --- |
| ***1.4A*** | Type of coding scheme. |  |  |  |
| ***1.4B*** | What percentage of claims or encounters was affected? |  |  |  |
| ***1.4C*** | For which services were codes or rates used? |  |  |  |
| ***1.4D*** | Were the codes or rates received on claim or encounter forms from providers, or generated by the claim or encounter system or processors? |  |  |  |
| ***1.4E*** | How were the codes or rates processed in the claim or encounter data system? |  |  |  |
| ***1.4F*** | If standard codes are grouped to nonstandard codes, were the original codes maintained in the claim or encounter processing system? |  |  |  |

**Table 1.5: *Complete this table if global billing codes, case rates or per diems were used during the measurement year.*** List each code type on a separate row in the table.

|  |  |  |
| --- | --- | --- |
| Services That Used Global Billing Codes, Case Rates or Per Diems | Percentage of Claims or  Encounters Affected | For Codes That Cover a Period  of Treatment, Date on Claim  or Encounter |
|  |  |  |
|  |  |  |
|  |  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Nonstandard Data Submission Forms

**Table 1.6:  *Nonstandard, state-specific or encounter forms (i.e., other than UB-04 or CMS 1500) used during the measurement year.***

|  |  |  |
| --- | --- | --- |
| Question | | Response |
| ***1.6A*** | Type of form. |  |
| ***1.6B*** | What percentage of claims or encounters was affected? |  |
| ***1.6C*** | For which services were nonstandard forms used? |  |

Data Elements

**Table 1.7: *Data elements captured in your claim or encounter system.*** How many elements are captured (e.g., number of CPT codes)? How many digits are captured? Indicate if the data element is:

**R Required:** The claim or encounter system requires the data element for all claims or encounters.

**O Optional:** The claim or encounter system requires the data element for some claims or encounters, but not all.

**N Not Required:** The claim or encounter system does not require or capture the data element.

**NA Not Applicable:** The data element does not apply to the claim or encounter system.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Required? (R,O,N,NA) | No. of Codes | No. of Digits | Description |
| Member ID number. |  |  |  |  |
| Rendering provider ID. |  |  |  |  |
| Prescribing provider ID. |  |  |  |  |
| **Claim Information** | | | | |
| Claim number. |  |  |  |  |
| First date of service. |  |  |  |  |
| Last date of service. |  |  |  |  |
| Rx written date. |  |  |  |  |
| Script filled date. |  |  |  |  |
| Discharge status. |  |  |  |  |
| Payment status. |  |  |  |  |
| **Codes** | | | | |
| Primary diagnosis. |  |  |  |  |
| Secondary diagnosis. |  |  |  |  |
| Primary procedure. |  |  |  |  |
| Secondary procedure. |  |  |  |  |
| Procedure modifiers. |  |  |  |  |
| Units of service. |  |  |  |  |
| UB revenue. |  |  |  |  |
| Type of bill. |  |  |  |  |

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Required? (R,O,N,NA) | No. of Codes | No. of Digits | Description |
| **Codes** | | | | |
| Place of service. |  |  |  |  |
| HCPCS. |  |  |  |  |
| CPT Level II. |  |  |  |  |
| NDC. |  |  |  |  |
| LOINC. |  |  |  |  |
| SNOMED-CT. |  |  |  |  |

**Table 1.8: *Claim or encounter system edit checks, including checks on parity, field sizes, date ranges and cross checks with member and practitioner files.***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***1.8A*** | Checks for valid procedure and diagnosis codes (e.g., obsolete codes, required number of digits). |  |
| ***1.8B*** | Checks for valid members. |  |
| ***1.8C*** | Checks for valid coding (e.g., recalculates the DRG or procedure valid for the members gender). |  |
| ***1.8D*** | Checks on field size. |  |
| ***1.8E*** | Checks on date ranges (e.g., “to” date is after “from” date; no future dates). |  |
| ***1.8F*** | Checks for valid practitioners. |  |

System Upgrades or Conversions

**Table 1.9: *Complete this table if significant changes were made to the claims or encounter data system or a new data system was implemented during the past three years.***

| Question | | Description |
| --- | --- | --- |
| ***1.9A*** | Describe the change, upgrade or consolidation. |  |
| ***1.9B*** | Which claim or encounter data systems and product lines or products were affected? |  |
| ***1.9C*** | Project start and end dates. |  |
| ***1.9D*** | Regarding data conversion: | |
| Which claims or encounters were converted to the new system (e.g., claims or encounters as of a certain date of service or receipt; all claims or encounters)? |  |
| Which claims or encounters were not converted to the new system? |  |
| Which data elements were converted to the new system? |  |
| Which elements were not converted to the new system? |  |
| ***1.9E*** | How were data mapped for conversion from the previous system to the new claim or encounter system? |  |
| ***1.9F*** | Did a parallel system run during the conversion? |  |
| ***1.9G*** | How did your organization ensure accuracy and completeness of data in the new system? |  |

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Policies and Procedures

**Table 1.10: *Claim or encounter data processes.***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***1.10A*** | How are claims or encounters obtained, processed and entered into the claim or encounter system? | |
| Describe any scanning or data-entry vendors involved in the process. |  |
| ***1.10B*** | Are encounters (i.e., submissions that are not linked to payment) processed differently from claims (i.e., submissions for payment)? |  |
| ***1.10C*** | How are claims or encounters batched? How are batch levels controlled (i.e., how are claims monitored to ensure that all claims received are entered)? |  |
| ***1.10D*** | Are any standard data elements from the claim (e.g., procedure codes, diagnosis codes, place of service codes, type of bill codes, units) mapped, deleted or changed during processing of the claim or encounter? |  |
| ***1.10E*** | How is a claim or encounter handled if it is submitted: | |
| With one or more required fields missing, incomplete or invalid? |  |
| With no diagnosis code, or an invalid code? Is a default code used? |  |
| With no procedure code, or an invalid code? Is a default code used? |  |
| ***1.10F*** | Are there situations where processors may change claim or encounter information submitted by a provider? |  |
| ***1.10G*** | Describe any system-generated codes. Are they standard codes used in DM or nonstandard? |  |
| ***1.10H*** | Describe any denial codes generated by the system? |  |

Electronic Submission of Claim or Encounter Data

**Table 1.11: *Complete this table if the claim or encounter system accepts electronically transferred claim or encounter data.***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***1.11A*** | Are electronic claims received directly or through clearing houses, or both? |  |
| ***1.11B*** | Are electronic claims received in HIPAA-standard compliant or proprietary formats? |  |
| ***1.11C*** | How are electronically received files uploaded into the claim or encounter processing system? |  |
| ***1.11D*** | Do electronically received claims or encounters receive the same edit checks as paper claims or encounters? |  |
| ***1.11E*** | Are electronic claims mapped, transformed or truncated before being uploaded into the claim or encounter system? |  |
| ***1.11F*** | How do you ensure that transmissions are properly monitored and controlled? |  |
| ***1.11G*** | What edit checks are performed to ensure that electronically transferred claim or encounter files are accurately and completely received and uploaded? |  |
| ***1.11H*** | How does your organization verify the accuracy of electronic submissions? |  |

Timeliness and Accuracy of Data Processing

**Table 1.12: *Timeliness of claim or encounter data processing during the measurement year.*** Complete this table if the claim or encounter system accepts electronically transferred claim or encounter data.

| Question | | Description |
| --- | --- | --- |
| ***1.12A*** | What were the time-to-process standards for claim or encounter data? |  |
| ***1.12B*** | What was the actual average time to process for claim or encounter data? |  |
| ***1.12C*** | Was there ever a backlog or delay in processing claim or encounter data? |  |

**Table 1.13: *Accuracy of claim or encounter processing during the measurement year.*** Complete this table if the claim or encounter system accepts electronically transferred claim or encounter data.

| Question | | Description |
| --- | --- | --- |
| ***1.13A*** | Were there audits of claim or encounter data processing? |  |
| ***1.13B*** | What was audited, and how often? |  |
| ***1.13C*** | What were the findings for the measurement year? |  |
| ***1.13D*** | Were deficiencies detected? |  |

Data Completeness

Payment Arrangements

**Table 1.14: *Contracted service providers or vendors.*** Complete a separate table or add extra columns to address all medical and ancillary service providers who do not submit claims or encounters through the normal transaction system.

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***1.14A*** | Name of external contracted service provider. |  |
| ***1.14B*** | Products or product lines affected. |  |
| ***1.14C*** | Contract start or end date. |  |
| ***1.14D*** | Types of services provided (e.g., behavioral healthcare, ambulatory, pharmacy, lab, radiology, vision, inpatient). |  |
| ***1.14E*** | Percentage of members with the benefit directed to this service provider. |  |
| ***1.14F*** | Type and frequency of data submission to the organization (e.g., monthly data file). |  |
| ***1.14G*** | Does the organization have service agreements in place requiring data submission? (Y/N) |  |
| ***1.14H*** | Were contracted services subject to oversight policies, processing standards or other requirements? |  |
| ***1.14I*** | Describe oversight and monitoring activities during the measurement year, including type and frequency of reviews and audits. |  |

**Table 1.14 *(continued)***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***1.14J*** | Were deficiencies detected with processing of enrollment or membership data during the measurement year? If yes, describe the nature of the deficiencies and corrective actions taken. |  |
| ***1.14K*** | Are there barriers to obtaining complete and accurate data? Consider all factors that influence your organization’s ability to collect such information from providers, including, but not limited to, system constraints or incompatibilities, lack of data reporting requirements, payment arrangements (e.g., capitation), data integration issues. |  |

Improvement of Data Completeness

**Table 1.15: *Data completeness activities during the measurement year.***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***1.15A*** | Did your organization take steps to improve completeness of claim or encounter data? |  |
| ***1.15B*** | Were all practitioners, provider groups, facilities and vendors required by contract to submit complete and accurate claim or encounter data? |  |
| ***1.15C*** | Were performance standards in place to ensure submission of claim or encounter data by practitioners, provider groups, facilities and vendors? |  |
| ***1.15D*** | Was compensation tied to submission of claim or encounter data by practitioners, provider groups, facilities and vendors? |  |
| ***1.15E*** | Were other incentive or penalty arrangements in place for submission of complete and accurate data by practitioners, provider groups, facilities and vendors? |  |
| ***1.15F*** | Were other activities undertaken to encourage claim or encounter data submission by practitioners, provider groups, facilities and vendors? |  |
| ***1.15G*** | What action, if any, was taken against practitioners, provider groups, facilities and vendors who routinely failed to submit complete and accurate claim or encounter data? |  |

Requested Documents

Provide the documents listed below and label them as instructed in the table. Use “NA” if the document is not applicable.

|  |  |  |
| --- | --- | --- |
| Document | Details | Label |
| **Claim or encounter data system flowchart** | A flowchart that gives an overview of the claim or encounter data system and processes, indicating steps in the process as well as the flow of claim or encounter data from all sources. | **1.1** |
| **Proprietary forms (if applicable)** | If proprietary claim or encounter forms were used during the measurement year, attach clean, blank copies of each. Applicable only to organizations that process claims or encounters from providers. | **1.2** |
| **Explanation of nonstandard codes (if applicable)** | If nonstandard codes were used during the measurement year, attach descriptions of internally developed codes, code definitions, translation procedures and code mapping schemes. Applicable only to organizations that process claims or encounters from providers. | **1.3** |
| **Claim lag, IBNR or completion factor reports** | Documentation (e.g., claim lag reports, IBNR reports, completion factor reports) of completeness of claim or encounter data at the time data files were generated for DM reporting. Applicable only to organizations that process claims or encounters from providers. | **1.4** |
| **Data completeness studies or analyses** | If applicable, attach copies of additional studies or analyses conducted on data completeness or under-reporting. | **1.5** |

Section Contact

***Who is responsible for completing this section of the Roadmap?***

|  |  |  |
| --- | --- | --- |
|  | Contact |  |
| Name |  |  |
| Title |  |  |
| Company |  |  |
| Address |  |  |
| City, state, zip |  |  |
| Telephone |  |  |
| Fax |  |  |
| E-mail address |  |  |
|  |  |  |

Section 1A: Laboratory Services and Processing *(IS 9.1)*

Introduction

***Vendors’ laboratory claim or encounter data systems and processes used during the measurement year.*** Vendors complete this section annually for each organization.

|  |  |
| --- | --- |
| Vendor information | **Vendor name:** |
| **Reporting for:** |
| **Completion date:** |
| Definitions |  |
| *Claim* | A submission for reimbursement (e.g., from fee-for-service providers). |
| *Encounter* | A submission that is not linked to payment (e.g., from capitated providers). |
| *Claim or encounter processing vendor* | Includes any external entity with which the organization has contracted to perform the following tasks.   * Provide a particular type of medical service. * Perform claim or encounter data processing functions. |
| *Significant change* | A change of (+/–)10% in volume of data processed, or a conversion, consolidation or upgrade to the data processing system. |
| Instructions | * Vendors complete Section 1A if they process claims or encounter data for reimbursement for the health plan or DM. If a vendor sends electronic results data to the health plan or DM and does not process claims or encounters, skip this section and complete Section 5. * Complete a separate Section 1A for each claim or encounter data processing system. * Where there are differences by product line or product, provide a separate response for each product line or product subject to audit. * Vendors completing this section should provide information relevant to only the organization above, including all calculations provided. |

Claim or Encounter System General Information

**Table 1A.1:** ***Claim or encounter data processing system described in this section.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Question | | Product Line A | Product Line B | Product Line C |
| ***1A.1A*** | Name of claim or encounter system. |  |  |  |
| ***1A.1B*** | Are claims processed or are encounters processed, or are both processed? |  |  |  |
| ***1A.1C*** | How often are data transmitted to the health plan or DM? |  |  |  |
| ***1A.1D*** | Location (city, state). |  |  |  |
| ***1A.1E*** | Percentage of claims or encounters processed: | |  |  |
| * On paper. |  |  |  |
| Electronically. |  |  |  |

Claim or Encounter System and Policy Questions

|  |  |
| --- | --- |
| ***1A.1-1*** | ***Q.*** Regarding claim or encounter policies in place during the measurement year, what was the time limit for when a practitioner could submit a claim or encounter?  ***A.*** |
| ***1A.1-2*** | ***Q.*** Does the vendor use the plan’s member identifier for claims processing? If not, how are claims mapped?  ***A.*** |
| ***1A.1-3*** | ***Q.*** How did you handle a claim or encounter submitted past the deadline?  ***A.*** |
| ***1A.1-4*** | ***Q.*** Can your organization identify the date on which a member exhausts a health benefit (e.g., uses the maximum number of allowed visits in a calendar year)? Describe differences by product line.  ***A.*** |
| ***1A.1-5*** | ***Q.*** How does your organization identify qualifying practitioners?  ***A.*** |

Coding Software

**Table 1A.2: *Automated coding software used for the claim or encounter data system described in this section.***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***1A.2A*** | Name of automated coding software. |  |
| ***1A.2B*** | How often are codes updated? |  |
| ***1A.2C*** | Does your organization verify procedure or diagnosis codes? |  |
| ***1A.2D*** | Does your organization group or ungroup procedure or diagnosis codes? |  |

Coding Schemes

**Table 1A.3: *Coding schemes used.*** Consider all non-standard coding methods, including state-specific codes (e.g., Medicaid), internally-developed codes and case and per diem rates.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Coding Scheme | | Type of Service | | | |
| Inpatient  Diagnosis | Inpatient  Procedure | Ambulatory Diagnosis | Ambulatory Procedure |
| ***1A.3A*** | Standard codes (e.g., ICD-9, CPT, UB Revenue, HCPCS, CPT II, SNOMED-CT). |  |  |  |  |
| ***1A.3B*** | Nonstandard codes: | | | | |
| State-specific (e.g., Medicaid). |  |  |  |  |
| Internally developed. |  |  |  |  |

**Table 1A.4: *Complete this table for each coding scheme if you used state-specific codes, internally developed codes or case or per diem rates for any service type in Table 1A.3.*** List each code type on a separate row in the table.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Question | | Description | | |
| ***1A.4A*** | Type of coding scheme. |  |  |  |
| ***1A.4B*** | What percentage of claims or encounters was affected? |  |  |  |
| ***1A.4C*** | For which services were codes or rates used? |  |  |  |
| ***1A.4D*** | Were codes or rates received on claim or encounter forms from providers, or generated by the claim or encounter system or processors? |  |  |  |
| ***1A.4E*** | How were codes or rates processed in the claim or encounter data system? |  |  |  |
| ***1A.4F*** | If standard codes are grouped to nonstandard codes, were the original codes maintained in the claim or encounter processing system? |  |  |  |

**Table 1A.5: *Complete this table if case rates or per diems were used during the measurement year.*** Complete a separate row for each different billing method.

|  |  |  |
| --- | --- | --- |
| Services That Used Case Rates or per Diems | Percentage of Claims or Encounters Affected | For Codes That Cover a Period of Treatment, Date Used on the Claim or Encounter |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

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Nonstandard Data Submission Forms

**Table 1A.6: *Were nonstandard, state-specific or encounter forms (i.e., other than UB or CMS 1500) used during the measurement year?***

|  |  |  |
| --- | --- | --- |
| Question | | Response |
| ***1A.6A*** | Type of form. |  |
| ***1A.6B*** | What percentage of claims or encounters was affected? |  |
| ***1A.6C*** | For which services were nonstandard forms used? |  |

Data Elements

**Table 1A.7: *Data elements captured in your claim or encounter system.*** How many elements are captured (e.g., number of CPT codes)? How many digits are captured? Indicate if the data element is:

**R Required:** The claim or encounter system requires the data element for all claims or encounters.

**O Optional:** The claim or encounter system requires the data element for some, but not all claims or encounters.

**N Not Required:** The claim or encounter system does not require or capture the data element.

**NA Not Applicable:** The data element does not apply to the claim or encounter system.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Required? (R,O,N,NA) | No. of Codes | No. of Digits | Description |
| Member ID number. |  |  |  |  |
| Rendering provider ID. |  |  |  |  |
| **Claim Information** | | | | |
| Claim number. |  |  |  |  |
| First date of service. |  |  |  |  |
| Last date of service. |  |  |  |  |
| Discharge status. |  |  |  |  |
| Paid, denied, pended. |  |  |  |  |
| **Codes** | | | | |
| Primary diagnosis. |  |  |  |  |
| Secondary diagnosis. |  |  |  |  |
| Primary procedure. |  |  |  |  |
| Secondary procedure. |  |  |  |  |
| Procedure modifiers. |  |  |  |  |
| Units of service. |  |  |  |  |
| UB revenue. |  |  |  |  |
| Type of bill. |  |  |  |  |
| Place of service. |  |  |  |  |
| HCPCS. |  |  |  |  |
| CPT Level II. |  |  |  |  |
| SNOMED-CT. |  |  |  |  |

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**Table 1A.8: *Claim or encounter system’s edit checks.***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***1A.8A*** | Checks for valid procedure and diagnosis codes (e.g., obsolete codes, required number of digits). |  |
| ***1A.8B*** | Checks for valid members. |  |
| ***1A.8C*** | Checks for valid coding (e.g., recalculates the DRG or procedure valid for the member’s gender. |  |
| ***1A.8D*** | Checks on field size. |  |
| ***1A.8E*** | Checks on date ranges (e.g., “to” date is after “from” date; no future dates). |  |
| ***1A.8F*** | Checks for valid practitioners. |  |

System Upgrades or Conversions

**Table 1A.9: *Complete this table if there were significant changes to the claims or encounter data system or a new data system was implemented during the past three years.***

| Question | | Description |
| --- | --- | --- |
| ***1A.9A*** | Describe the change, upgrade or consolidation. |  |
| ***1A.9B*** | What claim or encounter data systems and product lines or products were affected? |  |
| ***1A.9C*** | Project start and end dates. |  |
| ***1A.9D*** | Regarding data conversion: | |
| What claims or encounters were converted to the new system (e.g., claims or encounters as of a certain date of service or receipt; all claims or encounters)? |  |
| What claims or encounters were not converted to the new system? |  |
| What data elements were converted to the new system? |  |
| What data elements were not converted to the new system? |  |
| ***1A.9E*** | How were data mapped for conversion from the previous system to the new claim or encounter system? |  |
| ***1A.9F*** | How did your organization ensure accuracy and completeness of data in the new system? |  |

Policies and Procedures

**Table 1A.10: *Claim or encounter data processes.***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***1A.10A*** | How are claims or encounters obtained, processed and entered into the claim or encounter system? |  |
| ***1A.10B*** | Are encounters (i.e., submissions that are not linked to payment) processed differently from claims (i.e., submissions for payment)? |  |
| ***1A.10C*** | How are claims or encounters batched? How are batch levels controlled (i.e., how are claims monitored to ensure that all claims received are entered)? |  |
| ***1A.10D*** | Are any standard data elements from the claim (e.g., procedure codes, diagnosis codes, place of service codes, type of bill codes) mapped, deleted or changed during the processing of the claim or encounter? |  |
| ***1A.10E*** | How is a claim or encounter handled if it is submitted: | |
| With one or more required fields missing, incomplete or invalid? |  |
| With no diagnosis code, or an invalid code? Is a default code used? |  |
| With no procedure code, or an invalid code? Is a default code used? |  |
| ***1A.10F*** | Are there situations where processors may change claim or encounter information submitted by a provider? |  |

Electronic Submission of Claim or Encounter Data

**Table 1A.11: *Complete this table if the claim or encounter system accepts electronically transferred claim or encounter data.***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***1A.11A*** | Are electronic claims received directly or through clearing houses, or both? |  |
| ***1A.11B*** | Are electronic claims received in HIPAA-standard compliant or proprietary formats? |  |
| ***1A.11C*** | How are electronically received files uploaded into the claim or encounter processing system? |  |
| ***1A.11D*** | Do electronically received claims or encounters receive the same edit checks as paper claims or encounters? |  |
| ***1A.11E*** | Are electronic claims mapped, transformed or truncated before being uploaded into a claim or encounter system? |  |
| ***1A.11F*** | How does your organization ensure that transmissions are properly monitored and controlled? |  |
| ***1A.11G*** | What edit checks are performed to ensure that electronically transferred claim or encounter files are accurately and completely received and uploaded? |  |
| ***1A.11H*** | How does your organization verify the accuracy of electronic submissions? |  |

Timeliness and Accuracy of Data Processing

**Table 1A.12: *Timeliness of claim or encounter data processing during the measurement year.***

| Question | | Description |
| --- | --- | --- |
| ***1A.12A*** | What were the time-to-process standards for claim or encounter data? |  |
| ***1A.12B*** | What was the actual average time to process for claim or encounter data? |  |
| ***1A.12C*** | Was there ever a backlog or delay in processing claim or encounter data? |  |

**Table 1A.13: *Accuracy of claim or encounter processing during the measurement year.***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***1A.13A*** | Were there audits of claim or encounter data processing? |  |
| ***1A.13B*** | What was audited, and how often? |  |
| ***1A.13C*** | What were the findings for the measurement year? |  |
| ***1A.13D*** | Were deficiencies detected? |  |

Data Completeness

Improving Data Completeness

**Table 1A.14: *Data completeness activities during the measurement year.***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***1A.14A*** | Have steps been taken to improve completeness of claim or encounter data? |  |
| ***1A.14B*** | Were all practitioners, provider groups and facilities required by contract to submit complete and accurate claim or encounter data? |  |
| ***1A.14C*** | Were performance standards in place to ensure submission of claim or encounter data by practitioners, provider groups, facilities? |  |
| ***1A.14D*** | Was compensation tied to submission of claim or encounter data by practitioners, provider groups, facilities? |  |
| ***1A.14E*** | Were other incentive or penalty arrangements in place for practitioners, provider groups and facilities to submit complete and accurate data? |  |
| ***1A.14F*** | What action, if any, was taken against practitioners, provider groups, facilities and vendors who routinely failed to submit complete and accurate claim or encounter data? |  |

Requested Documents

Provide the documents listed below and label them as instructed in the table. Indicate “NA” if the document is not applicable.

|  |  |  |
| --- | --- | --- |
| Document | Details | Label |
| **Claim or encounter data system flowchart** | A flowchart that gives an overview of the claim or encounter data system and processes, indicating steps in the process as well as the flow of claim or encounter data from all sources. | **1A.1** |
| **Proprietary forms (if applicable)** | If proprietary claim or encounter forms were used during the measurement year, attach clean, blank copies of each. | **1A.2** |
| **Explanation of nonstandard codes (if applicable)** | If nonstandard codes were used during the measurement year, attach descriptions of internally developed codes, code definitions and translation procedures. | **1A.3** |
| **Claim lag, IBNR or completion factor reports** | Documentation (e.g., claim lag reports, IBNR reports, completion factor reports) of completeness of claim or encounter data at the time data files were generated for DM reporting. | **1A.4** |
| **Data completeness studies or analyses** | If applicable, attach copies of additional studies or analyses conducted on data completeness or under-reporting. | **1A.5** |

Section Contact

***Who is responsible for completing this section of the Roadmap?***

|  |  |  |
| --- | --- | --- |
|  | Contact |  |
| Name |  |  |
| Title |  |  |
| Company |  |  |
| Address |  |  |
| City, state, zip |  |  |
| Telephone |  |  |
| Fax |  |  |
| E-mail address |  |  |
|  |  |  |

Section 1B: Vision Services and Processing *(IS 9.1)*

Introduction

***Vendors’*** ***vision claim or encounter data system and processes used during the measurement year.*** Vendors complete this section annually for each organization.

|  |  |
| --- | --- |
| Vendor information | **Vendor name:** |
| **Reporting for:** |
| **Completion date:** |
| Definitions |  |
| *Claim* | A submission for reimbursement (e.g., from fee-for-service providers). |
| *Encounter* | A submission that is not linked to payment (e.g., from capitated providers). |
| *Claim or encounter processing vendor* | Includes any external entity with which the organization has contracted to perform the following tasks:   * Provide a particular type of medical service. * Perform claim or encounter data processing functions. |
| *Significant change* | A change of (+/–)10% in volume of data processed, or a conversion, consolidation or upgrade to the data processing system. |
| Instructions | * Vendors complete Section 1B if they process claims or encounter data for reimbursement for the health plan or DM. If a vendor sends electronic results data to the health plan or DM and does not process claims or encounters, skip this section and complete Section 5. * Where there are differences by product line or product, provide a separate response for each product line or product subject to audit. * Vendors completing this section should provide information relevant to only the organization above, including all calculations provided. |

Claim or Encounter System General Information

### Table 1B.1: *Claim or encounter data processing system described in this section.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Question | | Product Line A | Product Line B | Product Line C |
| ***1B.1A*** | Name of claim or encounter system. |  |  |  |
| ***1B.1B*** | Type of data processed. |  |  |  |
| ***1B.1C*** | Location (city, state). |  |  |  |
| ***1B.1D*** | Average monthly volume. |  |  |  |
| ***1B.1E*** | Percentage of claims or encounters submitted: | | | |
| * On paper. |  |  |  |
| * Electronically. |  |  |  |

Claim or Encounter Policy Questions

|  |  |
| --- | --- |
| ***1B.1-1*** | ***Q.*** Regarding claim or encounter policies in place during the measurement year, what was the time limit for practitioner submissions?  ***A.*** |
| ***1B.1-2*** | ***Q.*** Does the vendor use the plan’s member identifier for claims processing? If not, how are claims mapped?  ***A.*** |
| ***1B.1-3*** | ***Q.*** How did your organization handle a claim or encounter submitted past the deadline?  ***A.*** |

Coding Software

**Table 1B.2: *Automated coding software used for the claim or encounter data system described in this section.***

| Question | | Description |
| --- | --- | --- |
| ***1B.2A*** | Name of automated coding software. |  |
| ***1B.2B*** | How often are codes updated? |  |
| ***1B.2C*** | Does your organization verify procedure or diagnosis codes? |  |
| ***1B.2D*** | Does your organization group or ungroup procedure or diagnosis codes? |  |

Coding Schemes

**Table 1B.3: *Coding schemes.*** Consider all nonstandard coding methods, including state-specific codes (e.g., CPT, Medicaid), internally-developed codes and case and per diem rates.

| Coding Scheme | | Type of Service | | | |
| --- | --- | --- | --- | --- | --- |
| Inpatient Diagnosis | Inpatient Procedure | Ambulatory Diagnosis | Ambulatory Procedure |
| ***1B.3A*** | Standard codes (e.g., ICD-9, CPT, HCPCS, CPT II, SNOMED-CT). |  |  |  |  |
| ***1B.3B*** | Nonstandard codes: | | | | |
| State-specific (e.g., Medicaid). |  |  |  |  |
| Internally developed. |  |  |  |  |

**Table 1B.4: *Complete this table if state-specific codes or internally developed codes were used for any service.*** List each code type on a separate row in the table.

| Question | | Description |
| --- | --- | --- |
| ***1B.4A*** | Type of coding scheme. |  |
| ***1B.4B*** | What percentage of claims or encounters was affected? |  |
| ***1B.4C*** | For which services were codes or rates used? |  |
| ***1B.4D*** | Were codes or rates received on claim or encounter forms from providers, or generated by the claim or encounter system or processors? |  |
| ***1B.4E*** | How were codes or rates processed in the claim or encounter data system? |  |
| ***1B.4F*** | If standard codes are grouped to nonstandard codes, were the original codes maintained in the claim or encounter processing system? |  |

**Table 1B.5: *Complete this table if global billing codes, case rates or per diems were used during the measurement year.*** List each code type on a separate row in the table.

|  |  |  |
| --- | --- | --- |
| Services That Used Global Billing Codes, Case Rates or Per Diems | Percentage of Claims or Encounters Affected | For Codes That Cover a Period of Treatment, Date Used on the Claim or Encounter |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

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Nonstandard Data Submission Forms

**Table 1B.6:  *Were nonstandard, state-specific or encounter forms (i.e., other than UB-04 or CMS 1500) used during the measurement year?***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***1B.6A*** | Type of form. |  |
| ***1B.6B*** | What percentage of claims or encounters was affected? |  |
| ***1B.6C*** | For which services were nonstandard forms used? |  |

Data Elements

**Table 1B.7: *Data element captured in the claim or encounter system.*** How many elements are captured (e.g., number of CPT codes)? How many digits are captured? Indicate if the data element is:

**R Required:** The claim or encounter system requires the data element for all claims or encounters.

**O Optional:** The claim or encounter system requires the data element for some, but not all claims or encounters.

**N Not Required:** The claim or encounter system does not require or capture the data element.

**NA Not Applicable:** The data element does not apply to the claim or encounter system.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Required? (R,O,N,NA) | No. of Codes | No. of Digits | Description |
| Member ID number. |  |  |  |  |
| Rendering provider ID. |  |  |  |  |
| **Claim Information** | | | | |
| Claim number. |  |  |  |  |
| First date of service. |  |  |  |  |
| Last date of service. |  |  |  |  |
| Discharge status. |  |  |  |  |
| Payment status. |  |  |  |  |
| **Codes** | | | | |
| Primary diagnosis. |  |  |  |  |
| Secondary diagnosis. |  |  |  |  |
| Primary procedure. |  |  |  |  |
| Secondary procedure. |  |  |  |  |
| Procedure modifiers. |  |  |  |  |
| Units of service. |  |  |  |  |
| UB revenue. |  |  |  |  |
| Type of bill. |  |  |  |  |
| Place of service. |  |  |  |  |
| HCPCS. |  |  |  |  |
| CPT Level II. |  |  |  |  |
| SNOMED-CT. |  |  |  |  |

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**Table 1B.8: *Claim or encounter system’s edit checks.***

|  |  |  |
| --- | --- | --- |
| Claims or Encounter System Edit Checks | | Description |
| ***1B.8A*** | Checks for valid procedure and diagnosis codes (e.g., obsolete codes, required number of digits). |  |
| ***1B.8B*** | Checks for valid members. |  |
| ***1B.8C*** | Checks for valid coding (e.g., recalculates the DRG or procedure valid for the member’s gender). |  |
| ***1B.8D*** | Checks on field size. |  |
| ***1B.8E*** | Checks on date ranges (e.g., “to” date is after “from” date; no future dates). |  |
| ***1B.8F*** | Checks for valid practitioners. |  |

System Upgrades or Conversions

**Table 1B.9: *Complete this table if significant changes were made to the claims or encounter data system or a new data system was implemented during the past three years.***

| Question | | Description |
| --- | --- | --- |
| ***1B.9A*** | Describe the change, upgrade or consolidation. |  |
| ***1B.9B*** | What claim or encounter data systems and product lines or products were affected? |  |
| ***1B.9C*** | Project start and end dates. |  |
| ***1B.9D*** | Regarding data conversion: | |
| What claims or encounters were converted to the new system (e.g., claims or encounters as of a certain date of service or receipt; all claims or encounters)? |  |
| What claims or encounters were not converted to the new system? |  |
| What data elements were converted to the new system? |  |
| What data elements were not converted to the new system? |  |
| ***1B.9E*** | How were data mapped for conversion from the previous system to the new claim or encounter system? |  |
| ***1B.9F*** | Did a parallel system run during the conversion? |  |
| ***1B.9G*** | How did your organization ensure accuracy and completeness of data in the new system? |  |

Policies and Procedures

**Table 1B.10: *Claim or encounter data processes.***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***1B.10A*** | How are claims or encounters obtained, processed and entered into the claim or encounter system? |  |
| ***1B.10B*** | Are encounters (i.e., submissions that are not linked to payment) processed differently from claims (i.e., submissions for payment)? |  |
| ***1B.10C*** | How are claims or encounters batched? How are batch levels controlled (i.e., how are claims monitored to ensure that all claims received are entered)? |  |
| ***1B.10D*** | Are any standard data elements from the claim (e.g., procedure codes, diagnosis codes, place of service codes, type of bill codes, units) mapped, deleted or changed during processing of the claim or encounter? |  |
| ***1B.10E*** | How is a claim or encounter handled if it is submitted: | |
| With one or more required fields missing, incomplete or invalid? |  |
| With no diagnosis code, or an invalid code? is a default code used? |  |
| With no procedure code, or an invalid code? Is a default code used? |  |
| ***1B.10F*** | Are there situations where processors may change claim or encounter information submitted by a provider? |  |

Electronic Submission of Claim or Encounter Data

**Table 1B.11: *Complete this table if the claim or encounter system accepts electronically transferred claim or encounter data.***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***1B.11A*** | Are electronic claims received directly or through clearing houses, or both? |  |
| ***1B.11B*** | Are electronic claims received in HIPAA-standard compliant or proprietary formats? |  |
| ***1B.11C*** | How are electronically received files uploaded into the claim or encounter processing system? |  |
| ***1B.11D*** | Do electronically received claims or encounters receive the same edit checks as paper claims or encounters? |  |
| ***1B.11E*** | Are electronic claims mapped, transformed or truncated before being uploaded into the claim or encounter system? |  |
| ***1B.11F*** | How does your organization ensure that transmissions are properly monitored and controlled? |  |
| ***1B.11G*** | What edit checks are performed to ensure that electronically transferred claim or encounter files are accurately and completely received and uploaded? |  |
| ***1B.11H*** | How does your organization verify the accuracy of electronic submissions? |  |

Timeliness and Accuracy of Data Processing

**Table 1B.12: *Timeliness of claim or encounter data processing.***

| Question | | Description |
| --- | --- | --- |
| ***1B.12A*** | What were the time-to-process standards for claim or encounter data? |  |
| ***1B.12B*** | What was the actual average time to process for claim or encounter data? |  |
| ***1B.12C*** | Was there ever a backlog or delay in processing claim or encounter data? |  |

**Table 1B.13: *Accuracy of claim or encounter processing during the measurement year.***

| Question | | Description |
| --- | --- | --- |
| ***1B.13A*** | Were there audits of claim or encounter data processing? |  |
| ***1B.13B*** | What was audited, and how often? |  |
| ***1B.13C*** | What were the findings for the measurement year? |  |
| ***1B.13D*** | Were deficiencies detected? |  |

Data Completeness

Improving Data Completeness

**Table 1B.14: *Data completeness activities during the measurement year.***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***1B.14A*** | Were steps taken to improve completeness of claim or encounter data? |  |
| ***1B.14B*** | Were all practitioners, provider groups, facilities and vendors required by contract to submit complete and accurate claim or encounter data? |  |
| ***1B.14C*** | Were performance standards in place to ensure submission of claim or encounter data by practitioners, provider groups, facilities and vendors? |  |
| ***1B.14D*** | Was compensation tied to submission of claim or encounter data by practitioners, provider groups, facilities and vendors? |  |
| ***1B.14E*** | Were other incentive or penalty arrangements in place for practitioners, provider groups, facilities and vendors to submit complete and accurate data? |  |

Provide the documents listed below and label them as instructed in the table. Use “NA” if the document is not applicable.

|  |  |  |
| --- | --- | --- |
| Document | Details | Label |
| **Claim or encounter data system flowchart** | Provide a flowchart that gives an overview of the claim or encounter data system and processes, indicating steps in the process as well as the flow of claim or encounter data from all sources. | **1B.1** |
| **Proprietary forms (if applicable)** | If proprietary claim or encounter forms were used during the measurement year, attach clean, blank copies of each. | **1B.2** |
| **Explanation of nonstandard codes  (if applicable)** | If nonstandard codes were used during the measurement year, attach descriptions of internally developed codes, code definitions, translation procedures and code mapping schemes. | **1B.3** |
| **Data completeness studies or analyses** | If applicable, attach copies of additional studies or analyses conducted on data completeness or under-reporting. | **1B.4** |

Section Contact

***Who is responsible for completing this section of the Roadmap?***

|  |  |  |
| --- | --- | --- |
|  | Contact |  |
| Name |  |  |
| Title |  |  |
| Company |  |  |
| Address |  |  |
| City, state, zip |  |  |
| Telephone |  |  |
| Fax |  |  |
| E-mail address |  |  |
|  |  |  |

Section 1C: Pharmacy Services and Processing *(IS 9.1)*

Introduction

***Vendors’ pharmacy claim or encounter data system and processes used during the measurement year.*** Vendors complete this section annually for each organization.

|  |  |
| --- | --- |
| Vendor information | **Vendor name:** |
| **Reporting for:** |
| **Completion date:** |
| Definitions |  |
| *Claim* | A submission for reimbursement (e.g., from fee-for-service providers). |
| *Encounter* | A submission that is not linked to payment (e.g., from capitated providers). |
| *Claim or encounter processing vendor* | Includes any external entity with which the organization has contracted to perform the following tasks.   * Provide a particular type of medical service. * Perform claim or encounter data processing functions. |
| *Significant change* | A change of (+/–)10% in volume of data processed, or a conversion, consolidation or upgrade to the data processing system. |
| Instructions | * Vendors complete Section 1C if they process claims or encounter data for reimbursement for the health plan or DM. If a vendor sends electronic results data to the health plan or DM and does not process claims or encounters, skip this section and complete Section 5. * Where there are differences by product line or product, provide a separate response for each product line or product subject to audit. * For vendors completing this section, provide information relevant to only the organization above, including all calculations provided. |

Claim or Encounter System General Information

### Table 1C.1: *Claim or encounter data processing system described in this section.*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Question | | | Product Line A | | Product Line B | | | Product Line C | |
| ***1C.1A*** | | Name of claim or encounter system. |  | |  | | |  | |
| ***1C.1B*** | | Type of data processed (claim, encounter). |  | |  | | |  | |
| ***1C.1C*** | | Location (city, state). |  | |  | | |  | |
| ***1C.1D*** | | Average monthly volume. |  | |  | | |  | |
| ***1C.1E*** | | Percentage of claims or encounters submitted: | | | | | | | |
| * On paper. |  | |  | | |  | |
| * Electronically. |  | |  | | |  | |
| Question | | **PY** | **MY** | **PY** | | **MY** | **PY** | **MY** |
| ***1C.1F*** | Average PMPY pharmacy. |  |  | |  |  |  |  |
| ***1C.1G*** | Percentage of members with pharmacy benefit. |  |  | |  |  |  |  |

Pharmacy Claim Questions

|  |  |
| --- | --- |
| ***1C.1-1*** | ***Q.*** Can your organization identify the date on which a member exhausts a pharmacy benefit (e.g., uses the maximum covered amount in a calendar year)?  ***A.*** |
| ***1C.1-2*** | ***Q.*** Does the PBM use the plan’s member identifier for claims processing? If not, how are claims mapped?  ***A.*** |
| ***1C.1-3*** | ***Q.*** How often are enrollment files sent to the pharmacy organization? What is the reconciliation process?  ***A.*** |
| ***1C.1-4*** | ***Q.*** What provider ID is used to process claims? If the PBM uses an internal ID or the DEA number, what mapping information is given to the plan?  ***A.*** |
| ***1C.1-5*** | ***Q.*** Are prescriptions identified with codes other than NDC codes?  ***A.*** |
| ***1C.1-6*** | ***Q.*** How often are NDC codes updated in the system?  ***A.*** |

Coding Schemes

**Table 1C.2: *Coding schemes used.*** Consider all nonstandard coding methods, including state-specific codes (e.g., Medicaid), internally-developed codes and case and per diem rates.

| Coding Scheme | Type of Service | | |
| --- | --- | --- | --- |
| Retail | Specialty | Other |
| Standard codes (e.g., NDC, HCPCS). |  |  |  |
| Nonstandard codes: | | | |
| State-specific (e.g., Medicaid). |  |  |  |
| Regional or temporary drug codes. |  |  |  |

Data Elements

**Table 1C.3: *Data elements captured in the claim or encounter system.*** How many elements are captured (e.g., number of NDC codes)? How many digits are captured? Indicate if the data element is:

**R Required:** The claim or encounter system requires the data element for all claims or encounters.

**O Optional:** The claim or encounter system requires the data element for some, but not all claims or encounters.

**N Not Required:** The claim or encounter system does not require or capture the data element.

**NA Not Applicable:** The data element does not apply to the claim or encounter system.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Required? (R,O,N,NA) | No. of Codes | No. of Digits | Description |
| Member identification. |  |  |  |  |
| Prescriber ID. |  |  |  |  |
| Prescriber name. |  |  |  |  |
| NDC code. |  |  |  |  |
| Drug ID. |  |  |  |  |
| Date of service. |  |  |  |  |
| Scrip filled date. |  |  |  |  |
| Quantity/Units: |  |  |  |  |
| Ordered. |  |  |  |  |
| Dispensed. |  |  |  |  |
| Paid. |  |  |  |  |
| Days supply. |  |  |  |  |
| Payment status. |  |  |  |  |
| Refill indicator. |  |  |  |  |
| Paid amount. |  |  |  |  |
| Billed amount. |  |  |  |  |
| Reversal reason indicator. |  |  |  |  |
| Denial reason code. |  |  |  |  |

System Upgrades or Conversions

**Table 1C.4: *Complete this table if significant changes were made to the claims or encounter data system or a new data system was implemented during the past three years.***

| Question | | Description |
| --- | --- | --- |
| ***1C.4A*** | Describe the change, upgrade or consolidation. |  |
| ***1C.4B*** | What claim or encounter data systems and product lines or products were affected? |  |
| ***1C.4C*** | Project start and end dates. |  |
| ***1C.4D*** | Regarding data conversion: | |
| What claims or encounters were converted to the new system (e.g., claims or encounters as of a certain date of service or receipt; all claims or encounters)? |  |
| What claims or encounters were not converted to the new system? |  |
| What data elements were converted to the new system? |  |
| What elements were not converted to the new system? |  |
| ***1C.4E*** | How were data mapped for conversion from the previous system to the new claim or encounter system? |  |
| ***1C.4F*** | Did a parallel system run during the conversion? |  |
| ***1C.4G*** | How did your organization ensure accuracy and completeness of data in the new system? |  |

Policies and Procedures

Timeliness and Accuracy of Data Processing

**Table 1C.5: *Timeliness of claim or encounter data processing.***

| Question | | Description |
| --- | --- | --- |
| ***1C.5A*** | What were the time-to-process standards for claim or encounter data? |  |
| ***1C.5B*** | What was the actual average time to process for claim or encounter data? |  |
| ***1C.5C*** | Was there ever a backlog or delay in processing of claim or encounter data? |  |

**Table 1C.6: *Accuracy of claim or encounter processing during the measurement year.***

| Question | | Description |
| --- | --- | --- |
| ***1C.6A*** | Were there audits of claim or encounter data processing? |  |
| ***1C.6B*** | What was audited, and how often? |  |
| ***1C.6C*** | What were the findings for the measurement year? |  |
| ***1C.6D*** | Were deficiencies detected? |  |

Data Completeness

Improving Data Completeness

**Table 1C.7: *Data completeness activities during the measurement year.***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***1C.7A*** | Were steps taken to improve completeness of claim or encounter data? |  |
| ***1C.7B*** | Were all practitioners, provider groups, facilities and vendors required by contract to submit complete and accurate claim or encounter data? |  |
| ***1C.7C*** | Were performance standards in place to ensure submission of claim or encounter data by practitioners, provider groups, facilities and vendors? |  |
| ***1C.7D*** | Was compensation tied to submission of claim or encounter data by practitioners, provider groups, facilities and vendors? |  |
| ***1C.7E*** | Were other incentive or penalty arrangements in place for practitioners, provider groups, facilities and vendors to submit complete and accurate data? |  |
| ***1C.7F*** | Were other activities undertaken to encourage claim or encounter data submission by practitioners, provider groups, facilities and vendors? |  |
| ***1C.7G*** | What action, if any, was taken against practitioners, provider groups, facilities and vendors who routinely failed to submit complete and accurate claim or encounter data? |  |

Requested Documents

Provide the documents listed below and label them as instructed in the table. Use “NA” if the document is not applicable.

|  |  |  |
| --- | --- | --- |
| Document | Details | Label |
| **Claim or encounter data system flowchart** | A flowchart that gives an overview of the claim or encounter data system and processes, indicating steps in the process as well as the flow of claim or encounter data from all sources. | **1C.1** |
| **Proprietary forms  (if applicable)** | If proprietary claim or encounter forms were used during the measurement year, attach clean, blank copies of each. | **1C.2** |
| **Explanation of nonstandard codes (if applicable)** | If nonstandard codes were used during the measurement year, attach descriptions of internally developed codes, code definitions, translation procedures and code mapping schemes. | **1C.3** |
| **Data completeness studies  or analyses** | If applicable, attach copies of additional studies or analyses conducted on data completeness or under-reporting. | **1C.4** |

Section Contact

***Who is responsible for completing this section of the Roadmap?***

|  |  |  |
| --- | --- | --- |
|  | Contact |  |
| Name |  |  |
| Title |  |  |
| Company |  |  |
| Address |  |  |
| City, state, zip |  |  |
| Telephone |  |  |
| Fax |  |  |
| E-mail address |  |  |
|  |  |  |

Section 2: DM Eligibility *(IS 9.2)*

Introduction

***Individual DM eligibility data source and system used.***

|  |  |
| --- | --- |
| Organization information | **Organization name:** |
| **Date of completion:** |
| Definitions |  |
| *DM eligibility system* | Captures data about the individuals and their eligibility information, including eligibility dates or spans and benefits. |
| *Significant change* | A change of (+/–)20% in individual volume, or a conversion, consolidation or upgrade to the eligibility data system. |
| Instructions | * Complete Section 2 for every unique source of individual eligibility data (e.g., a DM vendor that contracts with multiple plans would complete separate section for each plan). |

DM Eligibility System

**Table 2.1: *DM eligibility system and data.***

|  |  |  |
| --- | --- | --- |
|  | | Description |
| ***2.1A*** | System name. |  |
| ***2.1B*** | From whom are individual eligibility files received? |  |
| ***2.1C*** | How often are individual eligibility files received? |  |
| ***2.1D*** | Describe how new individual data are obtained, processed and entered into the DM eligibility system. |  |
| ***2.1E*** | Describe procedures in place to ensure that transmissions are properly verified, monitored and controlled. |  |
| ***2.1F*** | What edit checks are performed to ensure the transferred individual eligibility files are: | |
| * Accurately and completely received? |  |
| * Uploaded to the system? |  |
| ***2.1G*** | Describe how changes to individual information are obtained, processed and entered into the DM eligibility system. |  |
| ***2.1H*** | Describe how individual termination data are obtained, processed and entered into the DM eligibility system. |  |
| ***2.1I*** | Have there been changes to the system since the last submission? |  |

**Table 2.2:  *Individual and eligibility* *information maintained* *in the system.*** Complete this table with all required elements captured by the system.

|  |  |
| --- | --- |
| **General Information** | **Captured?** |
| Full name. |  |
| Address. |  |
| Date of birth. |  |
| Gender. |  |
| Social security number. |  |
| Organization-designated number. |  |
| **Coverage Information** | **Captured?** |
| Relationship to subscriber. |  |
| Benefits (e.g., pharmacy, vision). |  |
| Effective date: | |
| * With organization. |  |
| * By DM program. |  |
| Termination date: | |
| * With organization. |  |
| * By DM program. |  |
| Does the system assign a unique ID? |  |
| Under what circumstances, if any, does the system allow: | |
| * More than one individual to have the same ID? |  |
| * The same individual to have more than one ID? |  |
| * A individual’s ID to change (e.g., re-enrollment, name change, program switch, change in marital status)? |  |
| Regarding individual whose IDs change: | |
| * Is the original eligibility date with the organization maintained? |  |
| * Are previous eligibility data maintained and linked to the new eligibility data? |  |
| Regarding eligibility requirements: | |
| * Must individuals enroll or disenroll only on a particular date each month? |  |
| * How many updates (i.e., lines of history) can the eligibility system maintain for each individual? |  |
| **Program Information** | **Description** |
| * Is the DM program an opt-in or an opt-out program? |  |
| * How is the individual’s choice to opt-in or opt-out recorded? |  |
| * How is the DM program name recorded? |  |
| * Health appraisals or other DM offerings. |  |
| **Individual Changes** | **Description** |
| Explain significant changes(+/–20%) in number of individuals over the past year. | |
| * Increase in number of individuals. |  |
| * Decrease in number of individuals. |  |

|  |  |
| --- | --- |
| ***2.2A*** | ***Q.*** Was any data element in Table 2.2 marked “NA”? Explain.  ***A.*** |

**Table 2.3: *Timeliness and data completeness.***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***2.3A*** | What were the time-to-process standards for individual eligibility data? |  |
| ***2.3B*** | What was the actual average time to process for individual eligibility data? |  |
| ***2.3C*** | Was there ever a backlog or delay in receiving data from data source? If yes, describe. |  |

**Table 2.4: *Accuracy of individual*** ***eligibility data.***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***2.4A*** | Were there audits of individual eligibility data processing? What was audited, and how often? |  |
| ***2.4B*** | What were the audit findings? |  |
| ***2.4C*** | Were deficiencies detected? If yes, describe. |  |
| ***2.4D*** | Were individual eligibility data reconciled against an external data source? If yes, answer the following questions. |  |
| * Describe the reconciliation process, including what was reconciled and how often. |  |
| * What were the reconciliation findings? |  |
| * Were deficiencies detected? If yes, describe. |  |
| ***2.4E*** | Were there barriers to obtaining complete and accurate individual data? Consider all factors that might influence your organization’s ability to collect such information from employer groups, individual enrollees or government agencies. |  |

**Table 2.5: *Upgrades and consolidations during the past three years.***

|  |  |  |
| --- | --- | --- |
|  | Question | Description |
| ***2.5A*** | Did a change, upgrade or consolidation affect the ability to identify individuals? If yes, describe. |  |
| ***2.5B*** | What data systems were affected? |  |
| ***2.5C*** | Project start and end dates. |  |
| ***2.5D*** | Regarding data conversion: | |
| * Which individuals were converted to the new system? |  |
| * Which individuals were not converted to the new system? |  |
| * Which data elements were converted to the new system? |  |
| * Which data elements were not converted to the new system? |  |
| ***2.5E*** | How were data mapped for conversion from the previous system to the new system? |  |

Requested Documents

The documents requested for this section are listed below. Label all documents as described in the table. Complete with state reporting requirements, as applicable.

|  |  |  |
| --- | --- | --- |
| Document | Details | Label |
| **DM eligibility data system flowchart** | A flowchart of the DM eligibility data system and processes, indicating steps in the data process and the flow of individual and eligibility data from all sources. | **2.1** |

Section Contact

***Who completed this section of the Roadmap?***

|  |  |  |
| --- | --- | --- |
|  | Contact |  |
| Name |  |  |
| Title |  |  |
| Company |  |  |
| Address |  |  |
| City, state, zip |  |  |
| Telephone |  |  |
| Fax |  |  |
| E-mail address |  |  |
|  |  |  |

Section 3: DM Registry Data *(IS 9.3)*

Introduction

***Disease management registry data and processes used during the measurement year.***

|  |  |
| --- | --- |
| Organization information | **Organization name:** |
| **Date of completion:** |
| Definition |  |
| *DM registry* | Collects relevant patient information through facilitated conversations with qualified staff. A DM registry may produce automated data files that are not claim and encounter data; that may be electronic and not follow a standard layout and format. |
| Instructions | * Complete Section 3. If multiple registries are used, complete separate sections for each. * Where there are differences by program, provide a separate response for each program subject to audit. |

### Table 3.1: *DM registry* *system used to track program activities.*

| Question | | Description |
| --- | --- | --- |
| ***3.1A*** | Name of DM registry system. |  |
| ***3.1B*** | Type of services offered. |  |
| ***3.1C*** | Type of data captured. |  |
| ***3.1D*** | Location (city, state). |  |
| ***3.1E*** | What modes of communication does your DM programs include? If this varies by program, indicate the program name. | |
| * Mail based. |  |
| * Phone. |  |
| * In person. |  |
| * Online. |  |
| ***3.1F*** | Were changes were made to the system in the last year? |  |

Software

**Table 3.2: *Software used for DM program data described in this section.***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***3.2A*** | Name of system or software. |  |
| ***3.2B*** | Programming language or application. |  |
| ***3.2C*** | Was the software internally developed? |  |
| ***3.2D*** | How often is the system or software updated? |  |

Disease Management Form

**Table 3.3: *Data elements captured in your DM system.***

|  |  |  |  |
| --- | --- | --- | --- |
| Data Elements Collected | | | |
|  | Yes | No | Describe (if applicable) |
| First name. |  |  |  |
| Middle name or initial. |  |  |  |
| Last name. |  |  |  |
| Health plan member ID. |  |  |  |
| DM specific ID. |  |  |  |
| DM program name. |  |  |  |
| Date of birth. |  |  |  |
| DM staff ID or name (performing outreach). |  |  |  |
| Date of contact. |  |  |  |
| Date of service. |  |  |  |
| Practitioner specialty or type. |  |  |  |
| Procedure code. |  |  |  |
| Diagnosis code. |  |  |  |
| Lab result. |  |  |  |
| LOINC code. |  |  |  |
| NDC code. |  |  |  |
| Topics or risks addressed. |  |  |  |
| Task/program completion. |  |  |  |
| Desired action. |  |  |  |
| Action status. |  |  |  |
| Desired outcome. |  |  |  |
| Outcome status. |  |  |  |
| Remeasurement data. |  |  |  |
| Vaccination history (specifically influenza and pneumococcal). |  |  |  |
| Tobacco use status. |  |  |  |
| Advice on tobacco use cessation. |  |  |  |
| OTC medication information (specifically aspirin use). |  |  |  |

|  |  |  |
| --- | --- | --- |
| Data Transformation | | Description |
| ***3.3A*** | ***Note:*** *Indicate fields that require mapping or transformation, cross-reference look-up or are coded to a specific value. For example, an immunization antigen name mapped to a standard procedure code; assign DM specific ID through a health plan ID number to member ID cross-reference.* | |
| Health plan member ID number. |  |
| Practitioner ID number. |  |
| Place of service. |  |
| Provider specialty or type. |  |
| Procedure code. |  |
| Diagnosis code. |  |
| Lab result. |  |
| LOINC code. |  |
| NDC code. |  |
| Other (describe). |  |
| ***3.3B*** | How are data integrated for internal use or measure reporting? |  |

**Table 3.4: *System edit checks.***

|  |  |
| --- | --- |
| System Edit Checks | |
| Checks for valid individual. |  |
| Checks on field size. |  |
| Checks on date ranges (e.g., no future dates). |  |

System Upgrades or Conversions

**Table 3.5: *Complete this table if significant changes were made to the DM program data system (e.g., data elements or data capture changes) or if a new data system was implemented during the past three years.***

| Question | |  |
| --- | --- | --- |
| ***3.5A*** | Describe the change, upgrade or consolidation. |  |
| ***3.5B*** | Which systems and programs were affected? |  |
| ***3.5C*** | Project start and end dates. |  |
| ***3.5D*** | Regarding data conversion: | |
| * Which data were converted to the new system (e.g., intervention data as of a certain date of service or receipt; all contact and intervention data)? |  |
| * Which data were not converted to the new system? |  |
| * Which data elements were converted to the new system? |  |
| * Which data elements were not converted to the new system? |  |
| ***3.5E*** | How were data mapped for conversion from the previous system to the new system? |  |
| ***3.5F*** | How did your organization ensure accuracy and completeness of data in the new system? |  |

Policies and Procedures

**Table 3.6: *DM* *Registry data processes.***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***3.6A*** | How is information on DM program activities obtained, processed and tracked? |  |
| ***3.6B*** | Are there situations where processors may change information submitted by a individual? |  |

Requested Documents

Provide the documents listed below and label them as instructed in the table.

|  |  |  |
| --- | --- | --- |
| Document | Details | Label |
| **DM program data flowchart** | A flowchart that gives an overview of the DM Registry data system and processes, indicating steps in the process as well as the flow of DM registry data from all sources. | **3.1** |
| **Data file layout** | A document or a sample of the file layout used to capture hold the data. | **3.2** |
| **Data transformation** | Documentation for all data element mapping. | **3.3** |
| **Data integration and maintenance** | Relevant policies, procedures and process or control descriptions applicable to DM registry data. | **3.4** |
| **Data validation** | Copies of data validation studies applicable to DM registry data. | **3.5** |

Section Contact

***Who completed this section of the Roadmap?***

|  |  |  |
| --- | --- | --- |
|  | Contact |  |
| Name |  |  |
| Title |  |  |
| Company |  |  |
| Address |  |  |
| City, state, zip |  |  |
| Telephone |  |  |
| Fax |  |  |
| E-mail address |  |  |
|  |  |  |

Section 4: Supplemental Data *(IS 9.4)*

Introduction

***Supplemental data and processes used during the measurement year.***

|  |  |
| --- | --- |
| Organization information | **Organization name:** |
| **Date of completion:** |
| Definitions |  |
| *Standard supplemental electronic files* | Files have a standard format that is well documented and remains stable from year to year:   * Laboratory data in HL-7 format. * Immunization data in state registries (may vary from state to state, but are consistent for all records in each state’s registry). |
| *Nonstandard supplemental electronic data* | Data come from sources that follow no standard layout; formats differ from one source to another:   * Electronic files from EHR records. * Electronic files from case management systems. |
| *External supplemental data* | Any automated data supplied by contracted practitioners, vendors or public agencies (e.g., pharmacies, labs, hospitals, schools, state public health agencies). |
| *External data files* | Files might be standard or nonstandard. They can also come from EHRs, which are typically developed and maintained at the hospital or physician office and may be integrated (or linked) to the organization’s system. |
| *Internal files* | Nonstandard files. Any automated data file created by the organization, which supplements the claim or encounter data in the measure repository. Data can come from internal systems. |
| Instructions | * Complete a separate Section 4 for each nonstandard supplemental database not already described in Sections 1A–1C. * Where there are differences by program, provide a separate response for each program subject to audit. |

Supplemental Data Source

### Table 4.1: *Data source used by the organization to supplement transaction system data (claims or encounters) for measure reporting.*

|  |  |  |
| --- | --- | --- |
| General Information | | Description |
| ***4.1A*** | Database name. |  |
| ***4.1B*** | Specific intended measure use. |  |
| ***4.1C*** | Expected measure impact (e.g., expected percentage rate increase). |  |
| ***4.1D*** | Internal use of data. |  |
| ***4.1E*** | Data volume. |  |
| Data Type *(Select One)* | | Description |
| ***4.1F*** | Internal nonstandard. |  |
| External standard. |  |
| External nonstandard. |  |
| Population *(Select One)* | | Description |
| ***4.1G*** | Entire membership. |  |
| Eligible population per measure specifications. |  |
| Other (describe). |  |
| Information Source *(Select One)* | | Description |
| ***4.1H*** | Medical record—Practitioner office. |  |
| Medical record—Hospital. |  |
| EHR. |  |
| Utilization or case management system or vendor. |  |
| Lab results. |  |
| Vision results. |  |
| Pharmacy vendor data. |  |
| Member-reported data in practitioner medical record. |  |
| State, county or other immunization registry. |  |
| Measure-specific exclusion data. |  |
| Other (describe). |  |
| Transmission Method *(Select One)* | | Description |
| ***4.1I*** | FTP transfer (secure or unsecured). |  |
| Portable media (CD, diskette, tape). |  |
| Fax or mail. |  |
| Other (describe). |  |

### Table 4.1 *(continued)*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Collection Timing *(Select One)* | | | | Description | | |
| ***4.1J*** | Ongoing. | | |  | | |
| Other (describe). | | |  | | |
| Data collection start and end dates. | | |  | | |
| Collection Method *(Select One)* | | | | Description | | |
| ***4.1K*** | Information request letter to provider (include copy with documents). | | |  | | |
| Querying data system. | | |  | | |
| Standard operational data feed. | | |  | | |
| Other (describe). | | |  | | |
| Data Elements Collected | | | | | | |
|  |  | Yes | No |  | Yes | No |
| ***4.1L*** | Member ID number. |  |  | Provider specialty or type. |  |  |
| Member first name. |  |  | Days supply. |  |  |
| Member middle name or initial. |  |  | Metric quantity. |  |  |
| Member last name. |  |  | Date of service. |  |  |
| Member DOB. |  |  | Procedure code. |  |  |
| HIC number. |  |  | Diagnosis code. |  |  |
| Social Security number. |  |  | Lab result. |  |  |
| State Medicaid or case number. |  |  | LOINC code. |  |  |
| Practitioner ID number. |  |  | NDC code. |  |  |
| Place of service. |  |  | Other (describe). | | |
| Data Transformation | | | | Description | | |
| ***4.1M*** | ***Note:*** *Indicate fields that require mapping or transformation, cross-reference look-up or are coded to a specific value. For example, an immunization antigen name mapped to a standard procedure code; assign member ID through a HIC number to member ID cross-reference.* | | | | | |
| Member ID number. | | |  | | |
| Practitioner ID number. | | |  | | |
| Place of service. | | |  | | |
| Provider specialty or type. | | |  | | |
| Procedure code. | | |  | | |
| Diagnosis code. | | |  | | |
| Lab result. | | |  | | |
| LOINC code. | | |  | | |
| NDC code. | | |  | | |
| Other (describe). | | |  | | |
| ***4.1N*** | How are data integrated for internal use or measure reporting? | | |  | | |
| Internal Validation Method | | | | Description | | |
| ***4.1O*** | Primary source verification. | | |  | | |
| ***4.1P*** | Review sample of records. | | |  | | |
| ***4.1Q*** | Other (describe). | | |  | | |

Requested Documents

Provide the documents listed below and label them as instructed in the table. Use “NA” if the document is not applicable.

|  |  |  |
| --- | --- | --- |
| Document | Details | Label |
| **Data file layout** | A document or a sample of the file layout used to capture hold the data. | **4.1** |
| **Data transformation** | Documentation for all data element mapping. | **4.2** |
| **Data integration and maintenance** | Relevant policies, procedures and process or control descriptions applicable to supplemental data. Provide copy of any information request letter to provider. | **4.3** |
| **Data validation** | Copies of data validation studies applicable to supplemental data. | **4.4** |

Section Contact

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Section 5: Data Integration (*IS 9.5, IS 9.6*)

Introduction

***General information about how your organization integrates data into a Measure repository to calculate rates for the measurement year.*** This section also requests information about how your organization manages its measure report production process, maintains its DM performance measure software and ensures measure data integrity.

|  |  |
| --- | --- |
| Organization information | **Organization name:** |
| **Date of completion:** |
| Definition |  |
| *Measure repository* | A central system into which all claim or encounter, membership, practitioner, vendor and other data are loaded and where calculations are performed to produce measure rates and results. The Measure repository may not be the same as the organization’s data warehouse. |
| Instructions | * Where there are differences by product lines and products, provide a separate response for each product line and product subject to audit. * Complete applicable tables for each product line and product, adding columns when necessary. * All questions relate to the measurement year systems and processes, unless otherwise indicated. |

Data Integration and Measure Production Responsibility

### Table 5.1: *Staff, application or vendor used for key steps in the measure production process.* Enter the name of the department or vendor responsible for each step; provide explanations where relevant.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| General Measure Production Functions | Internal Staff | Contracted Staff | Application | Vendor Name |
| Data integration. |  |  |  |  |
| Data warehouse maintenance. |  |  |  |  |
| Measure repository maintenance (indicate “NA” if the same as the data warehouse). |  |  |  |  |
| Source code development. |  |  |  |  |
| Rate calculation or measure production. |  |  |  |  |
| Entering data into the DM Measure Reporting Tool. |  |  |  |  |
| Measure report project management. |  |  |  |  |
| Other (indicate). |  |  |  |  |

### Table 5.1 *continued*

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***5.1A*** | Identify significant changes from the previous year’s measure cycle. |  |
| ***5.1B*** | Can the organization access member-level results that make up the summary-level results (i.e., drill-down feature in the measure application)? |  |

Data Sources and Completeness

### Table 5.2: *Data files used, the date on which the files were loaded into the measure repository and the date for planned data refresh for measure reporting.* Consider data received from vendors and any other external sources. Complete multiple tables if variations among product lines or products and add columns and rows, as appropriate.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Sources | | Data File Name | Date Loaded Into Repository | Planned Dates of Data Refreshes or Final Refresh |
| ***5.2A*** | Individual eligibility. |  |  |  |
| ***5.2B*** | Claim or encounter. |  |  |  |
| ***5.2C*** | DM Registry. |  |  |  |
| ***5.2D*** | Pharmacy. |  |  |  |
| ***5.2E*** | Laboratory claims. |  |  |  |
| ***5.2F*** | Lab results. |  |  |  |
| ***5.2G*** | Vision care. |  |  |  |
| ***5.2H*** | Public registry (e.g., immunization). |  |  |  |
| ***5.2I*** | Other. |  |  |  |
| ***5.2J*** | Administrative database or supplemental data (describe). |  |  |  |

### Table 5.3: *Consider all entities that provided or to which your organization delegated any aspect of data processing.* Were any data excluded from measure reporting for any reason? For example, incomplete data from a delegated claims vendor.

|  |  |  |
| --- | --- | --- |
|  | Question | Description |
| ***5.3A*** | What data were excluded? |  |
| ***5.3B*** | Why were data excluded? |  |
| ***5.3C*** | What percentage of members, practitioners or claims or encounters was affected? |  |

### Table 5.4: *Amount of data used to report measures.* Count services that represent a unique date of service, a unique provider identifier and a unique patient. For pharmacy, count unique prescriptions filled on the same day as separate counts for the measurement year (MY) and the prior year (PY).

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Type of Service** | | **PY** | **MY** | **PY** | **MY** | **PY** | **MY** |
| **Product Line/Product:** | |  | |  | |  | |
| Average per member per year (PMPY) ambulatory services. | |  |  |  |  |  |  |
| Average PMPY inpatient services. | |  |  |  |  |  |  |
| Average PMPY pharmacy. | |  |  |  |  |  |  |
| Average PMPY laboratory. | |  |  |  |  |  |  |
| Question | | | Description | | | | |
| ***5.4A*** | How were the PMPY numbers calculated? How was each type of service identified? Does your organization change its methodology from year to year? Explain. | |  | | | | |

Data Integration and Report Production

### Table 5.5: *Software packages, programming languages and mainframe or PC-based application programs your organization or vendor uses to prepare and calculate the measurement year measure report.* Consider all programs used to create eligible populations and numerators.

|  |  |  |  |
| --- | --- | --- | --- |
| Function | | Software Package or Programming Language  or Application | Activity or Measures Affected |
| ***5.5A*** | Data integration. |  |  |
| ***5.5B*** | Data warehouse or measure repository. |  |  |
| ***5.5C*** | Source code development for rate calculation. |  |  |

### Table 5.6: *Data integration and file consolidation in the measure repository.*

|  |  |  |
| --- | --- | --- |
| Data Integration | | |
| Question | | Description |
| ***5.6A*** | How are data integrated and consolidated for reporting? Consider data from all sources and indicate if rates are calculated by querying the processing system online, creating extract files or through a separate database, data repository or warehouse. |  |
| ***5.6B*** | Describe the extract-transform-load (ETL) process for landing measure data in the data warehouse or data repository. |  |
| ***5.6C*** | How does your organization ensure that all data (including any supplemental data) are transferred and properly formatted? |  |
| ***5.6D*** | Are denied claims or encounters captured for measure reporting if the services were provided? |  |
| ***5.6E*** | Describe any changes made to the data integration process for the measurement year. |  |
| ***5.6F*** | Describe testing activities used to validate changes. |  |
| File Consolidation | | |
| Question | | Description |
| ***5.6G*** | Describe the procedures used to link: |  |
| Claim or encounter (including vendor) data and eligibility data. |  |
| ***5.6H*** | With regard to accuracy of data integrated for reporting: | |
| What is your organization’s process for ensuring that the required level of coding detail is maintained? |  |
| How does your organization identify and handle duplicate records? |  |
| How does your organization identify and handle erroneous data? |  |
| How does your organization identify and handle missing data elements? |  |
| How does your organization ensure that the repository or warehouse accurately reflects the transaction files? |  |
| How does your organization ensure that no data are lost in the data integration process? |  |
| What algorithms does your organization use to check the reasonableness of data integrated to report measures? |  |
| If your organization uses nonstandard codes, how are the codes translated to standard codes for measure reporting? Attach a copy of the code mapping scheme and translation procedures. |  |

### Table 5.7: *Measure production and source code development used to prepare and calculate the measurement year measure report.* Consider all programs used to create eligible populations and numerators.

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***5.7A*** | What is the background and relevant experience of the staff involved in developing source code for measure production? |  |
| ***5.7B*** | How is their work overseen and monitored? |  |
| ***5.7C*** | What is your organization’s process for producing source code for the measurement year, including development, oversight, review, testing and version control? |  |
| ***5.7D*** | Describe revisions made to previous source code to accommodate first-year reporting of measures or changes in technical specifications, data processing systems (e.g., claim or encounter, individual eligibility) and measure rate production. |  |
| ***5.7E*** | What are your organization’s processes for running measure production reports for the measurement year, including production control mechanisms, job logs, supervisory review, error detection and reruns? |  |
| ***5.7F*** | How does your organization enter data into the DM Reporting tool? |  |
| ***5.7G*** | Regarding how continuous enrollment was calculated for the measurement year: | |
| How does continuous enrollment logic track member enrollment history, including separate coverage periods, change in benefits, change in ID number, change in relationship to subscriber, changes across product lines and re-enrollment? |  |
| Describe any system or data limitation that precludes full implementation of continuous enrollment requirements as specified. |  |
| ***5.7H*** | What tests and checks are performed to validate the accuracy and completeness of: | |
| Measure-specific rates? |  |
| Measure-specific eligible member populations? |  |

System Security or Back-Ups

### Table 5.8: *Claim or encounter, membership and DM Registry data processing systems.*

|  |  |  |
| --- | --- | --- |
|  | Question | Description |
| ***5.8A*** | How does your organization back up its data or systems? |  |
| ***5.8B*** | How is data-access authorization assigned? |  |
| ***5.8C*** | What type of physical security is in place, including fire protection and UPS? |  |
| ***5.8D*** | Did your organization experience any unexpected or unplanned system downtime during the measurement year? If yes, explain and describe how data integrity and completeness were validated. |  |
| ***5.8E*** | Did your organization restore data from back-up files during the measurement year? If yes, explain and describe how data integrity and completeness were validated. |  |
| ***5.8F*** | Did your organization experience data loss during the measurement year? If yes, explain and describe how data integrity and completeness were validated. |  |

### Table 5.9: *Internal measure repository, data warehouse or vendor measure repository data processing systems.*

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***5.9A*** | How are data or systems backed up? |  |
| ***5.9B*** | How is data-access authorization assigned? |  |
| ***5.9C*** | What type of physical security is in place, including fire protection and UPS? |  |
| ***5.9D*** | Did your organization experience any unexpected or unplanned system downtime during the measurement year? If yes, explain and describe how data integrity and completeness were validated. |  |
| ***5.9E*** | Did your organization restore data from back-up files during the measurement year? If yes, explain and describe how data integrity and completeness were validated. |  |
| ***5.9F*** | Did your organization experience data loss during the measurement year? If yes, explain and describe how data integrity and completeness were validated. |  |

Requested Documents

Provide the documents listed below and label them as instructed in the table. Use “NA” if the document is not applicable.

|  |  |  |
| --- | --- | --- |
| Document | Details | Label |
| **Data integration flow chart** | A flowchart that gives an overview of your management information systems structure, including how all claim, encounter, membership, provider and vendor data are integrated for measure reporting. | **5.1** |
| **Measure repository file structure** | A complete file structure, file format and field definitions for your measure repository. | **5.2** |
| **Vendor mapping documents (if a vendor is used for any aspect of data integration or measure rate production)** | A mapping document of the organization’s data elements to the vendor’s file structure. | **5.3** |
| **Mapping of nonstandard codes (if applicable)** | If your organization uses nonstandard codes for producing measures, provide the mapping scheme used to translate codes to standard codes for measure reporting. | **5.4** |
| **Source code development assignments** | A list of measures and the programmer assigned to its source code development. | **5.5** |
| **Disaster recovery or routine back-up processes** | Documentation that describes your routine back-up processes and disaster recovery procedures. If documentation was previously submitted to the audit firm, submit it only if it has been revised since the last submission. | **5.6** |

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