Appendix 2

HEDIS Roadmap

APPENDIX 2

HEDIS ROADMAP

Introduction

Welcome to the NCQA HEDIS Compliance Audit™ tool, the *HEDIS Record of Administration, Data Management and Processes* *(Roadmap)*. The HEDIS 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.

Changes to the HEDIS Roadmap

* Reworded question 4.2E.
* Removed references to the *Call Abandonment* measure from *Section 6: Member Call Center*.

The HEDIS 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 HEDIS 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 product lines (e.g., commercial, Child Health Insurance Program [CHIP], Medicaid, Medicare Special Needs Plan [SNP]), products (e.g., HMO, POS, PPO), it may complete one Roadmap, but it must provide separate responses for each product line, product or program when necessary.
* Provide answers only for product lines, products or 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–D. 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. |
| 3A. Practitioner Credentialing. | *Complete or update:*  One for the organization.  One for each credentialing system. |
| 3B. Practitioner Data Processing. | *Complete or update:*  One for the organization.  One for each practitioner vendor. |
| 4. Medical Record Review. | *Complete or update:*  One for the organization.  One for each MRR vendor. |
| 5. Supplemental Data. | *Complete or update:*  One for each supplemental database. |
| 6. Member Call Center. | *Complete or update:*  One for the organization. |
| 7. 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–1D 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 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 Roadmap, keep the following in mind:

* Ensure that all persons completing the Roadmap know which product lines, products or programs are subject to review and that they provide responses for *only* those product lines, products or programs.
* Distribute a copy of the instructions to everyone involved in completing the Roadmap.
* Provide electronic copies of completed 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 product line or product under review.
* Label all attachments accurately and add additional attachments to the applicable Requested Documents table.

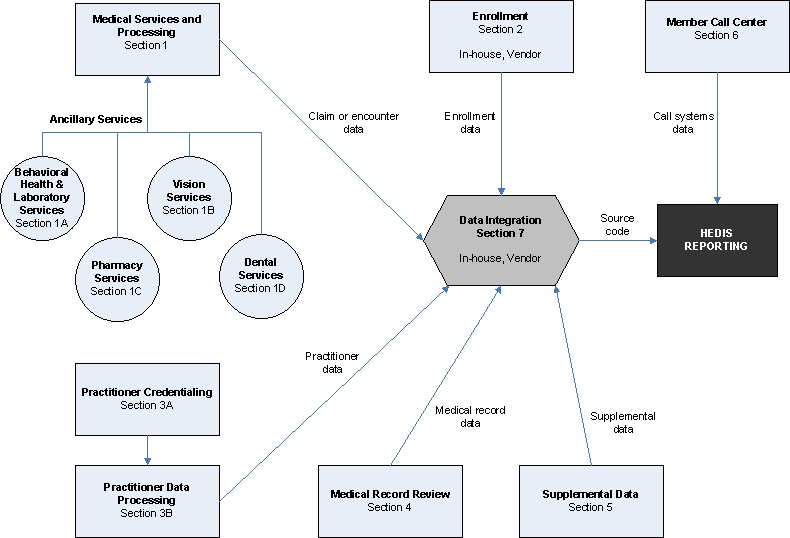
Auditors hold the Roadmap and attached documents in strict confidence; however, NCQA uses the Roadmap and attached documents to assess auditor performance.

HEDIS Roadmap Data Workflow Diagrams

The Roadmap was changed to help organizations of all types give auditors information about data they use for HEDIS—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 HEDIS Measure Reporting



General Information

Introduction

*HEDIS Roadmap Appendix 1* is an Excel file that includes general information, instructions and measure reporting tabs. Complete the spreadsheet for each product line or product under review.

Roadmap Appendix 1

* General information:
* About your organization.
* Contact information.
* Product lines or products undergoing an audit for the measurement year.
* State-specific reporting information.
* Instructions on reporting measures.
* What HEDIS measures are you reporting?
* Commercial measures.
* Medicaid measures.
* Medicare measures.
* SNP 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 HEDIS audit reports** | If your organization is using a new audit firm for the measurement year, attach the final report from the previous year’s commercial, Medicare, Medicaid or CHIP HEDIS Audit. | **GI.1** |
| **State reporting requirements** | Label and attach any state directives or policy letters that list the measures required by the state and additional audit requirements. Identify the source and date of the document. | **GI.2** |
| **Incentives** | Attach a list of every measure affected by incentive programs, regardless of the type of incentive. | **GI.3** |
| **Other submission tools** | Label and attach copies of tools used to submit data to entities other than NCQA, including policy directives or memos with reporting requirements. | **GI.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 |  |  |
|  |  |  |

Attestation\*

**Organization name:**

I declare that the information provided in this HEDIS 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 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 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. * Process claim or encounter data. |
| *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 vendors are used to collect ancillary services: * Complete***Section 1.A*** for behavioral healthcare or laboratory data. * Complete ***Section 1.B*** for vision data. * Complete ***Section 1.C*** for pharmacy data. * Complete ***Section 1.D*** for dental 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 processing 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.*** |

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., DRGs, 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 HEDIS codes (e.g., ICD-9, CPT, UB Revenue, MS DRG, HCPCS, CPT II). |  |  |  |  |
| ***1.3B*** | Nonstandard HEDIS codes: | | | | |
| State-specific (e.g., Medicaid, state DRGs). |  |  |  |  |
| 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 | | Product Line A | Product Line B | Product Line C |
| ***1.6A*** | Type of form. |  |  |  |
| ***1.6B*** | What percentage of claims or encounters was affected? |  |  |  |
| ***1.6C*** | For which services were nonstandard forms used? |  |  |  |

**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. |  |  |  |  |
| **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. |  |  |  |  |
| DRG. |  |  |  |  |
| HCPCS. |  |  |  |  |
| CPT Level II. |  |  |  |  |

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

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**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? |  |

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 HEDIS 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.***

| 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.***

| 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. | **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. | **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 HEDIS. | **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: Behavioral Healthcare and Laboratory Services  
and Processing *(IS 1)*

Introduction

***Vendors’ behavioral healthcare or 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. * Process claim or encounter data. |
| *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. If a vendor sends electronic results data to the health plan 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? |  |  |  |
| ***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 no, 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? |  |
| ***1A.2E*** | Does your organization use its own DRG grouper? |  |
| ***1A.2F*** | Which DRG grouper does your organization use? |  |
| ***1A.2G*** | Does your organization ensure accurate assignment of DRGs? |  |

Coding Schemes

**Table 1A.3: *Coding schemes used.*** Consider all non-HEDIS coding methods, including state-specific codes (e.g., DRGs, 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 HEDIS codes (e.g., ICD-9, CPT, UB Revenue, MS DRG, HCPCS, CPT II). |  |  |  |  |
| ***1A.3B*** | Nonstandard HEDIS codes: | | | | |
| DSM-IV. |  |  |  |  |
| State-specific (e.g., Medicaid, state DRGs). |  |  |  |  |
| 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 | | Product Line A | Product Line B | Product Line C |
| ***1A.6A*** | Type of form. |  |  |  |
| ***1A.6B*** | What percentage of claims or encounters was affected? |  |  |  |
| ***1A.6C*** | For which services were nonstandard forms used? |  |  |  |

**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. |  |  |  |  |
| DRG. |  |  |  |  |
| HCPCS. |  |  |  |  |
| CPT Level II. |  |  |  |  |

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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 HEDIS 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 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. * Process claim or encounter data. |
| *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. If a vendor sends electronic results data to the health plan 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 no, 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 HEDIS codes (e.g., ICD-9, CPT, HCPCS, CPT II). |  |  |  |  |
| ***1B.3B*** | Nonstandard HEDIS codes: | | | | |
| State-specific (e.g., Medicaid, state DRGs). |  |  |  |  |
| Internally developed. |  |  |  |  |

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**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 |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

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 | | Product Line A | Product Line B | Product Line C |
| ***1B.6A*** | Type of form. |  |  |  |
| ***1B.6B*** | What percentage of claims or encounters was affected? |  |  |  |
| ***1B.6C*** | Services for which nonstandard forms were used? |  |  |  |

**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. |  |  |  |  |
| DRG. |  |  |  |  |
| HCPCS. |  |  |  |  |
| CPT Level II. |  |  |  |  |

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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 members 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? |  |

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** | 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 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. * Process claim or encounter data. |
| *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. If a vendor sends electronic results data to the health plan 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 no, 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 HEDIS codes (e.g., NDC, HCPCS). |  |  |  |
| Nonstandard HEDIS codes: | | | |
| State-specific (e.g., Medicaid). |  |  |  |
| Regional or temporary drug codes. |  |  |  |

Data Submission Forms

**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 1D: Dental Services and Processing *(IS 1)  
(Medicaid Only)*

Introduction

***Vendors’ dental 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. * Process claim or encounter data. |
| *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 1D if they process claims or encounter data for reimbursement for the health plan. If a vendor sends electronic results data to the health plan 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 1D.1: *Claim or encounter data processing system described in this section.*

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

Claim or Encounter Policy Question

|  |  |
| --- | --- |
| ***1D.1-1*** | ***Q.*** Regarding claim or encounter policies in place during the measurement year, what was the time limit for practitioner submissions?  ***A.*** |
| ***1D.1-2*** | ***Q.*** Does the vendor use the plan’s member identifier for claims processing? If no, how are claims mapped?  ***A.*** |
| ***1D.1-3*** | ***Q.*** How was a claim or encounter handled if it was submitted past the deadline?  ***A.*** |

Coding Software

**Table 1D.2: *Automated coding software used for the claim or encounter data system.***

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

Coding Schemes

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

| Coding Scheme | Type of Service | | | |
| --- | --- | --- | --- | --- |
| Inpatient Diagnosis | Inpatient Procedure | Ambulatory Diagnosis | Ambulatory Procedure |
| Standard HEDIS codes (e.g., CDT, ICD-9, CPT, HCPCS). |  |  |  |  |
| Nonstandard HEDIS codes: | | | | |
| State-specific (e.g., Medicaid, state DRGs). |  |  |  |  |
| Internally developed. |  |  |  |  |

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**Table 1D.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.

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

**Table 1D.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 Claim or Encounter |
|  |  |  |
|  |  |  |
|  |  |  |

Nonstandard Data Submission Forms

**Table 1D.6:  *Nonstandard, state-specific or encounter forms (i.e., other than ADA Dental Claim form, UB-04 or CMS 1500) used during the measurement year.***

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

**Table 1D.7: *Data elements 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. |  |  |  |  |

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

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

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System Upgrades or Conversions

**Table 1D.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 |
| --- | --- | --- |
| ***1D.9A*** | Describe the change, upgrade or consolidation. |  |
| ***1D.9B*** | What claim or encounter data systems and product lines or products were affected? |  |
| ***1D.9C*** | Project start and end dates. |  |
| ***1D.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 elements were not converted to the new system? |  |
| ***1D.9E*** | How were data mapped for conversion from the previous system to the new claim or encounter system? |  |
| ***1D.9F*** | Was a parallel system run during the conversion? |  |
| ***1D.9G*** | How did your organization ensure accuracy and completeness of data in the new system? |  |

Policies and Procedures

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

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***1D.10A*** | How are claims or encounters obtained, processed and entered into the claim or encounter system? |  |
| ***1D.10B*** | Are encounters (i.e., submissions that are not linked to payment) processed differently from claims (i.e., submissions for payment)? |  |
| ***1D.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)? |  |
| ***1D.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? |  |

**Table 1D.10 *continued***

|  |  |  |  |
| --- | --- | --- | --- |
| Question | | Description | |
| ***1D.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? |  | |
| ***1D.10F*** | Are there situations where processors may change claim or encounter information submitted by a provider? |  | |

Electronic Submission of Claim or Encounter Data

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

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

Timeliness and Accuracy of Data Processing

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

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

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

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

Data Completeness

Improving Data Completeness

**Table 1D.14: *Information about data completeness activities during the measurement year.***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***1D.14A*** | Did your organization take steps to improve completeness of claim or encounter data? |  |
| ***1D.14B*** | Were all practitioners, provider groups, facilities and vendors required by contract to submit complete and accurate claim or encounter data? |  |
| ***1D.14C*** | Were performance standards in place to ensure submission of claim or encounter data by practitioners, provider groups, facilities and vendors? |  |
| ***1D.14D*** | Was compensation tied to submission of claim or encounter data by practitioners, provider groups, facilities and vendors? |  |
| ***1D.14E*** | Were other incentive or penalty arrangements in place for practitioners, provider groups, facilities and vendors to submit complete and accurate data? |  |
| ***1D.14F*** | Were other activities undertaken to encourage claim or encounter data submission by practitioners, provider groups, facilities and vendors? |  |
| ***1D.14G*** | 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. | **1D.1** |
| **Proprietary forms (if applicable)** | If proprietary claim or encounter forms were used during the measurement year, attach clean, blank copies of each. | **1D.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. | **1D.3** |
| **Data completeness studies  or analyses** | If applicable, attach copies of additional studies or analyses conducted on data completeness or under-reporting. | **1D.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: Enrollment *(IS 2)*

Introduction

***Enrollment or membership data source and system used during the measurement year.***

|  |  |
| --- | --- |
| Organization information | **Organization name:** |
| **Date of completion:** |
| Definitions |  |
| *Enrollment or membership system* | Captures data about the members and their enrollment information, including eligibility, enrollment dates or spans and benefits. |
| *Enrollment or membership processing vendor* | Includes any external entity with which the organization has contracted to perform enrollment or membership data processing functions. Vendors may include, but are not limited to, ancillary providers, third-party administrators, provider groups and intermediary organizations (e.g., IPAs, MSOs, PHOs). |
| *Significant change* | A change of (+/–)20% in membership volume, or a conversion, consolidation or upgrade to the enrollment system. |
| Instructions | * Complete a separate Section 2 for each membership system. * Where there are differences by product line or product, provide a separate response for each product line or product subject to audit. |

**Table 2.1: *The membership system.***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***2.1A*** | Is this an internal or vendor system? |  |
| ***2.1B*** | System name. |  |
| ***2.1C*** | How does the system ensure eligibility when processing claims or encounters? |  |
| ***2.1D*** | Is the system used to produce member-related HEDIS measures? |  |
| ***2.1E*** | Does the system maintain other membership data? Describe. |  |
| ***2.1F*** | What is the enrollment source? |  |
| ***2.1G*** | What percentage of members is maintained in this system? |  |

**Table 2.2: *Member information maintained* *in the system.*** Complete this table with all required elements captured by the system. Indicate if the data element is:

**R Required:** The membership system requires the data element for all members.

**O Optional:** The membership system requires the data element for some, but not all members.

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

**NA Not Applicable:** The data element does not apply to the membership.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **General Information** | | | | |
|  | | **Required? (R,O,N,NA)** | **Required? (R,O,N,NA)** | **Required? (R,O,N,NA)** |
| **Product Line/Product** | |  |  |  |
| Full name. | |  |  |  |
| Address. | |  |  |  |
| Date of birth. | |  |  |  |
| Gender. | |  |  |  |
| Social Security number. | |  |  |  |
| State ***or***  federal ID number (indicate one). | |  |  |  |
| Organization-designated number. | |  |  |  |
| Medicare number. | |  |  |  |
| Other (specify): | |  |  |  |
| **Coverage Information** | | | | |
| Relationship to subscriber. | |  |  |  |
| Primary care physician (PCP) selection. | |  |  |  |
| Benefit package. | |  |  |  |
| Date of enrollment notification. | |  |  |  |
| COB information. | |  |  |  |
| First year of enrollment. | |  |  |  |
| With organization. | |  |  |  |
| By product line or product. | |  |  |  |
| By benefit package. | |  |  |  |
| With organization. |  |  |  |
| By product line or product. |  |  |  |
| By benefit package. |  |  |  |
| **Race, Ethnicity and Language Information** | | | |
| Race. |  |  |  |
| Ethnicity. |  |  |  |
| Interpretive service needs. |  |  |  |
| Language spoken at home. |  |  |  |

**Table 2.2 *(continued)***

|  |  |  |  |
| --- | --- | --- | --- |
| **Member ID Information** | | | |
|  | **Required? (R,O,N,NA)** | **Required? (R,O,N,NA)** | **Required? (R,O,N,NA)** |
| Does the system assign a unique ID? |  |  |  |
| Under what circumstances, if any, does the enrollment or membership system allow: | | | |
| More than one member to have the same ID? |  |  |  |
| The same member to have more than one ID? |  |  |  |
| A member’s ID to change (e.g., re-enrollment, name change, product line or product switch, change in marital status)? |  |  |  |
| Regarding members whose IDs change: | | | |
| Is the original enrollment date with the organization maintained? |  |  |  |
| Are previous enrollment data maintained and linked to the new enrollment data? |  |  |  |
| Are previous claim or encounter data maintained and linked to the new enrollment data? |  |  |  |
| Regarding enrollment requirements: | | | |
| Must members enroll or disenroll only on a particular date each month? |  |  |  |
| How many updates (i.e., lines of history) can the enrollment or membership data system maintain for each member? |  |  |  |
| **Benefit Information** | | | |
| Benefit cap: | | | |
| Behavioral healthcare. |  |  |  |
| Pharmacy. |  |  |  |
| **Enrollment Changes** | | | |
| Explain significant changes (+/–20%) in membership: | | | |
| In new enrollment or disenrollment. |  |  |  |
| Of retroactive enrollment or disenrollment activity. |  |  |  |
| In any age group. |  |  |  |
| In either sex. |  |  |  |
| In race or ethnicity. |  |  |  |

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

Enrollment or Membership Systems

**Table 2.3: *Enrollment data.***

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***2.3A*** | How are data for new members obtained, processed and entered into the enrollment or membership system? Describe how new member data are processed. |  |
| ***2.3B*** | How are newborns assigned member IDs? |  |
| ***2.3C*** | How are mother-baby records linked? |  |
| ***2.3D*** | How are changes to member information obtained, processed and entered into the enrollment or membership system? Describe how enrollment changes are processed. |  |
| ***2.3E*** | How are data on member terminations obtained, processed and entered into the enrollment or membership system? Describe how member terminations are processed. |  |
| ***2.3F*** | How is data entry of enrollment or membership information verified? |  |
| ***2.3G*** | Does the enrollment or membership system include edit checks to ensure the accuracy of data entry? If yes, describe. |  |

**Table 2.4: *Timeliness and data completeness.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Product Line/Product | |  |  |  |
| ***2.4A*** | What were the time-to-process standards for enrollment or membership data? |  |  |  |
| ***2.4B*** | What was the actual average time to process for enrollment or membership data? |  |  |  |
| ***2.4C*** | Was there ever a backlog or delay in processing enrollment or membership data? If yes, describe. |  |  |  |
| ***2.4D*** | Was there ever a backlog or delay in receiving enrollment data from external sources (e.g., employer groups, state, CMS)? If yes, describe. |  |  |  |

**Table 2.5: *Accuracy of enrollment or membership data.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Product Line/Product | |  |  |  |
| ***2.5A*** | Were there audits of enrollment or membership data processing? What was audited, and how often? |  |  |  |
| ***2.5B*** | What were the findings for the measurement year? |  |  |  |
| ***2.5C*** | Were deficiencies detected? If yes, describe. |  |  |  |
| ***2.5D*** | During the measurement year, were enrollment or membership data reconciled against an external data source (e.g., employer group, Medicare, Medicaid, CHIP data)? If yes: |  |  |  |
| * Describe the reconciliation process, including what was reconciled and how often. |  |  |  |
| * What were the findings for the measurement year? |  |  |  |
| * Were deficiencies detected? If yes, describe. |  |  |  |

**Table 2.5 *(continued)***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Product Line/Product | |  |  |  |
| ***2.5E*** | During the measurement year, were staff incentives tied to the accuracy and timeliness of enrollment or membership data processing? If yes, describe. |  |  |  |
| ***2.5F*** | Were there barriers to obtaining complete and accurate enrollment or membership data? Consider all factors that might influence your organization’s ability to collect such information from employer groups, individual enrollees, contracted vendors and government agencies. |  |  |  |

**Table 2.6: *Upgrades and consolidations during the past three years.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Product Line/Product | |  |  |  |
| ***2.6A*** | Did a change, upgrade or consolidation affect the ability to identify members? If yes, describe. |  |  |  |
| ***2.6B*** | What enrollment or membership data systems and product lines or products were affected? |  |  |  |
| ***2.6C*** | Project start and end dates. |  |  |  |
| ***2.6D*** | Regarding data conversion: |  |  |  |
| * What members were converted to the new system (e.g., active members only, all members)? |  |  |  |
| * What members were not converted to the new system? |  |  |  |
| * What data elements were converted to the new system? |  |  |  |
| ***2.6E*** | How were data mapped for conversion from the previous system to the new claim or encounter system? |  |  |  |

**Table 2.7: *Electronically submitted data.***

|  |  |  |
| --- | --- | --- |
| **Question** | | **Description** |
| ***2.7A*** | From whom are electronic enrollment or membership files received? |  |
| ***2.7B*** | How often are electronic enrollment or membership files received? |  |
| ***2.7C*** | How are electronic files uploaded into the enrollment or membership processing system? |  |
| ***2.7D*** | What procedures are in place to ensure that transmissions are properly monitored and controlled? |  |
| ***2.7E*** | What edit checks are performed to ensure the electronically transferred enrollment or membership files are: | |
| Accurately and completely received? |  |
| Uploaded to the enrollment or membership system? |  |

**Note:** Vendors completing Section 2: Enrollment may skip Tables 2.8 and 2.9.

**Table 2.8:** ***Enrollment data sent to a vendor providing ancillary services (e.g., vision, laboratory, pharmacy, dental, behavioral healthcare).***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Vendor | | | | |
| Product Line/Product | |  |  |  |
| ***2.8A*** | Describe the process for submitting membership data to the ancillary vendor. |  |  |  |
| ***2.8B*** | How often are membership data submitted to the ancillary vendor? |  |  |  |
| ***2.8C*** | What percentage of members is affected by the ancillary vendor? |  |  |  |
| ***2.8D*** | Describe the process used to monitor membership data submissions. |  |  |  |
| ***2.8E*** | Describe the process to ensure that the ancillary vendor appropriately maintains the membership data in the system. |  |  |  |

**Table 2.9: *Vendor oversight. Organizations*** ***complete this section annually for each vendor.***

|  |  |  |
| --- | --- | --- |
| **Question** | | **Description** |
| ***2.9A*** | Vendor name. |  |
| ***2.9B*** | Contract start or end date. |  |
| ***2.9C*** | What standards of delegation, if any, were vendors subject to during the measurement year, including oversight policies, processing standards and predelegation requirements? |  |
| ***2.9D*** | What reporting requirements, if any, were vendors subject to during the measurement year, including type and frequency of reporting? |  |
| ***2.9E*** | What oversight and monitoring activities, if any, were vendors subject to during the measurement year, including type and frequency of reviews or audits? |  |
| ***2.9F*** | During the measurement year, were deficiencies detected with vendor processing of enrollment or membership data? If yes, describe the nature of the deficiencies and corrective actions taken. |  |

Requested Documents

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

|  |  |  |
| --- | --- | --- |
| Document | Details | Label |
| **Enrollment or membership data system flowchart** | A flowchart that gives an overview of the enrollment or membership data system and processes, indicating steps in the enrollment or membership data process as well as the flow of enrollment or membership data from all sources. | **2.1** |
| **Contracts with no-touch clauses  (if applicable)** | Provide all contracts that contain exclusive no-touch clauses (e.g., administrative services only [ASO] contracts that prohibit the organization from contacting members under any circumstances). The auditor must review these contracts if your organization requests that members be excluded from HEDIS reporting. | **2.2** |

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 3A: Practitioner Credentialing Data *(IS 3)*

Introduction

***Practitioner credentialing systems.***

|  |  |
| --- | --- |
| Organization information | **Organization name:** |
| **Date of completion:** |
| Definitions |  |
| *Practitioner credentialing system* | Any system used by the organization to maintain practitioner credentialing data other than the system used to process claims and encounters. |
| *Practitioner credentialing vendor* | An external entity to which the organization has delegated to capture data about practitioners and their credentialing information, including practitioner IDs, effective dates and board certification status. |
| *Significant change* | A change of (+/–)10% in practitioner volume, or a conversion, consolidation or upgrade to the data processing system. |
| Instructions | Complete this section for each credentialing system. |

General Information

**Table 3A.1:** ***Practitioner credentialing******systems for all product lines or products under review during the measurement year.***

| Question | | Description |
| --- | --- | --- |
| ***3A.1A*** | What data systems were used: | |
| * To maintain practitioner credentialing data? |  |
| * To generate the provider directory? |  |
| * To produce the *Board Certification* measure? |  |
| ***3A.1B*** | How does your organization receive practitioner credentialing data (e.g., paper applications, electronic data, Web submissions)? |  |
| ***3A.1C*** | In addition to practitioner credentialing system and practitioner data in the transaction system, does your organization maintain practitioner data in any other system or database? | |
| * If yes, describe the name and purpose of this additional system or database. |  |

**Note:** If there are different systems for different product lines, indicate applicable product lines in your response.

Practitioner Data Elements Captured

### Table 3A.2: *Practitioner data elements captured by each system or provided by each vendor.* Include any vendor responsible for 5 percent or more of your provider data; add columns for additional systems and vendors.

|  |  |  |  |
| --- | --- | --- | --- |
| Practitioner Data Elements | Captured? | | Credentialing System or Vendor |
| Yes | No |
| Practitioner name. |  |  |  |
| Practitioner SSN. |  |  |  |
| License number. |  |  |  |
| Office address or location. |  |  |  |
| TIN by location. |  |  |  |
| Organization-designated ID number. |  |  |  |
| State-issued ID number. |  |  |  |
| Medicaid ID number *(if different from above).* |  |  |  |
| Medicare ID number. |  |  |  |
| DEA number. |  |  |  |
| NPI. |  |  |  |
| PCP identification. |  |  |  |
| Specialty. |  |  |  |
| Effective date with your organization. |  |  |  |
| Termination date with your organization. |  |  |  |
| Board certification status. |  |  |  |
| Board certification effective date. |  |  |  |
| Board certification expiration date. |  |  |  |
| Board certification status for multiple specialties. |  |  |  |

|  |  |
| --- | --- |
| ***3A.2-1*** | ***Q.*** Was any data element in Table 3A.2 marked “No”? Explain.  ***A.*** |

**Table 3A.3:** ***How practitioner credentialing data systems were used.***

| Question | | Description |
| --- | --- | --- |
| ***3A.3A*** | Are practitioners required to be board certified or eligible in each specialty they practice? |  |
| ***3A.3B*** | What types of practitioner were considered PCPs? |  |
| ***3A.3C*** | May members select nonphysicians as PCPs? If yes, list the types of nonphysician practitioner allowed to practice as PCPs. |  |
| ***3A.3D*** | What is the unique practitioner ID in the following systems? | |
| Credentialing system. |  |
| Additional systems or databases if any, that your organization uses to store practitioner data. |  |
| ***3A.3E*** | What types of providers are not credentialed (e.g., residents, medical directors)? |  |

Practitioner Data Quality

**Table 3A.4:** ***Accuracy of practitioner credentialing data.***

| Question | | Description |
| --- | --- | --- |
| ***3A.4A*** | Did your organization conduct audits during the measurement year? Briefly describe the audit process and frequency. |  |
| ***3A.4B*** | What were findings for the measurement year? Include information on deficiencies and actions taken to address deficiencies. |  |
| ***3A.4C*** | How frequently are practitioner credentialing data elements (e.g., board status, effective and expiration dates) updated? |  |
| ***3A.4D*** | Were any changes implemented during the measurement year to improve practitioner data quality in the credentialing system? Describe. |  |

Delegated Entity or Vendor Oversight

### Table 3A.5: *Vendors or external entities to whom practitioner credentialing is delegated.* Do not include information on dental or pharmacy services.

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Vendor | Types of Practitioner Affected | Percentage of Network Affected | Method and Frequency of  Data Transmittal |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

### Table 3A.6: *Vendor oversight.* Organizations complete this section annually for each vendor.

| Question | | Description |
| --- | --- | --- |
| ***3A.6A*** | Vendor name. |  |
| ***3A.6B*** | Briefly describe the process and frequency of oversight for the vendors listed above. |  |
| ***3A.6C*** | Were vendor deficiencies detected during the measurement year? If yes, what corrective actions were taken? |  |
| ***3A.6D*** | What is your organization’s process for integrating credentialing data received from vendors or external entities? Include information on whether data are entered manually or are electronically downloaded from each vendor to whom credentialing was delegated. |  |
| ***3A.6E*** | How does your organization verify accuracy of credentialing data received from vendors? |  |

System Upgrades or Conversions

**Table 3A.7: *Complete this table if significant changes were made to the practitioner credentialing data system or a new data system was implemented during the past three years.***

| Question | | Description |
| --- | --- | --- |
| ***3A.7A*** | Describe the change, upgrade or consolidation. |  |
| ***3A.7B*** | New system’s name. |  |
| ***3A.7C*** | Method and results of audits conducted on data entry into the new system. |  |
| ***3A.7D*** | Results of reconciliation conducted to ensure accuracy and completeness of data transfer. |  |

Requested Documents

Provide the documents listed below, labeled as instructed in the table.

|  |  |  |
| --- | --- | --- |
| Document | Details | Label |
| **Practitioner credentialing data system flowchart** | A flowchart that gives an overview of the practitioner credentialing data system and processes, indicating steps in the practitioner credentialing data process as well as the flow of practitioner data received from all sources that entered in your credentialing system. | **3A.1** |
| **Source code for *Board Certification* measure (if applicable)** | Source code for the *Board Certification* measure, including provider specialty mapping, documentation of development and programmer assigned to the development, and indicate if certified software or non-certified software is used. | **3A.2** |

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 3B: Practitioner Data Processing *(IS 3)*

Introduction

***Practitioner data systems and processes.***

|  |  |
| --- | --- |
| Organization information | **Organization name:** |
| **Date of completion:** |
| Definitions |  |
| *Practitioner data system* | Any system used to process claims or encounters. |
| *Practitioner processing vendor* | Any external entity with which the organization has contracted to perform practitioner data processing functions. Vendors may include, but are not limited to, hospitals, integrated delivery systems, IPAs, medical groups, behavioral healthcare vendors. |
| *Significant change* | A change of (+/–)10% in practitioner volume, or a conversion, consolidation or upgrade to the practitioner data processing system. |
| Instructions | * Complete this section for each practitioner data system. * Where there are differences by product line or product, provide a separate response for each product line or product subject to audit review. |

General Information

**Table 3B.1:** ***Data systems.***

| Question | | Description |
| --- | --- | --- |
| ***3B.1A*** | What data systems were used: | |
| To maintain practitioner specialty data? |  |
| To maintain practitioner data for processing claims or encounters? |  |
| To generate the printed provider directory (if any)? |  |
| To generate the online provider directory? |  |
| ***3B.1B*** | In addition to practitioner data in the transaction system, does your organization maintain practitioner data in any other system or database? Describe. |  |

**Note:** If there are different systems for different product lines, indicate applicable product lines in your response.

### Table 3B.2: *Year-end number of PCPs (as defined in Volume 2, Appendix 3) for the past two years.*

|  |  |  |  |
| --- | --- | --- | --- |
| Product Line |  |  |  |
| Product |  |  |  |
| * Prior year. |  |  |  |
| * Measurement year. |  |  |  |

Practitioner Data Elements

### Table 3B.3: *Practitioner data elements captured by each system or vendor.* Add columns for additional systems or vendors.

|  |  |  |  |
| --- | --- | --- | --- |
| Practitioner Data Elements | Captured? | | System or Vendor |
| Yes | No |
| Practitioner name. |  |  |  |
| Practitioner SSN. |  |  |  |
| Medical license number. |  |  |  |
| Office address or location. |  |  |  |
| TIN by location. |  |  |  |
| Group affiliation. |  |  |  |
| Organization-designated ID number. |  |  |  |
| Type of payment arrangement. |  |  |  |
| State-issued ID number. |  |  |  |
| Medicaid ID number, if different from above. |  |  |  |
| Medicare ID number. |  |  |  |
| NPI. |  |  |  |
| PCP identification. |  |  |  |
| Specialty. |  |  |  |
| Effective date with your organization. |  |  |  |
| Effective date with your organization by product line. |  |  |  |
| Termination date with your organization. |  |  |  |
| Termination date with your organization by product line. |  |  |  |
| DEA license numbers. |  |  |  |

|  |  |
| --- | --- |
| ***3B.3A*** | ***Q.*** Was any data element in Table 3B.3 marked “No”? Explain.  ***A.*** |

**Table 3B.4: *Practitioner data processing.***

| Question | | Description |
| --- | --- | --- |
| ***3B.4A*** | During the measurement year, did any product lines or products under review experience: | |
| An increase in the number of practitioners? Why? |  |
| A decrease in the number of practitioners due to contract terminations? Why? |  |
| Significant turnover in the provider network? |  |
| ***3B.4B*** | What is the unique practitioner ID in the following systems? | |
| Practitioner data system used for processing claims or encounters. |  |
| Additional systems or databases if any. |  |
| ***3B.4C*** | Are practitioners contracted for more than one product or product line assigned the same ID number, or are they assigned a different number for each product or product line? |  |
| ***3B.4D*** | Under what circumstances, if any, would the following be allowed in your organization’s practitioner data system? Specify for each question, the system that would allow: | |
| More than one practitioner to have the same ID number. |  |
| The same practitioner to have more than one ID number. |  |
| A practitioner’s ID number to change (e.g., through recontracting, group affiliation change, product line or product switch). |  |

Practitioner Data Quality

### Table 3B.5: *Accuracy of practitioner data processing during the measurement year.* Provide information separately for each system if the organization uses more than one system and for each vendor that processes claims or encounters. Do not include information on dental and pharmacy providers or vendors.

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***3B.5A*** | For practitioner data in the system used for processing claims or encounters: | |
| Were any audits conducted during the measurement year? Briefly describe the audit process and frequency. |  |
| What were the findings for the measurement year? Include information on deficiencies. |  |

**Table 3B.6: *Reconciliation of practitioner data.***

|  |  |  |  |
| --- | --- | --- | --- |
| Question | | | Description |
| ***3B.6A*** | During the measurement year, were the following reconciliations conducted for practitioner data? Briefly describe the process and findings, including deficiencies. | | |
| Reconciliation between practitioner data in the credentialing system and claims processing system. |  | |
| Reconciliation between practitioner data in your organization’s practitioner data system and any other additional system your organization maintains to store practitioner data. |  | |
| ***3B.6B*** | Describe changes implemented during the measurement year to improve the practitioner data quality in the claims processing system. |  | |

Transfer of Practitioner Data for Claims or Encounter Data Processing

### Table 3B.7: *Vendors or external entities where claims or encounter processing is delegated or to whom your organization sends practitioner data.* Do not include information on dental or pharmacy services.

|  |  |  |
| --- | --- | --- |
| Name of Vendor | Type of Claim or Encounter Affected | Method and Frequency of  Data Transmittal to Vendor |
|  |  |  |
|  |  |  |
|  |  |  |

Practitioner Data Questions

|  |  |
| --- | --- |
| ***3B.7A*** | ***Q.*** During the measurement year, were any reconciliations conducted for practitioner data between your organization’s system and the vendors listed in Table 3B.7? If yes, briefly describe the process and findings, including deficiencies. Provide information separately for each vendor.  ***A.*** |
| ***3B.7B*** | ***Q.*** Were there any changes in classification or identification of practitioner specialties during the measurement year?  ***A.*** |

System Upgrades or Conversions

**Table 3B.8: *Complete this table if during the past three years, system conversions were used to store practitioner data for processing claims during the measurement year.***

| Question | | Description |
| --- | --- | --- |
| ***3B.8A*** | Describe the change, upgrade or consolidation. |  |
| ***3B.8B*** | Describe the process used to map practitioner data to the new system audits or reconciliation conducted to ensure accuracy and completeness of data transfer. |  |

Requested Documents

Provide the documents listed below, labeled as instructed in the table. Complete with state reporting requirements, as applicable.

|  |  |  |
| --- | --- | --- |
| Document | Details | Label |
| **Practitioner data system flowchart** | A flowchart that gives an overview of the practitioner data system and processes, indicating steps in the practitioner data process as well as the flow of practitioner data from all sources. | **3B.1** |
| **Provider type mapping** | A table of the organization’s provider types mapped to the HEDIS provider types (for measures that require provider type). | **3B.2** |

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 4: Medical Record *(IS 4)*

Introduction

***Processes used to abstract data from medical records for the measurement year.***

**Note:** Skip this section if your organization is not using the Hybrid Method for the measurement year.

|  |  |
| --- | --- |
| Organization information | **Organization name:** |
| **Date of completion:** |
| Vendor information | **Vendor name:** |
| **Date of completion:** |
| Definitions |  |
| *Staff* | Indicate in the appropriate tables the type of internal (full time, part time or HEDIS audit-specific contract) staff that perform the specified tasks, such as record retrieval. |
| *Vendor* | Indicate in the appropriate tables if a medical record vendor performs the specified tasks. |
| *NCQA Certified Software Vendor* | NCQA software certification applies to only the creation of the systematic sample frame, not to the vendor’s abstraction module. |
| *Algorithms* | Logic applied when medical record data is integrated into the measure repository for final measure calculation. |
| Instructions | * Where there are differences by product line or product, provide a separate response for each product line or product subject to audit. * If a vendor provides medical record services, the vendor completes the appropriate tables for the activities provided. |

Hybrid Sample Size Determination

### Table 4.1: *Determining the final sample size.* Complete a separate table for each product or product line if a separate process is used for different products.

| Product or Product Line | | | | | |
| --- | --- | --- | --- | --- | --- |
| Hybrid Measure | Current Year Admin Rate | Final Sample Size | Oversample Rate (5%, 10%, 15%, 20%) | Sample Reduced Based on Current Year Admin Rate? (Y/N) | Sample Reduced Based on Prior Year Reported Rate? (Y/N) |
| **ABA** Adult BMI Assessment |  |  |  |  |  |
| **AWC** Adolescent Well-Care Visits |  |  |  |  |  |
| **CBP** Controlling High Blood Pressure |  |  |  |  |  |
| **CCS**  Cervical Cancer Screening |  |  |  |  |  |
| **CDC**  Comprehensive Diabetes Care |  |  |  |  |  |
| **IMA** Immunizations for Adolescents |  |  |  |  |  |
| **HPV** Human Papillomavirus Vaccine for Female Adolescents |  |  |  |  |  |
| **CIS** Childhood Immunization Status |  |  |  |  |  |
| **CMC** Cholesterol Management for Patients With Cardiovascular Conditions |  |  |  |  |  |
| **COA** Care for Older Adults |  |  |  |  |  |
| **COL** Colorectal Cancer Screening |  |  |  |  |  |
| **FPC** Frequency of Ongoing Prenatal Care |  |  |  |  |  |
| **LSC** Lead Screening in Children |  |  |  |  |  |
| **MRP** Medication Reconciliation Post-Discharge |  |  |  |  |  |
| **PPC** Prenatal and Postpartum Care |  |  |  |  |  |
| **WCC** Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents |  |  |  |  |  |
| **WOP** Weeks of Pregnancy at Time of Enrollment |  |  |  |  |  |
| **W15** Well-Child Visits in the First 15 Months of Life |  |  |  |  |  |
| **W34**  Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life |  |  |  |  |  |

Hybrid Sample Validation and Distribution

### Table 4.2: *Validation and distribution of hybrid samples.*

|  |  |  |
| --- | --- | --- |
| Key Steps | | Description |
| ***4.2A*** | How does your organization determine that the denominator population for each hybrid sample is accurate? |  |
| ***4.2B*** | Describe the chase logic used to determine the most likely provider of services for hybrid measures. |  |
| ***4.2C*** | How does your organization determine the most likely provider site location for a provider with multiple clinic sites? |  |
| ***4.2D*** | How do persons or vendors who are conducting chart retrieval access the hybrid samples (e.g., Web portal, printed copy abstraction sheets, database)? |  |
| ***4.2E*** | When a reviewer finds no evidence that a member belonged in a denominator population (e.g., a 30-year-old in the *Colorectal Cancer Screening* denominator), what is the process for excluding the member from the sample? |  |
| ***4.2F*** | How does your organization identify exclusions? |  |
| ***4.2G*** | How are samples distributed between a vendor and in-house staff? |  |

Key Hybrid Retrieval, Abstraction and Validation Activities

### Table 4.3: *Complete this table by putting a “🗸” in the appropriate cell, regardless of whether abstraction is conducted by your organization’s internal staff or by a vendor.* If you check “Copy Service,” “Abstraction Vendor” or “Certified HEDIS Software Vendor” for any process, also complete Table 4.8. Indicate the type of staff responsible for key steps in the medical record review process and the number of persons responsible for each step.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Key Steps | | Organization Staff | Contracted or Temp. Staff | Practitioner Office Staff | Copy Service | Medical Record Vendor | Certified HEDIS Software Vendor |
| ***4.3A*** | Overall project management. |  |  |  |  |  |  |
| ***4.3B*** | Create hybrid samples. |  |  |  |  |  |  |
| ***4.3C*** | Create hybrid abstraction tools (electronic or printed copy). |  |  |  |  |  |  |
| ***4.3D*** | Populate abstraction tools or fields with administrative and member demographic data. |  |  |  |  |  |  |
| ***4.3E*** | Validate abstraction tool data elements. |  |  |  |  |  |  |
| ***4.3F*** | Train MRR staff. |  |  |  |  |  |  |
| ***4.3G*** | Conduct initial interrater reliability. |  |  |  |  |  |  |
| ***4.3H*** | Track ongoing interrater reliability through the project. |  |  |  |  |  |  |
| ***4.3I*** | Retrieve data for printed tools. |  |  |  |  |  |  |
| ***4.3J*** | Retrieve data for provider faxes. |  |  |  |  |  |  |
| ***4.3K*** | Retrieve data for scanned documents. |  |  |  |  |  |  |
| ***4.3L*** | Retrieve data from electronic medical records (EMR). |  |  |  |  |  |  |
| ***4.3M*** | Retrieve data from immunization registries. |  |  |  |  |  |  |
| ***4.3N*** | Retrieve data from supplemental data-bases, such as MRR exclusion data-bases, prior year MRR databases, utilization or case management data-bases, behavioral healthcare or lab results databases. |  |  |  |  |  |  |
| ***4.3O*** | Data entry from printed abstraction tool. |  |  |  |  |  |  |
| ***4.3P*** | Data entry from faxed abstraction. |  |  |  |  |  |  |
| ***4.3Q*** | Data entry from scanned document. |  |  |  |  |  |  |
| ***4.3R*** | Ensure data accuracy. |  |  |  |  |  |  |
| ***4.3S*** | Ensure data completeness. |  |  |  |  |  |  |
| ***4.3T*** | Monitor project timelines. |  |  |  |  |  |  |
| ***4.3U*** | Determine numerator compliance. |  |  |  |  |  |  |
| ***4.3V*** | Determine application of exclusion criteria. |  |  |  |  |  |  |
| ***4.3W*** | Substituting records (i.e., identifying the next record in the sample). |  |  |  |  |  |  |
| ***4.3X*** | Research records not found. |  |  |  |  |  |  |
| ***4.3Y*** | Sign off on closed incomplete chase  (i.e., record not found). |  |  |  |  |  |  |
| ***4.3Z*** | Ensure data security. |  |  |  |  |  |  |

Medical Record Abstraction Tools

### Table 4.4: *Medical record abstraction tools.*

| Question | | Description |
| --- | --- | --- |
| ***4.4A*** | Describe the type of tools used to abstract and maintain medical record data. |  |
| ***4.4B*** | What features have your organization incorporated into the abstraction tools to ensure accuracy of information collected? |  |
| ***4.4C*** | Who is responsible for updating or modifying tool layouts and fields? |  |
| ***4.4D*** | How do abstractors confirm that abstracted data meets the requirements for a numerator positive “hit” (e.g., hard edit prevents entry of date outside the required date range)? |  |

Medical Record Retrieval

### Table 4.5: *Medical record retrieval process.*

| Question | | Description |
| --- | --- | --- |
| ***4.5A*** | Regarding staff responsible for retrieving medical records: | |
| What are the education and HEDIS-specific experience requirements? |  |
| How are staff trained in the required data elements for retrieval? |  |
| Do staff retrieve only the required data elements or record pages or the entire chart? |  |
| ***4.5B*** | How does your organization request medical records from practitioners? |  |
| ***4.5C*** | How does your organization obtain medical records from practitioners (e.g., fax or mail, site visit, practitioner abstraction)? |  |
| ***4.5D*** | If a record is abstracted in the provider’s office, what portion, of the record is copied, if any? |  |
| ***4.5E*** | What action is taken if: | |
| Providers or medical record retrievers submit incomplete medical records, or no records? |  |
| A numerator event is not identified in the record received from providers or medical record retrievers? |  |
| A provider office refuses access to medical records? |  |
| A provider office uses electronic medical record or printed copies of medical records? |  |
| An auditor requests a copy of a medical record for medical record validation? |  |

Medical Record Abstraction

### Table 4.6: *Medical record abstraction process.*

|  | | Question | Description |
| --- | --- | --- | --- |
| ***4.6A*** | Regarding staff responsible for abstracting data from medical records: | | |
| What is their HEDIS-specific background and experience? | |  |
| How are they trained? | |  |
| ***4.6B*** | Regarding oversight of abstracting data from medical records: | | |
| How is interrater reliability (e.g., comparisons of reviewer abstracted data) ensured? | |  |
| Are over-reads (i.e., re-review of abstracted data) performed on selected records? If yes, what percentage of records is over-read? | |  |
| How are records selected for over-reads? | |  |
| ***4.6C*** | Regarding accuracy standards for medical record reviewers: | | |
| How does your organization define critical versus non-critical abstraction errors? | |  |
| What are the minimum accuracy standards? | |  |
| What action is taken if reviewers fall below standards? | |  |

Data Entry

### Table 4.7: *Medical record data entry processes.*

| Question | | Description |
| --- | --- | --- |
| ***4.7A*** | Regarding staff responsible for data entry of MRR findings: | |
| What is their relevant background and experience? |  |
| How are they trained? |  |
| ***4.7B*** | Are reviews of data entry conducted? If yes: | |
| What percentage of records is reviewed? |  |
| How are records selected for review? |  |
| ***4.7C*** | What are the minimum accuracy standards for data entry staff? |  |
| ***4.7D*** | What action is taken if data entry staff fall below standards? |  |

Vendor-Specific Activities

Complete the following questions if, for the measurement year, vendors or other external entities are responsible for medical record retrieval, scanning, downloading or printing from an electronic medical record (EMR), uploading scanned or retrieved data to a Web portal or other data access source, record abstraction, data entry, data integration or any other aspect of the medical record review process.

### Table 4.8: *Vendor activities.*

|  |  |  |
| --- | --- | --- |
| For Each Vendor | | |
| Question | | Process Description |
| ***4.8A*** | What MRR data are collected by the copy service, and how are the data provided to your organization and integrated for measure HEDIS reporting? |  |
| ***4.8B*** | What process does the copy service use to make data available to either a medical record abstraction vendor or internal organization abstractors? |  |
| ***4.8C*** | How are copy service employees trained? |  |
| ***4.8D*** | How is copy service introduced to the provider sites? |  |
| ***4.8E*** | How does your organization ensure that the copy service meets HEDIS reporting standards and time frames? |  |
| ***4.8F*** | Describe any applicable performance penalties. |  |
| ***4.8G*** | How does your organization ensure accuracy and completeness of data received? |  |
| ***4.8H*** | How does your organization follow-up on incomplete or illegible records? |  |
| ***4.8I*** | What data are collected by the MRR vendor, and how are the data provided to your organization and integrated for HEDIS reporting? |  |
| ***4.8J*** | What process does the MRR vendor use to make data available to your organization and to medical record abstractors? |  |
| ***4.8K*** | How are MRR vendor abstractors trained? |  |
| ***4.8L*** | How are vendor abstractors introduced to the provider sites? |  |
| ***4.8M*** | How are medical records substituted when contraindications or valid data errors are identified? |  |
| ***4.8N*** | What administrative data, if any, are used to populate medical record review tools? |  |
| ***4.8O*** | Describe applicable performance penalties. |  |
| ***4.8P*** | How does your organization ensure accuracy and completeness of data it receives? |  |
| ***4.8Q*** | How does your organization follow up on incomplete or erroneous abstractions? |  |
| ***4.8R*** | Describe the vendor’s data interface with your organization’s HEDIS data warehouse. |  |
| ***4.8S*** | Describe the vendor’s data interface with your organization’s NCQA certified HEDIS software for administrative data, if applicable. |  |

Data Integration

### Table 4.9: *Medical record data integration process.*

| Question | | Process Description |
| --- | --- | --- |
| ***4.9A*** | Are administrative data used to populate medical record review tools? Describe. |  |
| ***4.9B*** | Did your organization discover any deficient areas for the previous measurement year? Describe. |  |
| ***4.9C*** | Did your organization discover any deficient areas for the measurement year? Describe. |  |
| ***4.9D*** | How are medical record review data integrated with administrative data for final rate calculation? |  |
| ***4.9E*** | What data take priority when both medical record and administrative data are present for the same service? |  |

### Table 4.10: *Vendor oversight.*

| Question | | Description |
| --- | --- | --- |
| ***4.10A*** | Describe the overall project management, coordination and monitoring of vendor performance. |  |
| ***4.10B*** | How does your organization conduct interrater reliability testing of the MRR vendor’s abstraction accuracy? |  |
| ***4.10C*** | How does your organization ensure that the MRR vendor meets HEDIS reporting standards and time frames? |  |
| ***4.10D*** | How does your organization verify accuracy of data received from the vendor? |  |

### Table 4.11: *Medical record process changes.*

| Question | | Description |
| --- | --- | --- |
| ***4.11A*** | Were changes made to the MRR processes from last year? If yes, describe. |  |

Requested Documents

Provide the required documents listed below, labeled as instructed in the table.

|  |  |  |
| --- | --- | --- |
| Document | Details | Label |
| **MRR timeline** | A timeline that indicates key dates in the MRR process, including sample generation, training, MRR start or end dates, oversight, administrative data refreshes and so on. | **4.1** |
| **MRR flowchart** | A flowchart that provides an overview of your MRR process, indicating the key steps in the process as well as the flow of MRR data to and from all sources. | **4.2** |
| **MRR tools** | Copies of all MRR tools to be used by reviewers. | **4.3** |
| **MRR training agenda** | A copy of the agenda used to train your MRR staff. | **4.4** |
| **MRR training manual** | A copy of training manual or tool instruction manual. | **4.5** |
| **Quality assurance documentation** | Copies of quality assurance standards, findings and policies used for MRR oversight. | **4.6** |

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 5: Supplemental Data *(IS 5)*

Introduction

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

|  |  |
| --- | --- |
| Organization information | **Organization name:** |
| **Date of completion:** |
| Definitions |  |
| *Standard supplemental electronic files* | Files with 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). * Encounter data from behavioral healthcare vendors. |
| *Nonstandard supplemental electronic data* | Come from sources that follow no standard layout and the formats differ from one source to another:   * Electronic files from HER records. * Electronic files from disease management systems. * Electronic files from case management systems. * Electronic files from measure-exclusion databases. |
| *External supplemental data* | Any automated data supplied by contracted practitioners, vendors or public agencies (e.g., pharmacies, labs, hospitals, schools, state public health agencies). |
| *Internal files* | Nonstandard, automated data files created by the organization, which supplements the claim or encounter data in the measure repository. Data can come from internal systems such as DM programs. |
| Instructions | * Complete a separate Section 5 for each nonstandard supplemental database not already described in Sections 1A–1D. * Where there are differences by product line, product or program, provide a separate response for each product line, product or program subject to audit. |

Supplemental Data Source

### Table 5.1: *Data source used by the organization to supplement transaction system data (claims or encounters) for measure reporting.*

|  |  |  |
| --- | --- | --- |
| General Information | | Description |
| ***5.1A*** | Database name. |  |
| ***5.1B*** | Specific intended measure use. |  |
| ***5.1C*** | Expected measure impact (e.g., expected percentage rate increase). |  |
| ***5.1D*** | Internal use of data. |  |
| ***5.1E*** | Data volume. |  |
| Data Type *(Select One)* | | Description |
| ***5.1F*** | Internal nonstandard. |  |
| External standard. |  |
| External nonstandard. |  |
| Population *(Select One)* | | Description |
| ***5.1G*** | Entire membership. |  |
| Eligible population per measure specifications. |  |
| Noncompliant members in the measure-specific eligible population per specifications. |  |
| Eligible population (other specification (e.g., disease management program population). |  |
| Other (describe). |  |
| Information Source *(Select One)* | | Description |
| ***5.1H*** | Medical record—Practitioner office. |  |
| Medical record—Hospital. |  |
| EHR. |  |
| Disease management registry system or vendor. |  |
| Utilization or case management system or vendor. |  |
| Lab results. |  |
| Vision results. |  |
| Pharmacy vendor data. |  |
| Behavioral healthcare vendor or data source (e.g., county department of mental health). |  |
| Member-reported data in practitioner medical record. |  |
| State, county or other immunization registry. |  |
| Measure-specific exclusion data. |  |
| Other (describe). |  |
|  | Transmission Method *(Select One)* | Description |
| ***5.1I*** | FTP transfer (secure or unsecured). |  |
| Portable media (CD, diskette, tape). |  |
| Fax or mail. |  |
| Other (describe). |  |

### Table 5.1 *(continued)*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Collection Timing *(Select One)* | | | Description | | |
| ***5.1J*** | Ongoing. | | |  | | |
| Measurement year. | | |  | | |
| Prior to reporting year. | | |  | | |
| Other (describe). | | |  | | |
| Data collection start and end dates. | | |  | | |
|  | Collection Method *(Select One)* | | | Description | | |
| ***5.1K*** | Information request letter to provider (include copy with documents). | | |  | | |
| Querying data system. | | |  | | |
| Standard operational data feed. | | |  | | |
| Disease management program. | | |  | | |
| Other (describe). | | |  | | |
| Data Elements Collected *(Check All That Apply)* | | | | | | |
|  |  | Yes | No |  | Yes | No |
| ***5.1L*** | 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 | | |
| ***5.1M*** | ***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). | | |  | | |
| ***5.1N*** | How are data integrated for internal use or measure reporting? | | |  | | |
|  | Internal Validation Method | | | Description | | |
| ***5.1O*** | Primary source verification. | | |  | | |
| ***5.1P*** | Review sample of records. | | |  | | |
| ***5.1Q*** | 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. | **5.1** |
| **Data transformation** | Documentation for all data element mapping. | **5.2** |
| **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. | **5.3** |
| **Data validation** | Copies of data validation studies applicable to supplemental data. | **5.4** |
| **Staff and training (for internal data)** | Provide a list of the staff who maintain the internal supplemental data and their credentials. Provide any training documents used outside of the policies and procedures. | **5.5** |

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 6: Member Call Center *(IS 6)*

Introduction

***Automated call systems or automatic call distribution (ACD) systems used to track incoming member service calls during the measurement year.***

|  |  |
| --- | --- |
| Organization information | **Organization name:** |
| **Date of completion:** |
| Definitions |  |
| *ACD system* | A system used by the designated call center during member service operating hours, to track incoming calls. |
| *Call center vendor* | Any external entity with which the organization contracts to answer member service telephone inquiries about enrollment, benefits or claims processing. |
| *Call* | Telephone contact initiated by an external caller who connects to the organization member services call center. For calls transferred from other organization departments, measure time after the call is transferred to the customer or member services call center. |
| Instructions | * Complete this section for each ACD system that handles member inquiries about enrollment, benefits or claims processing. * Where different systems are used in different locations or for different member groups, provide a separate response for each system subject to audit. * Where there are differences by product lines and products, provide a separate response for each product line and product subject to audit. * All questions relate to the systems used during the measurement year, unless otherwise indicated. * Complete all tables for each system used, adding columns when necessary. |

Automatic Call Distribution System Tables

### Table 6.1: *Systems and products.*

|  |  |  |  |
| --- | --- | --- | --- |
| General Information | | System 1 | System 2 |
| ***6.1A*** | **Call System Name:** |  |  |
| ***6.1B*** | **Product/Product Line:** |  |  |
| ***6.1C*** | Type of calls processed (i.e., member or provider calls). |  |  |
| ***6.1D*** | Differentiate between member and provider inquiries? |  |  |
| ***6.1E*** | Benefits affected (e.g., medical, dental, pharmacy). |  |  |
| ***6.1F*** | Location (city, state). |  |  |
| ***6.1G*** | Year system was implemented. |  |  |
| ***6.1H*** | Organization or vendor operated? |  |  |
| ***6.1I*** | Number of phones. |  |  |
| ***6.1J*** | Variations in installation or system customization. |  |  |
| ***6.1K*** | Measure performance only during business hours? |  |  |
| ***6.1L*** | Capture calls sent to voicemail? |  |  |
| ***6.1M*** | Use call-blocking technology? |  |  |

### Table 6.2: *Data elements captured by systems and products.*

|  |  | System 1 | System 2 |
| --- | --- | --- | --- |
| ***6.2A*** | **Call System Name:** |  |  |
| ***6.2B*** | **Product/Product Line:** |  |  |
| ***6.2C*** | Date of call. |  |  |
| ***6.2D*** | Number of calls received (by organization, if applicable). |  |  |
| ***6.2E*** | Number of calls received by product or product line. |  |  |
| ***6.2F*** | Call waiting time. |  |  |
| ***6.2G*** | Length of wait in seconds (if in increments, list the unit [e.g., 7 seconds]). |  |  |
| ***6.2H*** | Timeliness rate: 30 seconds, 45 seconds, other? |  |  |
| ***6.2I*** | Transfers in. |  |  |

### Table 6.3: *Automatic call distribution system questions.*

|  |  |  |
| --- | --- | --- |
| Question | | Process Description |
| ***6.3A*** | Does the ACD system use automated software to route the call after it is picked up but before a member services representative answers it? If yes, describe. |  |
| ***6.3B*** | At what point does the ACD begin tracking call wait time? For example, does the system begin tracking time when the member elects the option to speak to a Member Services representative, or does the system begin tracking wait time as soon as the phone is answered? |  |
| ***6.3C*** | Does the ACD system accept member services calls internally transferred from another department? Can it separate those calls from the regular incoming member service calls? |  |
| ***6.3D*** | What are the operating hours of live call-center operation indicated by membership materials? |  |
| ***6.3E*** | What happens when a member calls the ACD after normal operating hours? |  |
| ***6.3F*** | What happens when there is a power outage or a period when the ACD system cannot process calls? |  |
| ***6.3G*** | Describe any significant periods during the measurement year when the ACD did not process calls accurately. |  |
| ***6.3H*** | Were changes or upgrades made to the system? Describe. |  |
| ***6.3I*** | How was call rate calculated (metrics)? |  |
| ***6.3J*** | Who calculated this rate? Give background and experience. |  |

Requested Documents

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

|  |  |  |
| --- | --- | --- |
| Document | Details | Label |
| **ACD flowchart** | A graphic workflow to show how calls are handled. Show the flow of a call prior to the system tracking it, once the call enters the call processing system, and how the ACD routes calls (e.g., number of switching modules, system ports, trunks, representatives for each call center). | **6.1** |
| **ACD call volume reports** | Call volume reports for the call processing system for the measurement year. Include total calls received and calls answered within 30 seconds. Specify which calls are included in this report. | **6.2** |
| **Call measurement parameters** | System settings used during the measurement year (reports or screen shots). | **6.3** |
| **Source code for call measure (if applicable)** | Source code, method or ACD reports used to calculate the HEDIS Call Answer Timeliness measure. | **6.4** |

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 7: Data Integration

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 HEDIS or 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. * Complete the appropriate tables in Section 7, depending on whether the source code is: * Produced internally without a software vendor. * Produced using an NCQA Certified software vendor, whether the measure production is run in house or outsourced to the certified software vendor. * Produced using a noncertified vendor, whether the measure production is run  in house or outsourced to the software vendor. * All questions relate to the measurement year systems and processes, unless otherwise indicated. |

Data Integration and Measure Production Responsibility

### Table 7.1: *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 (NCQA certified measures). | |  |  |  |  |
| Source code development (measures outside of software certification). | |  |  |  |  |
| Source code development (CAHPS sample frame). | |  |  |  |  |
| Rate calculation or measure production. | |  |  |  |  |
| Loading data into the IDSS (certified measures). | |  |  |  |  |
| Loading data into the IDSS (measures outside of certification). | |  |  |  |  |
| Measure report project management. | |  |  |  |  |
| Other (indicate): | |  |  |  |  |
| Question | | | Description | | |
| ***7.1A*** | Identify significant changes from the previous year’s measure cycle. | |  | | |
| ***7.1B*** | 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 7.2: *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 |
| ***7.2A*** | Enrollment or membership. |  |  |  |
| ***7.2B*** | Practitioner. |  |  |  |
| ***7.2C*** | Claim or encounter. |  |  |  |
| ***7.2D*** | Behavioral healthcare. |  |  |  |
| ***7.2E*** | Pharmacy. |  |  |  |
| ***7.2F*** | Laboratory claims. |  |  |  |
| ***7.2G*** | Lab results. |  |  |  |
| ***7.2H*** | Vision care. |  |  |  |
| ***7.2I*** | Public registry (e.g., immunization). |  |  |  |
| ***7.2J*** | Other. |  |  |  |
| ***7.2K*** | Administrative database or supplemental data (describe). |  |  |  |

### *Table 7.3: 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 |
| ***7.3A*** | What data were excluded? |  |
| ***7.3B*** | Why were data excluded? |  |
| ***7.3C*** | What percentage of members, practitioners or claims or encounters was affected? |  |

Sampling Methodology and Timing

**Table 7.4: *Sampling process.*** Complete a table for each product or product line if a separate process is used for different products.

| Sampling Methodology and Timing | | Process Description |
| --- | --- | --- |
| ***7.4A*** | Does your organization use an NCQA certified software vendor to produce the samples? |  |
| If yes, are all hybrid measures included in the vendor’s sample creation process? |  |
| If no, what hybrid samples are not generated by the certified software? |  |
| ***7.4B*** | If the systematic sample program logic is produced in house, was the program source code for all hybrid measures auditor-approved prior to drawing the samples? If no, explain. |  |
| ***7.4C*** | Did your organization create samples for any membership-dependent denominator (CIS, IMA, HPV, LSC, CCS, COL, COA, W15, W34, AWC) prior to December 1 of the measurement year? Why? |  |
| ***7.4D*** | Did your organization draw the sample for the membership-dependent denominators on or between December 1 and December 31of the measurement year? If yes, describe how your organization: |  |
| * Oversampled to account for persons who were found to be noncompliant with the denominator after December 31. |  |
| * Verified that members included in the sample remained eligible on or after December 31. |  |
| ***7.4E*** | For measures for which the eligible population is determined through claims data (ABA, WCC, CBP, CMC, CDC, MRP, PPC, FPC, WOP), did your organization draw samples for any measures prior to January of the reporting year? |  |
| ***7.4F*** | Did your organization draw samples for any claim-dependent measures prior to January of the reporting year? If yes, describe the process for identifying and incorporating eligible members from claims received after December 31 of the measurement year. |  |
| ***7.4G*** | Does your organization use an oversample rate of >20% for any measure? If yes, enter the oversample rate and provide evidence of NCQA approval of this oversample rate. |  |
| ***7.4H*** | Does your organization report on MRSS or FSS? |  |
| ***7.4I*** | Does your organization use any other form of sampling (e.g., complex probability sampling or a stratified sample)? If yes, describe the sampling process and provide evidence of NCQA approval of the process. |  |
| ***7.4J*** | Are administrative exclusions removed from the samples (Volume 2, Approach 1 or 2), or from the EP prior to sampling (Volume 2, Approach 3)? |  |

### Table 7.5: *Sampling and data refresh activities for reporting hybrid HEDIS measures.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Measure | | Sampling Method | Date of Original Sample Draw | Can Plan Reproduce Systematic Sample to Select Additional Members for Oversample? | Planned Data Refresh Dates |
| **ABA** Adult BMI Assessment | |  |  |  |  |
| **WCC** Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents | |  |  |  |  |
| **CIS** Childhood Immunization Status | |  |  |  |  |
| **IMA** Immunizations for Adolescents | |  |  |  |  |
| **HPV** Human Papillomavirus Vaccine for Female Adolescents | |  |  |  |  |
| **LSC** Lead Screening in Children | |  |  |  |  |
| **CCS** Cervical Cancer Screening | |  |  |  |  |
| **COL** Colorectal Cancer Screening | |  |  |  |  |
| **COA** Care for Older Adults | |  |  |  |  |
| **CMC** Cholesterol Management for Patients With Cardiovascular Conditions | |  |  |  |  |
| **CBP** Controlling High Blood Pressure | |  |  |  |  |
| **CDC** Comprehensive Diabetes Care | |  |  |  |  |
| **MRP** Medication Reconciliation Post-Discharge | |  |  |  |  |
| **PPC** Prenatal and Postpartum Care | |  |  |  |  |
| **FPC** Frequency of Ongoing Prenatal Care | |  |  |  |  |
| **W15** Well-Child Visits in the First 15 Months of Life | |  |  |  |  |
| **W34** Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life | |  |  |  |  |
| **AWC** Adolescent Well-Care Visits | |  |  |  |  |
| **WOP** Weeks of Pregnancy at Time of Enrollment | |  |  |  |  |
| Question | | Description | | | |
| ***7.5A*** | How were calculations handled with administrative data refresh? |  | | | |

### Table 7.6: *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.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Type of Service** | | **Prior Year (PY)** | **Measurement Year (MY)** | **Prior Year (PY)** | **Measurement Year (MY)** | **Prior Year (PY)** | **Measurement Year (MY)** |
| **Product Line:** | |  | |  | |  | |
| **Product:** | |  | |  | |  | |
| Average per member per year (PMPY) ambulatory services. | |  |  |  |  |  |  |
| Average PMPY inpatient services. | |  |  |  |  |  |  |
| Average PMPY pharmacy. | |  |  |  |  |  |  |
| Average PMPY behavioral healthcare. | |  |  |  |  |  |  |
| Average PMPY laboratory. | |  |  |  |  |  |  |
| Question | | | Description | | | | |
| ***7.6A*** | 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 (Measures Produced Without Certified Software)

### Table 7.7: *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 denominators, numerators and samples.

|  |  |  |  |
| --- | --- | --- | --- |
| Function | | Software Package or Programming Language or Application | Activity or Measures Affected |
| ***7.7A*** | Data integration. |  |  |
| ***7.7B*** | Data warehouse or measure repository. |  |  |
| ***7.7C*** | Source code development for rate calculation. |  |  |

### Table 7.8: *Data integration and file consolidation in the measure repository.*

|  |  |  |
| --- | --- | --- |
| Data Integration | | |
| Question | | Description |
| ***7.8A*** | 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. |  |
| ***7.8B*** | Describe the extract-transform-load (ETL) process for landing measure data in the data warehouse or data repository. |  |
| ***7.8C*** | How does your organization ensure that all data (including any supplemental or MRR data) are transferred and properly formatted? |  |
| ***7.8D*** | Are denied claims or encounters captured for measure reporting if the services were provided? |  |
| ***7.8E*** | Describe any changes made to the data integration process for the measurement year. |  |
| ***7.8F*** | Describe testing activities used to validate changes. |  |
| File Consolidation | | |
| Question | | Description |
| ***7.8G*** | Describe the procedures used to link: |  |
| Claim or encounter (including vendor) data and membership data. |  |
| Claim or encounter (including vendor) data and practitioner data. |  |
| ***7.8H*** | 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 7.9: *Measure production and source code development used to prepare and calculate the measurement year measure report.* Consider all programs used to create denominators, numerators and samples.

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***7.9A*** | What is the background and relevant experience of the staff involved in developing source code for measure production? |  |
| ***7.9B*** | How is their work overseen and monitored? |  |
| ***7.9C*** | What is your organization’s process for producing source code for the measurement year, including development, oversight, review, testing and version control? |  |
| ***7.9D*** | 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, membership, practitioner, vendor) and measure rate production. |  |
| ***7.9E*** | 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? |  |
| ***7.9F*** | How does your organization enter data into the Interactive Data Submission System (IDSS) or final measure reporting format? Do you perform direct data entry or use an import template? |  |
| ***7.9G*** | Regarding how continuous enrollment and member months were 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? |  |
| How does member months logic determine member age, sex and enrollment determination date (e.g., the first day, last day, 15th day of the month)? |  |
| Describe any system or data limitation that precludes full implementation of continuous enrollment or member months requirements as specified. |  |
| ***7.9H*** | Regarding calculation of hybrid measures for the measurement year: | |
| How are hybrid samples generated? |  |
| If applicable, how are sample sizes reduced using the prior year’s hybrid rate or this year’s administrative rates? |  |
| How are data obtained through medical record review integrated back into the administrative data for measure calculation? |  |
| Describe any system or data limitation that precludes full implementation of sampling requirements as specified. |  |
| ***7.9I*** | What tests and checks are performed to validate the accuracy and completeness of: | |
| Measure-specific rates? |  |
| Measure-specific denominators (i.e., eligible member population)? |  |
| Member month-calculations? |  |

Data Integration and Report Production (Measures Produced Using Certified Software)

### Table 7.10: *Software packages, programming languages and mainframe or pc-based application programs your organization or vendor uses to prepare and calculate the measurement year report.* Consider all programs used to create denominators, numerators and samples.

|  |  |  |  |
| --- | --- | --- | --- |
| Function | | Software Package or Programming Language or Application | Activity or Measures Affected |
| ***7.10A*** | Data integration. |  |  |
| ***7.10B*** | Data warehouse or measure repository. |  |  |
| ***7.10C*** | Source code development for measure rate calculation. |  |  |

### Table 7.11: *Information about data integration and consolidation into the measure repository.*

|  |  |  |
| --- | --- | --- |
| Data Integration | | |
| Question | | Description |
| ***7.11A*** | Are data from your organization transferred to the vendor’s systems? If yes, provide an overview of the process. Describe how the data are mapped from your file formats to the vendor’s file formats. |  |
| ***7.11B*** | How does your organization ensure that all data (including MRR data) are transferred and properly formatted? |  |
| ***7.11C*** | Are denied claims or encounters captured for measure reporting if the services were provided? |  |
| ***7.11D*** | Did your organization make to the data integration process for the measurement year? Describe. |  |
| ***7.11E*** | What testing activities were used to validate the changes? |  |
| ***7.11F*** | How does the vendor link: | |
| Claim or encounter (including vendor) data and membership data? |  |
| Claim or encounter (including vendor) data and practitioner data? |  |
| ***7.11G*** | Regarding ensuring the accuracy of data integrated for measure 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 from your organization? |  |
| How do your organization and your vendor 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 do the codes translate to standard codes for measure reporting? Attach a copy of the code mapping scheme and translation procedures. |  |

### Table 7.12: *Measure production used to prepare and calculate the measurement year report.* Consider all programs used to create denominators, numerators and samples.

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***7.12A*** | If your organization uses certified software but produce the measures in house, how does it ensure that it is using the latest versions or patches of the vendor’s software? |  |
| ***7.12B*** | How does your organization integrate vendor-supplied information with organization-supplied information (e.g., board certification, call answer timeliness, call abandonment) for the final data submission? |  |
| ***7.12C*** | What is the process for entering data into the IDSS or final measure reporting format? Do you perform direct data entry or use an import template? |  |
| ***7.12D*** | Regarding calculation of hybrid measures for the measurement year: | |
| * How are hybrid samples generated? |  |
| * If applicable, how are sample sizes reduced using the prior year’s hybrid rate or this year’s administrative rates? |  |
| * How are data obtained through medical record review integrated back into the administrative data for measure calculation? |  |
| * Describe any system or data limitation that precludes full implementation of measure sampling requirements as specified. |  |
| ***7.12E*** | What tests and checks are performed to validate the accuracy and completeness of: | |
| * Measure-specific rates? |  |
| * Measure-specific denominators (i.e., eligible member population)? |  |
| * Member-month calculations? |  |

System Security or Back-Ups

### Table 7.13: *Claim or encounter, membership and practitioner data processing systems.*

|  |  |  |
| --- | --- | --- |
|  | Question | Description |
| ***7.13A*** | How does your organization back up its data or systems? |  |
| ***7.13B*** | How is data-access authorization assigned? |  |
| ***7.13C*** | What type of physical security is in place, including fire protection and UPS? |  |
| ***7.13D*** | 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. |  |
| ***7.13E*** | 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. |  |
| ***7.13F*** | Did your organization experience data loss during the measurement year? If yes, explain and describe how data integrity and completeness were validated. |  |

### Table 7.14: *Internal measure repository, data warehouse or vendor measure repository data processing systems.*

|  |  |  |
| --- | --- | --- |
| Question | | Description |
| ***7.14A*** | How are data or systems backed up? |  |
| ***7.14B*** | How is data-access authorization assigned? |  |
| ***7.14C*** | What type of physical security is in place, including fire protection and UPS? |  |
| ***7.14D*** | 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. |  |
| ***7.14E*** | 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. |  |
| ***7.14F*** | 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. | **7.1** |
| **Measure repository file structure (if applicable)** | A complete file structure, file format and field definitions for your measure repository. | **7.2** |
| **Vendor mapping documents (if using NCQA certified software)** | A mapping document of the organization’s data elements to the NCQA Certified Software’s file structure. | **7.3** |
| **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. | **7.4** |
| **Source code development assignments (if non-certified source code is used)** | A list of measures and the programmer assigned to its source code development. | **7.5** |
| **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. | **7.6** |

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 |  |  |
|  |  |  |