

**Appendix 2**  
**PO IS Standards Compliance Tool**



## APPENDIX 2

### PO IS STANDARDS COMPLIANCE TOOL

*(To be completed by the auditor)*

#### IS Standards Compliance Tool Instructions

This tool is used by Certified HEDIS Compliance Auditors to determine PO compliance with IS standards and if there is an impact on P4P reporting. A completed copy of this tool must appear in the auditor’s work papers. The last column indicates the IS system’s designation:

**S** = Significant impact on P4P reporting    **M** = Minimal impact on P4P reporting    **N** = No impact on P4P reporting

#### IS Standards’ Audit Team Participants

Standard	Audit Activities			P4P Impact		
	Pre-Onsite Review and Results	Onsite Review and Results	Post-Onsite Review and Results	S	M	N
<b>IS 1.0 Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry</b>						
IS 1.1	Industry standard codes (e.g., ICD-9-CM, CPT, DRG, HCPCS) are used and all characters are captured.					
IS 1.2	Principal codes are identified and secondary codes are captured.					
IS 1.3	Nonstandard coding schemes are fully documented and mapped back to industry standard codes.					
IS 1.4	Standard submission forms are used and capture all fields relevant to P4P reporting. All proprietary forms capture equivalent data. Electronic transmission procedures conform to industry standards.					
IS 1.5	Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files for P4P reporting.					

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Standard	Audit Activities			P4P Impact		
	Pre-Onsite Review and Results	Onsite Review and Results	Post-Onsite Review and Results	S	M	N
<b>IS 1.0 Medical Services Data—Sound Coding Methods and Data Capture, Transfer and Entry</b>						
IS 1.6	The PO continually assesses data completeness and takes steps to improve performance.					
IS 1.7	The PO regularly monitors vendor performance against expected performance standards.					
<b>IS 2.0 Enrollment Data—Data Capture, Transfer and Entry</b>						
IS 2.1	The PO has procedures for submitting P4P-relevant information for data entry. Electronic transmissions of membership data have necessary procedures to ensure accuracy.					
IS 2.2	Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files.					
IS 2.3	The PO continually assesses data completeness and takes steps to improve performance.					
IS 2.4	The PO regularly monitors vendor performance against expected performance standards.					
<b>IS 3.0 Practitioner Data—Data Capture, Transfer and Entry</b>						
IS 3.1	Provider specialties are fully documented and mapped to P4P provider specialties.					
IS 3.2	The organization has effective procedures for submitting P4P-relevant information for data entry. Electronic transmissions of practitioner data are checked to ensure accuracy.					
IS 3.3	Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.					
IS 3.4	The organization continually assesses data completeness and takes steps to improve performance.					
IS 3.5	The organization regularly monitors vendor performance against expected performance standards.					

Standard	Audit Activities			P4P Impact		
	Pre-Onsite Review and Results	Onsite Review and Results	Post-Onsite Review & Results	S	M	N
<b>IS 4.0 Supplemental Data—Capture, Transfer and Entry</b>						
IS 4.1	Nonstandard coding schemes are fully documented and mapped to industry standard codes.					
IS 4.2	The PO has effective procedures for submitting P4P-relevant information for data entry. Electronic transmissions of data have checking procedures to ensure accuracy.					
IS 4.3	Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.					
IS 4.4	The PO continually assesses data completeness and takes steps to improve performance.					
IS 4.5	The PO regularly monitors vendor performance against expected performance standards.					
<b>IS 5.0 Data Integration—Accurate P4P Reporting, Control Procedures That Support P4P Reporting Integrity</b>						
IS 5.1	Nonstandard coding schemes are fully documented and mapped to industry standard codes.					
IS 5.2	Data transfers to P4P repository from transaction files are accurate.					
IS 5.3	File consolidations, extracts and derivations are accurate.					
IS 5.4	Repository structure and formatting are suitable for P4P measures and enable required programming efforts.					
IS 5.5	Report production is managed effectively and operators perform appropriately.					
IS 5.6	P4P reporting software is managed properly with regard to development, methodology, documentation, revision control and testing.					
IS 5.7	Physical control procedures ensure P4P data integrity such as physical security, data access authorization, disaster recovery facilities and fire protection.					



# **Appendix 3**

## **Glossary**



## APPENDIX 3

### GLOSSARY

<b>accuracy</b>	The extent to which recorded data (on forms and computer databases) are error-free and reflect the defining events. Error sources are miscoding, misrepresenting facts, maintaining out-of-date findings, recording data for the wrong person, data entry errors and computer programming errors.
<b>administrative database</b>	Any automated data, including claims and encounter systems used by the PO or health plan to manage the delivery of health services to members.
<b>administrative methodology</b>	Requires the PO and health plan to identify a measure denominator and numerator using transaction data or other administrative databases.
<b>anchor date</b>	A date on which the member must be enrolled with the PO. No gaps in enrollment may include this date.
<b>audit result</b>	Defines the suitability of measures for reporting. These results include <i>Report</i> and <i>Not Report</i> .
<b>attestation</b>	A statement ensuring the validity of a report or document (e.g., data submission file attestation, Roadmap attestation).
<b>bias (degree of bias)</b>	Degree of error. P4P rate measures are reported using a 95 percent confidence interval. A greater than 5 percent error in the reported rate is considered materially biased and receives a <i>Not Report</i> .
<b>bundling</b>	When the PO accepts a single code as representative of several services or encounters. For example, prenatal care visits are bundled with delivery, or all hospital services may be under the revenue code for room and board.
<b>carve out</b>	An arrangement under which services (e.g., mental health or laboratory) are contracted to a third party by the PO, health plan or employer.
<b>claims audit/error rate</b>	A rate that indicates the reliability of a claims processing system. Most POs review a sample of claims after they are processed to compute an error rate, usually expressed as financial and nonfinancial.
<b>claims dependent denominator</b>	To determine the eligible population through claims data (e.g., diabetic members are identified by claims showing diagnoses for diabetes or dispensing of insulin).
<b>comprehensive data</b>	Complete records of patient care. Information about a member's every encounter with the health care system.
<b>concurrent audit</b>	Evaluation of methods and data during the data collection period. P4P Audit Reviews take place during data collection, allowing POs to correct errors before data are reported.
<b>continuous enrollment</b>	The minimum amount of time, including allowed gaps, that a member must be enrolled in the PO and/or health plan to be eligible for the measure.
<b>corrective action</b>	An activity the PO or plan completes between the onsite visit and data submission to correct problems that may result in a <i>Not Report</i> .
<b>database</b>	Data collected and organized in a computer file for ease of expansion, updating and retrieval.

<b>data completeness</b>	Determination or evaluation of missing data. Data-completeness issues must be quantified, and <i>Not Report</i> must be supported by determination of material bias.
<b>data completeness assessment</b>	An assessment of the impact of claims lag, encounter data submission rates and studies on PO and/or health plan data completeness.
<b>data consolidation</b>	A combination of data from multiple sources, such as multiple electronic sources or electronic and medical record sources.
<b>data extraction</b>	Collecting data from medical records or pulling data from electronic and automated systems.
<b>data integration</b>	A combining of data from multiple sources, with additional steps that ensure that duplicate data are removed and that the data is refined.
<b>data integrity</b>	Data that are unimpaired and not altered or destroyed, accidentally or intentionally.
<b>data reliability</b>	A measure of data consistency based on reproducibility and an estimation of measurement error.
<b>delegate</b>	A formal process by which the PO or health plan gives another entity the authority to perform certain functions on its behalf, such as provision of mental health care or laboratory services.
<b>deviation</b>	Any process that does not strictly comply with P4P standards as published by NCQA. All deviations must be documented in writing to NCQA before an audit.
<b>DMHC</b>	Department of Managed Health Care; the licensing body for managed care in California that oversees all full and partial Knox Keene licensed health care organizations.
<b>EDI</b>	Electronic data interface. Standard electronic formats used for collecting data that are imported into or exported from various systems.
<b>FAQ</b>	Frequently asked questions posted to the NCQA Web site on the 15th of each month.
<b>P4P repository</b>	A database or file system that stores all the P4P information, including claims and membership and which may be updated during the data collection period.
<b>health plan</b>	An organized health care system that is accountable for both the financing and delivery of a broad range of comprehensive health services to an enrolled population.
<b>homegrown code</b>	A diagnosis or procedure code not recognized nationally but used by the PO or health plan. Commonly found in mental health and preventive care. Some POs and health plans continue to accept obsolete codes as homegrown codes after they are deleted from coding books.
<b>HMO</b>	Health maintenance organization. See health plan.
<b>inclusiveness</b>	The extent to which an entire population or defined group is intentionally included in a database.

<b>industry standard code</b>	A code used by the majority of health care facilities and providers. P4P measures use these codes in the specifications (CPT, ICD-9-CM, DRG, CMS1500 Place of Service codes, UB-92 Type of Bill, Revenue codes).
<b>internally built database</b>	A PO-created database containing claims or medical record information. These databases are often designed for other purposes and, if used for measure collection, are subject to audit. Examples include case management databases, utilization management databases or databases populated with medical record information.
<b>map</b>	A document showing how the PO or health plan cross-references homegrown codes to codes specified by HEDIS. The map must be complete and accurate.
<b>MCO</b>	Managed care organization. See definition of health plan above.
<b>measurement year</b>	The year that the health plan is evaluating through P4P measures, often referred to as the <b>data year</b> . The measurement year is also the year prior to the P4P reporting year; for example, P4P reporting year 2009 is based on measurement year 2006.
<b>member</b>	An individual (and eligible dependents) who participates in a health plan and who with other participants compose a health plan's enrolled population. Members usually receive specified health care services from a defined network for a specified time period. For POs this refers to members who are assigned to a provider contracting with or working for the PO for a specified period of time.
<b>nonstandard code</b>	A code not used or recognized by the majority of practitioners and facilities (see <b>industry standard code</b> and <b>homegrown code</b> ). These plan-specific codes must be mapped to industry codes for inclusion in HEDIS.
<b>PHI</b>	Protected health information. Information that can identify a specific person. Person-identified information is associated with names, social security numbers, alphanumeric codes or other unique individual information.
<b>PO</b>	Physician organization. Independent Practice Associations (IPA) or medical groups that contract with individual doctors to provide health care services. POs accept risk and manage the business of contracting and compliance with health plans on behalf of the PO's individual providers.
<b>POS</b>	Point of service. A HMO with an opt-out option that is accountable for financing and delivering a broad range of comprehensive health services to an enrolled population.
<b>positive numerator event</b>	Evidence of one measure-required service/event/diagnosis.
<b>positive numerator hit</b>	A member who satisfies the numerator requirements of a measure and who may be counted in the numerator. Some measures have multiple numerator requirements; for example, in the Childhood Immunization Status measure, the DTP/DTaP numerator requires four separate immunizations for a member to be a positive numerator hit.
<b>practitioner</b>	A professional who provides health care services. Practitioners are usually required to be licensed as defined by law.

<b>product</b>	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, PPO).
<b>product line</b>	Commercial, Medicaid, Medicare.
<b>provider</b>	<p>An institution or organization that provides medical services to patients. Examples of providers include hospitals and home health agencies.</p> <p>NCQA uses the term <b>practitioner</b> to refer to professionals who provide health care services; however, it recognizes that a <b>provider directory</b> generally includes both providers and practitioners, and that the inclusive definition is the more common usage of <i>provider</i>.</p>
<b>reporting year</b>	The year in which HEDIS/P4P is reported and for which the volume is named. The year immediately following the measurement year.
<b>required benefit</b>	P4P measures evaluate performance and hold plans accountable for services provided in their members' benefits package. Measure specifications include benefits or coverage categories (e.g., medical, pharmacy, mental health) that are required during the continuous enrollment period.
<b>supplemental database</b>	Automated data supplied by contracted practitioners, vendors or public agencies (e.g. immunization registries, schools or state public health agencies).
<b>validity</b>	The extent to which data corresponds to an actual state or an instrument that measures what it purports to measure.