

## **Appendix 1**

# **Roadmap for Self-Reporting POs Measurement Year 2011**

Released November 2011

# APPENDIX 1

## PHYSICIAN ORGANIZATION ROADMAP

### Introduction

Welcome to NCQA's Roadmap (*Record of Administration, Data Management and Processes*) for physician organizations (PO). The Roadmap collects information about how your organization's information management practices affect P4P clinical measure reporting; it is not meant to evaluate the effectiveness of your organization's information systems.

### Changes to the Roadmap

- There were no changes to the PO Roadmap.

### Completing the PO Roadmap

Completing the Roadmap is a required component of the P4P Audit Review 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 each question accurately and completely. An electronic copy of the Roadmap is available on the IHA Web site at <http://iha.org/> and provides additional guidance for plans using certified software. Keep the following in mind.

- Each organization that participates in the HEDIS audit process must complete or update a Roadmap. The organization must complete a new Roadmap—or update a previous one—every year.
- The auditor may not prepare the Roadmap for the organization.
- When a single organization reports for multiple product lines (e.g., commercial, Medicare), it may complete one Roadmap, but it must provide separate responses for each product line, when necessary.
- Provide answers for only the populations 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 PO Roadmap
General Information	<i>Complete or update:</i> <ul style="list-style-type: none"> <li>One for the organization</li> </ul>
1. Medical Services	<i>Complete or update:</i> <ul style="list-style-type: none"> <li>One for the organization</li> <li>One for each Medical Services vendor</li> </ul>
1A-B. Ancillary Services	<i>Complete or update:</i> <ul style="list-style-type: none"> <li>One for each Ancillary Services vendor</li> </ul>
2. Enrollment	<i>Complete or update:</i> <ul style="list-style-type: none"> <li>One for the organization</li> <li>One for each Enrollment vendor</li> </ul>
3. Practitioner Data Processing	<i>Complete or update:</i> <ul style="list-style-type: none"> <li>One for the organization</li> <li>One for each Practitioner vendor</li> </ul>
4. Supplemental Data	<i>Complete or update:</i> <ul style="list-style-type: none"> <li>One for each supplemental database</li> </ul>
5. Data Integration	<i>Complete or update:</i> <ul style="list-style-type: none"> <li>One for the organization</li> <li>One for each software vendor</li> </ul>

If your organization’s data systems, processes or P4P production are centralized and serve several organizations, you may need to submit only 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 Audit standards. You are encouraged to refer to the relevant standards as you prepare the Roadmap.

### Requested Documents

At the end of each section, the Requested Documents table lists workflow diagrams, reports and other documents that should be attached. 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 that 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 a more efficient onsite visit 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 are subject to review and that they provide responses for *only* those product lines.
- Distribute a copy of the instructions to all persons involved in completing the Roadmap.
- Refer to definitions in the glossary in the back of this manual (*P4P Audit Manual, Appendix 3*).
- Provide electronic copies of completed Roadmap sections and attachments wherever 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 under review.
- Label all attachments accurately and add additional attachments to the applicable Requested Documents table.

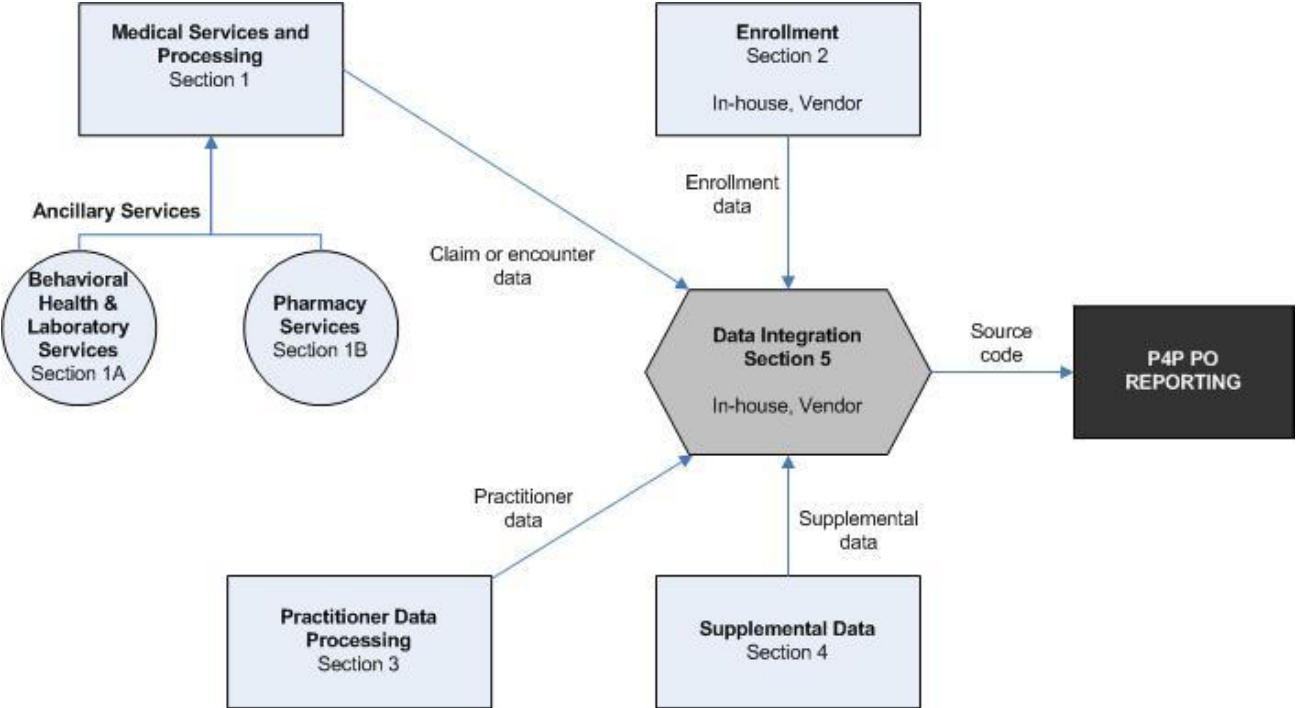
Auditors hold the Roadmap and attached documents in strict confidence; however, NCQA uses the Roadmap and attached documents to assess auditor performance.

## PO Roadmap Data Workflow

The Roadmap was changed to help organizations of all types give auditors information about data they use for P4P measure reporting—where the data come from and how data are organized. It also helps you send the right set of questions to the right people.

Below is a visual representation of the data sources and variations possible for organizations completing the Roadmap.

**PO Roadmap Data Workflow Diagram**



## General Information

### Introduction

#### *About your organization.*

**Definitions**      The **organization** is the entity reporting the audited measures.

- Instructions**
- Where there are differences by product line, provide a separate response for each product line subject to audit.
  - Complete applicable tables for each product line, adding or removing columns when necessary.

**Table GI.1: *About your organization.***

Organization name:	
<b>GI.1A</b>	Year of incorporation.
<b>GI.1B</b>	Did your organization acquire or merge with another organization during the measurement year? If so, explain.
<b>GI.1C</b>	What quality improvement activities that affected P4P rates were in place during the measurement year?

**Table GI.2: *Contact information.***

	Primary Audit Contact	Secondary Audit Contact
Name	_____	_____
Title	_____	_____
Company	_____	_____
Address	_____	_____
City, state, zip	_____	_____
Telephone	_____	_____
Fax	_____	_____
E-mail address	_____	_____

**Table GI.3: Product lines or products undergoing an audit for the measurement year.** Complete a separate column for each reporting entity.

		Commercial	Medicare
<b>GI.3A</b>	PO Name:		
<b>GI.3B</b>	Product (HMO, POS, other):		
<b>GI.3C</b>	Month and year of first enrollment.		
<b>GI.3D</b>	Membership on 12/31/ prior year.		
<b>GI.3E</b>	Membership on 12/31/ measurement year.		
<b>GI.3F</b>	Percentage of members with...		
	• Behavioral health benefits		
	• Pharmacy benefits		
<b>GI.3G</b>	Year of first P4P audit review.		
<b>GI.3H</b>	Prior year's IDs assigned by DMHC, NCQA, and DDD		
	• DMHC ID (5 digit organizational code supplied by NCQA)		
	• DMHC Sub ID (2 digit code supplied by NCQA)		
	• Dataset Unique ID (4 digit code assigned by DDD)		

**Table GI.4: Measurement Year P4P Clinical Report.** Indicate one of the following for each measure for the product line/product under review.

- A** Measure reported using administrative (i.e., claims and encounter) data.
- NB** The members' health plan did not offer the health benefit required by the measure (e.g., pharmacy) or, for Medicare measures, did not have a Medicare population.
- NR** The reporting entity did not report the measure.
- C** Measure reported on Commercial population.
- M** Measure reported on Medicare population.

Clinical Domain					
Measure		A, NB, NR	Commercial	Medicare	If Not Reporting, Explain
<b>Encounter Rate Threshold for Clinical Measures</b>					
ENRST	Encounter Rate by Service Type <sup>N</sup>				
<b>Cardiovascular</b>					
MPM	Annual Monitoring for Patients on Persistent Medications <sup>D</sup>				
CMC	Cholesterol Management for Patients With Cardiovascular Conditions				
	• LDL Screening <sup>M</sup>				
	• LDL Control				

Clinical Domain					
Measure		A, NB, NR	Commercial	Medicare	If Not Reporting, Explain
<b>Diabetes Care</b>					
CDC	Diabetes Care				
	• HbA1c Testing				
	• HbA1c Poor Control (<9%) <sup>M</sup>				
	• HbA1c Control (<8%)				
	• HbA1c Control (<7% for a Selected Population)				
	• LDL Screening <sup>M</sup>				
	• LDL Control (<100) <sup>M</sup>				
	• Nephropathy Monitoring <sup>M</sup>				
	• Blood Pressure Control (<140/90)				
	• Optimal Diabetes Care <sup>N</sup>				
<b>Musculoskeletal</b>					
LBP	Use of Imaging Studies for Low Back Pain				
<b>Preventive Care</b>					
CIS	Childhood Immunization Status—24-Month Continuous Enrollment <sup>D</sup>				
IMA	Immunization for Adolescents				
CHL	Chlamydia Screening in Women				
ECS	Evidence-Based Cervical Cancer Screening of Average-Risk, Asymptomatic Women <sup>N</sup>				
BCS	Breast Cancer Screening <sup>D,M</sup>				
COL	Colorectal Cancer Screening <sup>M</sup>				
<b>Respiratory</b>					
AMR	Asthma Medication Ratio <sup>N</sup>				
CWP	Appropriate Testing for Children With Pharyngitis				
URI	Appropriate Treatment for Children With Upper Respiratory Infection				
AAB	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis				

<sup>D</sup>There is a difference between what is reported for P4P MY 2011 and what is reported by health plans for HEDIS.

<sup>N</sup>Measures reported for P4P MY 2011 are not HEDIS measures.

<sup>M</sup>MY 2011 measures that are collected and publicly reported for Medicare Advantage by self-reporting POs.

**Requested Documentation**

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 P4P audit reports	If you are using a new audit firm for the measurement year, attach the final report from the previous year’s P4P audit review.	GI.1

**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 Roadmap is accurate and complete, to the best of my knowledge.

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Signature

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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.*

<b>Organization information</b>	<b>Organization name:</b>
	<b>Completion date:</b>

### Definitions

<b>Claim</b>	A submission for reimbursement (e.g., from fee-for-service providers).
<b>Encounter</b>	A submission that is not linked to payment (e.g., from capitated providers).
<b>Claim or encounter processing vendor</b>	Includes any external entity with which the organization has contracted to perform the following tasks. <ul style="list-style-type: none"> <li>• Provide a particular type of medical service.</li> <li>• Perform claim or encounter data processing functions.</li> </ul>
<b>Vendor</b>	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).
<b>Significant change</b>	A change of (+/–)10% in claim or encounter volume. The change can be a result of upgrades or consolidations.

### Instructions

- Complete a separate Section 1 for each claim or encounter data processing system. Include all ancillary services produced in-house.
- If vendors are used to collect ancillary services:
  - Complete **Section 1.A** for behavioral health or laboratory data.
  - Complete **Section 1.B** for pharmacy data.
- Where there are differences by product line provide a separate response for each product line 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 claims or encounters submitted:			
• On paper			
• Electronically			

**Claim or Encounter Policy Questions**

1.1A	Q. Regarding claim or encounter policies in place during the measurement year, what was the time limit for practitioner submissions? A.
1.1B	Q. How did your organization handle claims submitted past the deadline? A.
1.1C	Q. Are denied claims or encounters captured for reporting if the services were provided? 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 your own grouper?	
1.2F Which grouper does your organization use? Does the grouper retain codes for reporting?	
1.2G Does your organization ensure the accurate assignment of DRGs?	

## Coding Schemes

**Table 1.3: Coding schemes.** Consider all nonstandard coding methods, including state-specific codes (e.g., DRGs), internally-developed codes and case and per diem rates. Indicate which coding schemes are captured by the organization.

Coding Scheme	Type of Service			
	Inpatient Diagnosis	Inpatient Procedure	Ambulatory Diagnosis	Ambulatory Procedure
<b>1.3A</b> Standard codes ICD-9, CPT, Revenue, MS or CMS DRG, HCPCS, CPT II, Standard Units).				
<b>1.3B</b> Nonstandard codes:				
• State-specific (e.g., 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 column in the table.

Question	Description
<b>1.4A</b> Type of coding scheme.	
<b>1.4B</b> What percentage of claims or encounters was affected?	
<b>1.4C</b> For which services were codes or rates used?	
<b>1.4D</b> Were the codes or rates received on claim or encounter forms from providers, or generated by the claim or encounter system or processors?	
<b>1.4E</b> How were the codes or rates processed in the claim or encounter data system?	
<b>1.4F</b> 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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**Non-Standard Data Submission Forms**

**Table 1.6: Nonstandard, state-specific or encounter forms (i.e., other than UB-92, UB-04 or CMS 1500) used during the measurement year.**

Question	Product Line A	Product Line B	Product Line C
<b>1.6A</b> Type of form.			
<b>1.6B</b> What percentage of claims or encounters were affected.			
<b>1.6C</b> 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, but not all claims or encounters.
- N Not Required:** The claim or encounter system does not requires 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	Explanation
Member ID number				
Rendering provider ID				
<b>Claim Information</b>				
Claim number				
First date of service				
Last date of service				
Discharge status				
Payment status				
<b>Codes</b>				
Primary Diagnosis				
Secondary Diagnosis				
Primary Procedure				
Secondary Procedure				
Procedure Modifiers				
Units of Service				
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.**

System Edit Checks		Description
<b>1.8A</b>	Checks for valid Procedure and Diagnosis codes (e.g., obsolete codes, required number of digits).	
<b>1.8B</b>	Checks for valid member.	
<b>1.8C</b>	Checks for valid coding (e.g., recalculates the DRG or procedure valid for the members gender).	
<b>1.8D</b>	Checks on field size.	
<b>1.8E</b>	Checks on date ranges (e.g., "to date" is after "from date"; no future dates).	
<b>1.8F</b>	Checks for valid practitioner.	

### 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
<b>1.9A</b> Describe the change, upgrade or consolidation.	
<b>1.9B</b> Which claim or encounter data systems and product lines or products were affected?	
<b>1.9C</b> Project start and end dates?	
<b>1.9D</b> Regarding data conversion:	
<ul style="list-style-type: none"> <li>• 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)?</li> </ul>	
<ul style="list-style-type: none"> <li>• What claims or encounters were not converted to the new system?</li> </ul>	
<ul style="list-style-type: none"> <li>• What data elements were converted to the new system?</li> </ul>	
<ul style="list-style-type: none"> <li>• What elements were not converted to the new system?</li> </ul>	
<b>1.9E</b> How were data mapped for conversion from the previous system to the new claim or encounter system?	
<b>1.9F</b> Did a parallel system run during the conversion?	
<b>1.9G</b> 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?	
1.10B	Describe any scanning or data-entry vendors involved in the process	
1.10C	Are encounters (i.e., submissions that are not linked to payment) processed differently from claims (i.e., submissions for payment)?	
1.10D	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)?	
1.10E	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?	
1.10F	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?	
1.10G	Under what circumstances can processors change claim or encounter information submitted by a provider?	
1.10H	Describe any system-generated codes, are they standard codes used in HEDIS or non-standard?	
1.10I	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
<b>1.12A</b> What were the time-to-process standards for claim or encounter data?	
<b>1.12B</b> What was the actual average time to process for claim or encounter data?	
<b>1.12C</b> 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
<b>1.13A</b> Were there audits of claim or encounter data processing?	
<b>1.13B</b> What was audited, and how often?	
<b>1.13C</b> What were the findings for the measurement year?	
<b>1.13D</b> 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
<b>1.14A</b> Name of external contracted service provider	
<b>1.14B</b> Products or product lines affected	
<b>1.14C</b> Contract start or end date.	
<b>1.14D</b> Types of services provided (e.g., behavioral health, ambulatory, pharmacy, lab, radiology, vision, inpatient)	
<b>1.14E</b> Percentage of members with the benefit directed to this service provider?	
<b>1.14F</b> Type and frequency of data submission to the organization (e.g., monthly data file)?	
<b>1.14G</b> Does the organization have service agreements in place requiring data submission? (Y/N)	
<b>1.14H</b> Were contracted services subject to oversight policies, processing standards or other requirements?	
<b>1.14I</b> Describe oversight and monitoring activities during the measurement year, including type and frequency of reviews and audits.	

**Claim and Encounter Data Question**

**Q.** What barriers are there to obtaining complete and accurate claim or encounter data? Consider all factors that influence your ability to collect such information from practitioners, including, but not limited to, system constraints or incompatibilities, lack of reporting requirements, payment arrangements (e.g., capitation), data integration issues.

**A.**

**Improvement of Data Completeness**

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

Question		Description
<b>1.15A</b>	Did your organization take steps to improve completeness of claim or encounter data?	
<b>1.15B</b>	Were all practitioners, provider groups, facilities and vendors required by contract to submit complete and accurate claim or encounter data?	
<b>1.15C</b>	Were performance standards in place to ensure submission of claim or encounter data by practitioners, provider groups, facilities and vendors?	
<b>1.15D</b>	Was compensation tied to submission of claim or encounter data by practitioners, provider groups, facilities and vendors?	
<b>1.15E</b>	Were other incentive or penalty arrangements in place for submission of complete and accurate data by practitioners, provider groups, facilities and vendors?	
<b>1.15F</b>	Were other activities undertaken to encourage claim or encounter data submission by practitioners, provider groups, facilities and vendors?	
<b>1.15G</b>	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 Documentation**

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

Document	Details	Label
<b>Claim or encounter data system flowchart</b>	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.	<b>1.1</b>
<b>Proprietary forms (if applicable)</b>	If proprietary claim or encounter forms were used during the measurement year, attach clean, blank copies of each.	<b>1.2</b>
<b>Explanation of nonstandard codes (if applicable)</b>	If nonstandard codes were used during the measurement year, attach descriptions of internally developed codes, code definitions, translation procedures and code mapping schemes.	<b>1.3</b>
<b>Claim lag, IBNR or completion factor reports</b>	Provide 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 reporting.	<b>1.4</b>
<b>Data completeness studies or analyses</b>	If applicable, attach copies of additional studies or analyses conducted on data completeness or under-reporting.	<b>1.5</b>

**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 Health Services and Processing (IS 1)

### Introduction

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

Vendor information	Vendor name:
	Reporting for:
	Completion date:

### Definitions

**Claim** A submission for reimbursement (e.g., from fee-for-service providers).

**Encounter** A submission that is not linked to payment (e.g., from capitated providers).

**Claim or encounter processing vendor** Includes any external entity with which the organization has contracted to perform the following tasks.

- Provide a particular type of medical service.
- Perform claim or encounter data processing functions.

**Significant change** A change of (+/–)10% in volume of data processed, or a conversion, consolidation or upgrade to the data processing system.

**Instructions**

- Vendors complete Section 1A if they process claims or encounter data for reimbursement for the health plan. 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
<b>1A.1A</b> Name of claim or encounter system.			
<b>1A.1B</b> Are claims processed or are encounters processed, or are both processed?			
<b>1A.1C</b> How often are data transmitted to the health plan?			
<b>1A.1D</b> Location (city, state).			
<b>1A.1E</b> Percentage of claims or encounters processed:			
• On paper			
• Electronically			

## Claim or Encounter System and Policy Questions

<b>1A.1-1</b>	<b>Q.</b> 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? <b>A.</b>
<b>1C.1-2</b>	<b>Q.</b> Does the vendor use the plan's member identifier for claims processing? If not, how are claims mapped? <b>A.</b>
<b>1A.1-3</b>	<b>Q.</b> How did you handle a claim or encounter submitted past the deadline? <b>A.</b>
<b>1A.1-4</b>	<b>Q.</b> 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. <b>A.</b>
<b>1A.1-5</b>	<b>Q.</b> How does your organization identify qualifying practitioners? <b>A.</b>

## Coding Software

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

Question	Description
<b>1A.2A</b> Name of automated coding software.	
<b>1A.2B</b> How often are codes updated?	
<b>1A.2C</b> Does your organization verify procedure or diagnosis codes?	
<b>1A.2D</b> Does your organization group or ungroup procedure or diagnosis codes?	
<b>1A.2E</b> Does your organization use its own DRG grouper?	
<b>1A.2F</b> Which DRG grouper does your organization use?	
<b>1A.2G</b> Does your organization ensure accurate assignment of DRGs?	

**Coding Schemes**

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

Coding Scheme	Type of Service			
	Inpatient Diagnosis	Inpatient Procedure	Ambulatory Diagnosis	Ambulatory Procedure
<b>1A.3A</b> Standard HEDIS codes (e.g., ICD-9, CPT, Revenue, MS DRG, HCPCS, CPT II).				
<b>1A.3B</b> Nonstandard HEDIS codes:				
• DSM-IV				
• State-specific (e.g., Medicaid, state DRGs)				
• Internally developed				
<b>1A.3C</b> Codes used to identify lab tests or results?				
• LOINC				

**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
<b>1A.4A</b> Type of coding scheme.	
<b>1A.4B</b> What percentage of claims or encounters was affected?	
<b>1A.4C</b> For which services were codes or rates used?	
<b>1A.4D</b> Were codes or rates received on claim or encounter forms from providers, or generated by the claim or encounter system or processors?	
<b>1A.4E</b> How were codes or rates processed in the claim or encounter data system?	
<b>1A.4F</b> 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
<b>1A.6A</b> Type of form.			
<b>1A.6B</b> What percentage of claims or encounters was affected?			
<b>1A.6C</b> 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?

	Required?	No. of Codes	No. of Digits	Explanation
Member ID number				
Rendering provider ID				
<b>Claim Information</b>				
Claim number				
First date of service				
Last date of service				
Discharge status				
Paid, denied, pended				
<b>Codes</b>				
Primary Diagnosis				
Secondary Diagnosis				
Primary Procedure				
Secondary Procedure				
Procedure Modifiers				
Units of Service				
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.**

<b>1A.8A</b>	Checks for valid procedure and diagnosis codes (e.g., obsolete codes, required number of digits).	
<b>1A.8B</b>	Checks for valid members.	
<b>1A.8C</b>	Checks for valid coding (e.g., recalculates the DRG or procedure valid for the member's gender).	
<b>1A.8D</b>	Checks on field size.	
<b>1A.8E</b>	Checks on date ranges (e.g., "to" date, is after "from" date; no future dates).	
<b>1A.8F</b>	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
<b>1A.9A</b>	Describe the change, upgrade or consolidation.
<b>1A.9B</b>	What claim or encounter data systems and product lines or products were affected?
<b>1A.9C</b>	Project start and end dates.
<b>1A.9D</b>	Regarding data conversion: <ul style="list-style-type: none"> <li>• 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)?</li> <li>• What claims or encounters were not converted to the new system?</li> <li>• What data elements were converted to the new system?</li> <li>• What data elements were not converted to the new system?</li> </ul>
<b>1A.9E</b>	How were data mapped for conversion from the previous system to the new claim or encounter system?
<b>1A.9F</b>	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
<b>1A.10A</b> How are claims or encounters obtained, processed and entered into the claim or encounter system?	
<b>1A.10B</b> Are encounters (i.e., submissions that are not linked to payment) processed differently from claims (i.e., submissions for payment)?	
<b>1A.10C</b> 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)?	
<b>1A.10D</b> 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?	
<b>1A.10E</b> How is a claim or encounter handled if it is submitted: <ul style="list-style-type: none"> <li>• With one or more required fields missing, incomplete or invalid?</li> <li>• With no diagnosis code, or an invalid code? Is a default code used?</li> <li>• With no procedure code, or an invalid code? Is a default code used?</li> </ul>	
<b>1A.10F</b> 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
<b>1A.11A</b> Are electronic claims received directly or through clearing houses, or both?	
<b>1A.11B</b> Are electronic claims received in HIPAA-standard compliant or proprietary formats?	
<b>1A.11C</b> How are electronically received files uploaded into the claim or encounter processing system?	
<b>1A.11D</b> Do electronically received claims or encounters receive the same edit checks as paper claims or encounters?	
<b>1A.11E</b> Are electronic claims mapped, transformed or truncated before being uploaded into a claim or encounter system?	
<b>1A.11F</b> How does your organization ensure that transmissions are properly monitored and controlled?	
<b>1A.11G</b> What edit checks are performed to ensure that electronically transferred claim or encounter files are accurately and completely received and uploaded?	
<b>1A.11H</b> 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
<b>1A.12A</b> What were the time-to-process standards for claim or encounter data?	
<b>1A.12B</b> What was the actual average time to process for claim or encounter data?	
<b>1A.12C</b> 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
<b>1A.13A</b> Were there audits of claim or encounter data processing?	
<b>1A.13B</b> What was audited, and how often?	
<b>1A.13C</b> What were the findings for the measurement year?	
<b>1A.13D</b> Were deficiencies detected?	

## Data Completeness

### Improving Data Completeness

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

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

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

Document	Details	Label
<b>Claim or encounter data system flowchart</b>	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.	<b>1A.1</b>
<b>Proprietary forms (if applicable)</b>	If proprietary claim or encounter forms were used during the measurement year, attach clean, blank copies of each.	<b>1A.2</b>
<b>Explanation of nonstandard codes (if applicable)</b>	If nonstandard codes were used during the measurement year, attach descriptions of internally developed codes, code definitions and translation procedures.	<b>1A.3</b>
<b>Claim lag, IBNR or completion factor reports</b>	Provide 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 reporting.	<b>1A.4</b>
<b>Data completeness studies or analyses</b>	If applicable, attach copies of additional studies or analyses conducted on data completeness or under-reporting.	<b>1A.5</b>

## 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: Laboratory Services and Processing (IS 1)

### Introduction

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

**Vendor  
information**

**Vendor name:**

---

**Reporting for:**

---

**Completion date:**

---

### Definitions

**Claim** A submission for reimbursement (e.g., from fee-for-service providers).

---

**Encounter** A submission that is not linked to payment (e.g., from capitated providers).

---

**Claim or encounter processing vendor** Includes any external entity with which the organization has contracted to perform the following tasks.

- Provide a particular type of medical service.
- Perform claim or encounter data processing functions.

---

**Significant change** A change of (+/–)10% in volume of data processed, or a conversion, consolidation or upgrade to the data processing system.

---

### Instructions

- Vendors complete Section 1B if they process claims or encounter data for reimbursement for the health plan. 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
<b>1B.1A</b> Name of claim or encounter system			
<b>1B.1B</b> Type of data processed			
<b>1B.1C</b> Location (city, state)			
<b>1B.1D</b> Average monthly volume			
<b>1B.1E</b> Percentage of claims or encounters submitted:			
• On paper			
• Electronically			

## Claim or Encounter Policy Questions

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

## Coding Software

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

Question	Description
<b>1B.2A</b> Name of automated coding software.	
<b>1B.2B</b> How often are codes updated?	
<b>1B.2C</b> Does your organization verify procedure or diagnosis codes?	
<b>1B.2D</b> 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
<b>1B.3A</b> Standard HEDIS codes (e.g., ICD-9, CPT, HCPCS, CPT II).				
<b>1B.3B</b> Nonstandard HEDIS codes:				
• State-specific (e.g., Medicaid, state DRGs)				
• Internally developed				

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

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

## Nonstandard Data Submission Forms

**Table 1B.5: 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
<b>1B.5A</b> Type of form.			
<b>1B.5B</b> What percentage of claims or encounters was affected?			
<b>1B.5C</b> Services for which nonstandard forms were used?			

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**Table 1B.6: 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	Explanation
Member ID number				
Ordering provider ID				
<b>Claim Information</b>				
Claim number				
First date of service				
Last date of service				
Payment status				
<b>Codes</b>				
Primary Diagnosis				
Secondary Diagnosis				
Primary Procedure				
Secondary Procedure				
Units of Service				
Revenue				
HCPCS				
CPT Level II				

**Table 1B.7: Claim or encounter system’s edit checks.**

Claims or Encounter System Edit Checks	Description
<b>1B.7A</b> Checks for valid procedure and diagnosis codes (e.g., obsolete codes, required number of digits).	
<b>1B.7B</b> Checks for valid members.	
<b>1B.7C</b> Checks for valid coding (e.g., recalculates the DRG or procedure valid for the members gender).	
<b>1B.7D</b> Checks on field size.	
<b>1B.7E</b> Checks on date ranges (e.g., “to” date is after “from” date; no future dates).	
<b>1B.7F</b> Checks for valid practitioners.	

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## System Upgrades or Conversions

**Table 1B.8: 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
<b>1B.8A</b> Describe the change, upgrade or consolidation.	
<b>1B.8B</b> What claim or encounter data systems and product lines or products were affected?	
<b>1B.8C</b> Project start and end dates.	
<b>1B.8D</b> Regarding data conversion:	
<ul style="list-style-type: none"> <li>• 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)?</li> </ul>	
<ul style="list-style-type: none"> <li>• What claims or encounters were not converted to the new system?</li> </ul>	
<ul style="list-style-type: none"> <li>• What data elements were converted to the new system?</li> </ul>	
<ul style="list-style-type: none"> <li>• What data elements were not converted to the new system?</li> </ul>	
<b>1B.8E</b> How were data mapped for converting data from the previous system to the new claim or encounter system?	
<b>1B.8F</b> Did a parallel system run during the conversion?	
<b>1B.8G</b> How did your organization ensure accuracy and completeness of data in the new system?	

## Policies and Procedures

**Table 1B.9: Claim or encounter data processes.**

	Question	Description
<b>1B.9A</b>	How are claims or encounters obtained, processed and entered into the claim or encounter system?	
<b>1B.9B</b>	Are encounters (i.e., submissions that are not linked to payment) processed differently from claims (i.e., submissions for payment)?	
<b>1B.9C</b>	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)?	
<b>1B.9D</b>	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?	
<b>1B.9E</b>	How is a claim or encounter handled if it is submitted:	
	<ul style="list-style-type: none"> <li>• With one or more required fields missing, incomplete or invalid?</li> </ul>	
	<ul style="list-style-type: none"> <li>• With no diagnosis code, or an invalid code? Is a default code used?</li> </ul>	
<ul style="list-style-type: none"> <li>• With no procedure code, or an invalid code? Is a default code used?</li> </ul>		
<b>1B.9F</b>	Are there situations where processors may change claim or encounter information submitted by a provider?	

## Electronic Submission of Claim or Encounter Data

**Table 1B.10: Complete this table if the claim or encounter system accepts electronically transferred claim or encounter data.**

	Question	Description
<b>1B.10A</b>	Are electronic claims received directly or through clearing houses, or both?	
<b>1B.10B</b>	Are electronic claims received in HIPAA-standard compliant or proprietary formats?	
<b>1B.10C</b>	How are electronically received files uploaded into the claim or encounter processing system?	
<b>1B.10D</b>	Do electronically received claims or encounters receive the same edit checks as paper claims or encounters?	
<b>1B.10E</b>	Are electronic claims mapped, transformed or truncated before being uploaded into the claim or encounter system?	
<b>1B.10F</b>	How does your organization ensure that transmissions are properly monitored and controlled?	
<b>1B.10G</b>	What edit checks are performed to ensure that electronically transferred claim or encounter files are accurately and completely received and uploaded?	
<b>1B.10H</b>	How does your organization verify the accuracy of electronic submissions?	

## Timeliness and Accuracy of Data Processing

**Table 1B.11: Timeliness of claim or encounter data processing.**

Question	Description
<b>1B.11A</b> What were the time-to-process standards for claim or encounter data?	
<b>1B.11B</b> What was the actual average time to process for claim or encounter data?	
<b>1B.11C</b> Was there ever a backlog or delay in processing claim or encounter data?	

**Table 1B.12: Accuracy of claim or encounter processing during the measurement year.**

Question	Description
<b>1B.12A</b> Were there audits of claim or encounter data processing?	
<b>1B.12B</b> What was audited, and how often?	
<b>1B.12C</b> What were the findings for the measurement year?	
<b>1B.12D</b> Were deficiencies detected?	

## Data Completeness

### Improving Data Completeness

**Table 1B.13: Data completeness activities during the measurement year.**

Question	Description
<b>1B.13A</b> Were steps taken to improve completeness of claim or encounter data?	
<b>1B.13B</b> Were all practitioners, provider groups, facilities and vendors required by contract to submit complete and accurate claim or encounter data?	
<b>1B.13C</b> Were performance standards in place to ensure submission of claim or encounter data by practitioners, provider groups, facilities and vendors?	
<b>1B.13D</b> Was compensation tied to submission of claim or encounter data by practitioners, provider groups, facilities and vendors?	
<b>1B.13E</b> Were other incentive or penalty arrangements in place for practitioners, provider groups, facilities and vendors to submit complete and accurate data?	

**Requested Documentation**

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

Document	Details	Label
<b>Claim or encounter data system flowchart</b>	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.	<b>1B.1</b>
<b>Proprietary forms (if applicable)</b>	If proprietary claim or encounter forms were used during the measurement year, attach clean, blank copies of each.	<b>1B.2</b>
<b>Explanation of nonstandard codes (if applicable)</b>	If nonstandard codes were used during the measurement year, attach descriptions of internally developed codes, code definitions, translation procedures and code mapping schemes.	<b>1B.3</b>
<b>Claim lag, IBNR or completion factor reports</b>	Provide 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 reporting.	<b>1B.4</b>
<b>Data completeness studies or analyses</b>	If applicable, attach copies of additional studies or analyses conducted on data completeness or under-reporting.	<b>1B.5</b>

**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.
- Perform claim or encounter data processing functions.

**Significant change** A change of (+/–)10% in volume of data processed, or a conversion, consolidation or upgrade to the data processing system.

#### Instructions

- Vendors complete Section 1C if they process claims or encounter data for reimbursement for the health plan. 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	
<b>1C.1A</b>	Name of claim or encounter system.						
<b>1C.1B</b>	Type of data processed (claim, encounter).						
<b>1C.1C</b>	Location (city, state).						
<b>1C.1D</b>	Average monthly volume.						
<b>1C.1E</b>	Percentage of claims or encounters submitted:						
	<ul style="list-style-type: none"> <li>• On paper</li> <li>• Electronically</li> </ul>						
		<b>PY</b>	<b>MY</b>	<b>PY</b>	<b>MY</b>	<b>PY</b>	<b>MY</b>
<b>1C.1F</b>	Average PMPY pharmacy.						
<b>1C.1G</b>	Percentage of members with pharmacy benefit.						

**Pharmacy Claim Questions**

<b>1C.1-1</b>	<p><b>Q.</b> 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)?</p> <p><b>A.</b></p>
<b>1C.1-2</b>	<p><b>Q.</b> Does the PBM use the plan's member identifier for claims processing? If not, how are claims mapped?</p> <p><b>A.</b></p>
<b>1C.1-3</b>	<p><b>Q.</b> How often are enrollment files sent to the pharmacy organization? What is the reconciliation process?</p> <p><b>A.</b></p>
<b>1C.1-4</b>	<p><b>Q.</b> 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?</p> <p><b>A.</b></p>
<b>1C.1-5</b>	<p><b>Q.</b> Are prescriptions identified with codes other than NDC codes?</p> <p><b>A.</b></p>
<b>1C.1-6</b>	<p><b>Q.</b> How often are NDC codes updated in the system?</p> <p><b>A.</b></p>

## Coding Schemes

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

Coding Scheme	Type of Service		
	Retail Pharmacies	Specialty Pharmacies	Other
Standard codes (e.g. NDC, HCPCS)			
Nonstandard codes:			
• State-specific (e.g., DRGs)			
• 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 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	Explanation
Member identification				
Prescriber ID				
Prescriber name				
Date of service				
Scrip fill date				
Quantity/units:				
• Ordered				
• Dispensed				
• Paid				
Days supply				
Payment status				
Refill indicator				
Diagnosis				
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
<b>1C.4A</b> Describe the change, upgrade or consolidation.	
<b>1C.4B</b> What claim or encounter data systems and product lines or products were affected?	
<b>1C.4C</b> Project start and end dates.	
<b>1C.4D</b> Regarding data conversion: <ul style="list-style-type: none"> <li>• 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)?</li> <li>• What claims or encounters were not converted to the new system?</li> <li>• What data elements were converted to the new system?</li> <li>• What elements were not converted to the new system?</li> </ul>	
<b>1C.4E</b> How were data mapped for conversion from the previous system to the new claim or encounter system?	
<b>1C.4F</b> Did a parallel system run during the conversion?	
<b>1C.4G</b> 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
<b>1C.5A</b> What were the time-to-process standards for claim or encounter data?	
<b>1C.5B</b> What was the actual average time to process for claim or encounter data?	
<b>1C.5C</b> 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
<b>1C.6A</b> Were there audits of claim or encounter data processing?	
<b>1C.6B</b> What was audited, and how often?	
<b>1C.6C</b> What were the findings for the measurement year?	
<b>1C.6D</b> Were deficiencies detected?	

## Data Completeness

### Improving Data Completeness

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

	Question	Description
<b>1C.7A</b>	Were steps taken to improve completeness of claim or encounter data?	
<b>1C.7B</b>	Were all practitioners, provider groups, facilities and vendors required by contract to submit complete and accurate claim or encounter data?	
<b>1C.7C</b>	Were performance standards in place to ensure submission of claim or encounter data by practitioners, provider groups, facilities and vendors?	
<b>1C.7D</b>	Was compensation tied to submission of claim or encounter data by practitioners, provider groups, facilities and vendors?	
<b>1C.7E</b>	Were other incentive or penalty arrangements in place for practitioners, provider groups, facilities and vendors to submit complete and accurate data?	
<b>1C.7F</b>	Were other activities undertaken to encourage claim or encounter data submission by practitioners, provider groups, facilities and vendors?	
<b>1C.7G</b>	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 Documentation

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

Document	Details	Label
<b>Claim or encounter data system flowchart</b>	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.	<b>1C.1</b>
<b>Proprietary forms (if applicable)</b>	If proprietary claim or encounter forms were used during the measurement year, attach clean, blank copies of each.	<b>1C.2</b>
<b>Explanation of nonstandard codes (if applicable)</b>	If nonstandard codes were used during the measurement year, attach descriptions of internally developed codes, code definitions, translation procedures and code mapping schemes.	<b>1C.3</b>
<b>Data completeness studies or analyses</b>	If applicable, attach copies of additional studies or analyses conducted on data completeness or under-reporting.	<b>1C.4</b>

**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)
<b>Product Line/Product</b>			
Full name			
Address			
Date of birth			
Gender			
Social Security number			
State <i>or</i> 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			

**Table 2.2: Member information maintained in the system (continued)**

Termination Date			
	Required? (R,O,N,NA)	Required? (R,O,N,NA)	Required? (R,O,N,NA)
With organization.			
By product line or product.			
By benefit package.			
Race, Ethnicity and Language Information			
Race.			
Ethnicity.			
Interpretive service needs.			
Language spoken at home.			
Member ID Information			
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 health			
• 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
<b>2.3A</b> How are data for new members obtained, processed and entered into the enrollment or membership system? Describe how new member data are processed.	
<b>2.3B</b> How are newborns assigned member IDs?	
<b>2.3C</b> How are mother-baby records linked?	
<b>2.3D</b> How are changes to member information obtained, processed and entered into the enrollment or membership system? Describe how enrollment changes are processed.	
<b>2.3E</b> How are data on member terminations obtained, processed and entered into the enrollment or membership system? Describe how member terminations are processed.	
<b>2.3F</b> How is data entry of enrollment or membership information verified?	
<b>2.3G</b> Does the enrollment or membership system include edit checks to ensure the accuracy of data entry? If so, describe.	

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

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

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

Product Line/Product			
<b>2.5A</b> Were there audits of enrollment or membership data processing? What was audited, and how often?			
<b>2.5B</b> What were the findings for the measurement year?			
<b>2.5C</b> Were deficiencies detected? If so, describe.			
<b>2.5D</b> During the measurement year, were enrollment or membership data reconciled against an external data source (e.g., employer group, Medicare, Medicaid, SCHIP data)? If so:			
<ul style="list-style-type: none"> <li>Describe the reconciliation process, including what was reconciled and how often.</li> </ul>			
<ul style="list-style-type: none"> <li>What were the findings for the measurement year?</li> </ul>			
<ul style="list-style-type: none"> <li>Were deficiencies detected? If so, describe.</li> </ul>			

**Table 2.5: Accuracy of enrollment or membership data (continued)**

Product Line/Product			
<b>2.5E</b>	During the measurement year, were staff incentives tied to the accuracy and timeliness of enrollment or membership data processing? If so, describe.		
<b>2.5F</b>	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			
<b>2.6A</b>	Did a change, upgrade or consolidation affect the ability to identify members? If so, describe.		
<b>2.6B</b>	What enrollment or membership data systems and product lines or products were affected?		
<b>2.6C</b>	Project start and end dates.		
<b>2.6D</b>	Regarding data conversion: <ul style="list-style-type: none"> <li>• What members were converted to the new system (e.g., active members only, all members)?</li> <li>• What members were not converted to the new system?</li> <li>• What data elements were converted to the new system?</li> </ul>		
<b>2.6E</b>	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
<b>2.7A</b>	From whom are electronic enrollment or membership files received?
<b>2.7B</b>	How often are electronic enrollment or membership files received?
<b>2.7C</b>	How are electronic files uploaded into the enrollment or membership processing system?
<b>2.7D</b>	What procedures are in place to ensure that transmissions are properly monitored and controlled?
<b>2.7E</b>	What edit checks are performed to ensure the electronically transferred enrollment or membership files are: <ul style="list-style-type: none"> <li>• Accurately and completely received?</li> <li>• Uploaded to the enrollment or membership system?</li> </ul>

**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 health).**

Vendor				
Product Line/Product				
<b>2.8A</b>	Describe the process for submitting membership data to the ancillary vendor.			
<b>2.8B</b>	How often are membership data submitted to the ancillary vendor?			
<b>2.8C</b>	What percentage of members is affected by the ancillary vendor?			
<b>2.8D</b>	Describe the process used to monitor membership data submissions.			
<b>2.8E</b>	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
<b>2.9A</b> Vendor name.	
<b>2.9B</b> Contract start or end date.	
<b>2.9C</b> What standards of delegation, if any, were vendors subject to during the measurement year, including oversight policies, processing standards and predelegation requirements?	
<b>2.9D</b> What reporting requirements, if any, were vendors subject to during the measurement year, including type and frequency of reporting?	
<b>2.9E</b> What oversight and monitoring activities, if any, were vendors subject to during the measurement year, including type and frequency of reviews or audits?	
<b>2.9F</b> During the measurement year, were deficiencies detected with vendor processing of enrollment or membership data? If so, describe the nature of the deficiencies and corrective actions taken.	

**Requested Documentation**

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

Document	Details	Label
<b>Enrollment or membership data system flowchart</b>	Provide 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.	<b>2.1</b>

**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 3: 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 health vendors.

**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 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 3.1: Data systems for all product lines under review during the measurement year.**

Question	Description
<b>3.1A</b> What data systems were used to:	
• Maintain practitioner specialty data?	
• Maintain practitioner data for processing claims or encounters?	
• Generate the hard copy provider directory (if any)?	
• Generate the online provider directory?	
<b>3.1B</b> 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 3.2: 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 3.3: Practitioner data elements captured by each system or vendor.** Add columns for additional systems or vendors.

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

**3.3A Q.** Was any data element in Table 3B.3 marked "No"? Explain.

**A.**

**Table 3.4: Practitioner data processing.**

Question	Description
<b>3.4A</b> During the measurement year, did any product lines or products under review experience: <ul style="list-style-type: none"> <li>• An increase in the number of practitioners? Why?</li> <li>• A decrease in the number of practitioners due to contract terminations? Why?</li> <li>• Significant turnover in the provider network?</li> </ul>	
<b>3.4B</b> What is the unique practitioner ID in the following systems? <ul style="list-style-type: none"> <li>• Practitioner data system used for processing claims or encounters</li> <li>• Additional systems or databases if any</li> </ul>	
<b>3.4C</b> 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?	
<b>3.4D</b> Can the system uniquely ID rendering provider?	
<b>3.4E</b> 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: <ul style="list-style-type: none"> <li>• More than one practitioner to have the same ID number</li> <li>• The same practitioner to have more than one ID number</li> <li>• A practitioner's ID number to change (e.g., through recontracting, group affiliation change, product line or product switch)</li> </ul>	

## Practitioner Data Quality

**Table 3.5: Accuracy of practitioner data processing.**

Question	Description
<b>3.5A</b> For practitioner data in the system used for processing claims or encounters: <ul style="list-style-type: none"> <li>• Were any audits conducted during the measurement year? Briefly describe the audit process and frequency.</li> <li>• What were the findings for the measurement year? Include information on deficiencies.</li> </ul>	

**Table 3.7: Reconciliation of practitioner data.**

Question		Description
3.7A	During the measurement year, were the following reconciliations conducted for practitioner data? Briefly describe the process and findings, including deficiencies.	
	<ul style="list-style-type: none"> <li>• Reconciliation between practitioner data in the credentialing system and claims processing system</li> <li>• Reconciliation between practitioner data in your organization's practitioner data system and any other additional system your organization maintains to store practitioner data</li> </ul>	
3.7B	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 3.8: 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 Claims or Encounters Affected	Method and Frequency of Data Transmittal to Vendor

### Practitioner Data Questions

3.8A	<p><b>Q.</b> During the measurement year, were any reconciliations conducted for practitioner data between your organization's system and the vendors listed in Table 3B.8? If so, briefly describe the process and findings, including deficiencies. Provide information separately for each vendor.</p> <p><b>A.</b></p>
3.8B	<p><b>Q.</b> Were there any changes in classification or identification of practitioner specialties during the measurement year?</p> <p><b>A.</b></p>

### System Upgrades or Conversions

**Table 3.9: 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 Documentation**

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

Document	Details	Label
Practitioner data system flowchart	Provide 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.	3.1

**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: Supplemental Data (IS 4)

### Introduction

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

<b>Organization information</b>	<b>Organization name:</b> <hr/> <b>Date of completion:</b> <hr/>
<b>Definitions</b>	<ul style="list-style-type: none"> <li>• <b>Standard supplemental electronic files</b> have a standard format that is well documented and remains stable from year to year. <ul style="list-style-type: none"> <li>– Laboratory data in HL-7 formats</li> <li>– Immunization data in state registries (may vary from state to state, but are consistent for all records in each state’s registry)</li> <li>– Encounter data from behavioral health vendors</li> </ul> </li> <li>• <b>Nonstandard supplemental electronic data</b> come from sources that follow no standard layout and the formats differ from one source to another. <ul style="list-style-type: none"> <li>– Electronic files from EMR records</li> <li>– Electronic files from disease management or case management systems</li> <li>– Electronic files from measure-exclusion databases</li> </ul> </li> <li>• Any automated data supplied by contracted practitioners, vendors or public agencies (e.g., pharmacies, labs, hospitals, schools, state public health agencies) constitute <b>external supplemental data</b>.   External data can also come from EMRs, which are typically developed and maintained at the hospital or physician office and may be integrated (or linked) to the organization’s system. External data files can be standard or nonstandard.</li> <li>• Any automated data file created by the organization, which supplements the claim or encounter data in the P4P repository. The data can come from internal systems such as DM programs. <b>Internal files</b> are nonstandard.</li> </ul>
<b>Instructions</b>	<ul style="list-style-type: none"> <li>• Complete a separate Section 4 for each non-standard supplemental database not already described in Section 1A-D.</li> <li>• Where there are differences by product line or product, provide a separate response for each product line or product subject to audit.</li> </ul>

**Supplemental Data Source**

**Table 4.1: Data source used by the organization to supplement transaction system data (claims or encounters) for P4P reporting.**

General Information		Description
<b>4.1A</b>	Database name.	
<b>4.1B</b>	Specific intended measure use.	
<b>4.1C</b>	Expected measure impact (e.g., expected percentage rate increase).	
<b>4.1D</b>	Internal use of data.	
<b>4.1E</b>	Data volume.	
Data Type (select one)		Description
<b>4.1F</b>	Internal nonstandard.	
	External standard.	
	External nonstandard.	
Population (Select One)		Description
<b>4.1G</b>	Entire membership.	
	Measure eligible population per HEDIS specifications.	
	Noncompliant members in the measure-specific eligible population per HEDIS specifications.	
	Eligible population (other specification (e.g., disease management program population).	
	Other (describe):	
Information Source (Select One)		Description
<b>4.1H</b>	Medical record—Practitioner office.	
	Medical record—Hospital.	
	EMR.	
	Disease management system or vendor.	
	Utilization or case management system or vendor.	
	Lab results.	
	Vision results.	
	Pharmacy vendor data.	
	Behavioral health 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
<b>4.1I</b>	FTP transfer (secure or unsecured).	
	Portable media (CD, diskette, tape).	
	Fax or mail.	
	Other (describe):	

Table 4.1 (continued)

Collection Timing (Select One)		Description				
4.1J	Ongoing					
	Measurement year					
	Prior to reporting year					
	Other (describe)					
	Data collection start and end dates					
Collection Method (Select One)		Description				
4.1K	Information request letter to provider (include copy with documents)					
	Querying data system					
	Standard operational data feed					
	Disease management program					
	Other (describe):					
Data Elements Collected (Check All That Apply)						
		Yes	No		Yes	No
4.1L	Member ID number			Provider specialty or type		
	Member first name			Days supply		
	Member middle name or initial			Metric quantity		
	Member last name			Date of service		
	Member DOB			Procedure code		
	HIC number			Diagnosis code		
	Social Security number			Lab result		
	State Medicaid or case number			LOINC code		
	Practitioner ID number			NDC code		
	Place of service			Other (describe):		
Data Transformation			Description			
4.1M	<i>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.</i>					
	Member ID number					
	Practitioner ID number					
	Place of service					
	Provider specialty or type					
	Procedure code					
	Diagnosis code					
	Lab result					
	LOINC code					
	NDC code					
Other (describe):						
4.1N	How are data integrated for internal use or HEDIS reporting?					
Internal Validation Method		Description				
4.1O	Primary source verification					
4.1P	Review sample of records					
4.1Q	Other (describe):					

**Requested Documentation**

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	Provide a document or a sample of the file layout used to capture hold the data.	4.1
Data Transformation	Provide documentation for all data element mapping.	4.2
Data Integration and Maintenance	Provide any relevant policies, procedures, and process or control descriptions applicable to supplemental data. Provide a copy of any information request letter to provider.	4.3
Data Validation	Provide copies of data validation studies applicable to supplemental data.	4.4
Staff and Training (for internal data)	Provide a list of the staff who maintains the internal supplemental data and their credentials. Provide any training documents used outside of the policies and procedures.	4.5

**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 5: Data Integration (IS 5)

### Introduction

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

**Organization information**

**Organization name:**

---

**Date of completion:**

---

### Definitions

---

**P4P 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.
- 

### 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 5, depending on whether the P4P 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 P4P Measure Production Responsibility

**Table 5.1: Staff or type responsible for key steps in the production process.** Enter the number of persons responsible for each step; provide explanations where relevant.

General Production Functions	Number of Internal Staff and Type	Contracted Staff	Vendor Name
Data integration.			
Data warehouse or repository.			
Source code development.			
Rate calculation or measure production.			
Project management.			
Other (indicate).			
<b>5.1A</b> Identify significant changes from the previous year's cycle.			

### Data Sources and Completeness

**Table 5.2: Data files used, the date on which the files were loaded into the P4P repository and the date for planned data refresh for 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 HEDIS Repository	Planned Dates of Data Refreshes or Final Refresh
<b>5.2A</b> Enrollment or membership.			
<b>5.2B</b> Practitioner.			
<b>5.2C</b> Claim or encounter.			
<b>5.2D</b> Behavioral health.			
<b>5.2E</b> Pharmacy.			
<b>5.2F</b> Laboratory claims.			
<b>5.2G</b> Lab results.			
<b>5.2H</b> Vision care.			
<b>5.2I</b> Public registry (e.g., immunization).			
<b>5.2J</b> Other.			
<b>5.2K</b> Administrative database or supplemental data (describe).			

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

Question		Description
<b>5.3A</b>	What data were excluded?	
<b>5.3B</b>	Why were data excluded?	
<b>5.3C</b>	What percentage of members, practitioners or claims or encounters was affected?	

**Table 5.4: Amount of data used to report.** 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 separately.

Type of Service	Prior Year (PY)	Measurement Year (MY)	Prior Year (PY)	Measurement Year (MY)	Prior Year (PY)	Measurement Year (MY)
<b>Product Line:</b>						
<b>Product:</b>						
Average per member per year (PMPY) ambulatory services						
Average PMPY inpatient services						
Average PMPY pharmacy						
Average PMPY behavioral health						
Average PMPY laboratory						
Question		Description				
<b>5.4A</b>	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 5.5 Software packages, programming languages and mainframe or pc-based application programs your organization or vendor uses to prepare and calculate the measurement year report.** Consider all programs used to create denominators and numerators.

Function	Software Package or Programming Language or Application	Activity or HEDIS Measures Affected
<b>5.5A</b> Data integration.		
<b>5.5B</b> Data warehouse or HEDIS repository.		
<b>5.5C</b> Source code development for HEDIS rate calculation.		

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

<b>Data Integration</b>	
<b>Question</b>	<b>Description</b>
<b>5.6A</b> How are data integrated and consolidated for HEDIS 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.	
<b>5.6B</b> Describe the extract-transform-load (ETL) process for landing HEDIS data in the data warehouse or HEDIS data repository.	
<b>5.6C</b> How does your organization ensure that all data (including any supplemental or MRR data) are transferred and properly formatted?	
<b>5.6D</b> Are denied claims or encounters captured for HEDIS reporting if the services were provided?	
<b>5.6E</b> Describe any changes made to the data integration process for the measurement year.	
<b>5.6F</b> Describe testing activities used to validate changes.	
<b>File Consolidation</b>	
<b>Question</b>	<b>Description</b>
<b>5.6G</b> Describe the procedures used to link: <ul style="list-style-type: none"> <li>• Claim or encounter (including vendor) data and membership data</li> <li>• Claim or encounter (including vendor) data and practitioner data</li> </ul>	
<b>5.6H</b> With regard to accuracy of data integrated for HEDIS reporting: <ul style="list-style-type: none"> <li>• What is your organization's process for ensuring that the required level of coding detail is maintained?</li> <li>• How does your organization identify and handle duplicate records?</li> <li>• How does your organization identify and handle erroneous data?</li> <li>• How does your organization identify and handle missing data elements?</li> <li>• How does your organization ensure that the repository or warehouse accurately reflects the transaction files?</li> <li>• How does your organization ensure that no data are lost in the data integration process?</li> <li>• What algorithms does your organization use to check the reasonableness of data integrated to report HEDIS?</li> <li>• If your organization uses nonstandard HEDIS codes, how are the codes translated to standard codes for HEDIS reporting? Attach a copy of the code mapping scheme and translation procedures.</li> </ul>	

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

Question	Description
5.7A What is the background and relevant experience of the staff involved in developing source code for HEDIS production.	
5.7B How is their work overseen and monitored?	
5.7C What is your organization's process for producing source code for the measurement year, including development, oversight, review, testing and version control?	
5.7D Describe revisions made to previous source code to accommodate first-year reporting of measures or changes in technical specifications, data processing systems (e.g., claim or encounter, membership, practitioner, vendor) and HEDIS rate production.	
5.7E What are your organization's processes for running HEDIS production reports for the measurement year, including production control mechanisms, job logs, supervisory review, error detection and reruns.	
5.7F Describe the process for entering data into the final reporting format. Do you perform direct data entry or use an import template?	
<p>5.7G Regarding how continuous enrollment and member months were calculated for the measurement year:</p> <ul style="list-style-type: none"> <li>• 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?</li> <li>• 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)?</li> <li>• Describe any system or data limitation that precludes full implementation of HEDIS continuous enrollment or member months requirements as specified.</li> </ul>	
<p>5.7H What tests and checks are performed to validate the accuracy and completeness of:</p> <ul style="list-style-type: none"> <li>• Measure-specific rates?</li> <li>• Measure-specific denominators (i.e., eligible member population)?</li> <li>• Member month-calculations?</li> </ul>	

### Data Integration and Report Production (P4P Measures Produced Using Certified Software)

**Table 5.8: 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 and numerators.

Function	Software Package or Programming Language or Application	Activity or HEDIS Measures Affected
<b>5.8A</b> Data integration		
<b>5.8B</b> Data warehouse or HEDIS repository		
<b>5.8C</b> Source code development for HEDIS rate calculation		

**Table 5.9: Information about data integration and consolidation into the P4P repository.**

Data Integration	
Question	Description
<b>5.9A</b> Are data from your organization transferred to the vendor's systems? If so, provide an overview of the process. Describe how the data are mapped from your file formats to the vendor's file formats.	
<b>5.9B</b> How does your organization ensure that all data (including MRR data) are transferred and properly formatted?	
<b>5.9C</b> Are denied claims or encounters captured for P4P reporting if the services were provided?	
<b>5.9D</b> Did your organization make to the data integration process for the measurement year? Describe.	
<b>5.9E</b> What testing activities were used to validate the changes?	

Table 5.9 (continued)

<b>File Consolidation</b>	
<b>Question</b>	<b>Description</b>
<p><b>5.9F</b> How does the vendor link:</p> <ul style="list-style-type: none"> <li>• Claim or encounter (including vendor) data and membership data?</li> <li>• Claim or encounter (including vendor) data and practitioner data?</li> </ul>	
<p><b>5.9G</b> Regarding ensuring the accuracy of data integrated for P4P reporting:</p> <ul style="list-style-type: none"> <li>• What is your organization's process for ensuring that the required level of coding detail is maintained?</li> <li>• How does your organization identify and handle duplicate records?</li> <li>• How does your organization identify and handle erroneous data?</li> <li>• How does your organization identify and handle missing data elements?</li> <li>• How does your organization ensure that the repository or warehouse accurately reflects the transaction files from your organization?</li> <li>• How do your organization and your vendor ensure that no data are lost in the data integration process?</li> <li>• What algorithms does your organization use to check the reasonableness of data integrated to report P4P?</li> <li>• If your organization uses nonstandard HEDIS codes, how do the codes translate to standard codes for P4P reporting? Attach a copy of the code mapping scheme and translation procedures.</li> </ul>	

**Table 5.10: Measure production used to prepare and calculate the measurement year report.** Consider all programs used to create denominators and numerators.

Questions		Description
<b>5.10A</b>	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?	
<b>5.10B</b>	How does your organization integrate vendor-supplied information with organization-supplied information (e.g., board certification, call answer timeliness, call abandonment) for the final HEDIS submission?	
<b>5.10C</b>	What is the process for entering data into the IDSS or final HEDIS reporting format? Do you perform direct data entry or use an import template?	
<b>5.10D</b>	Regarding calculation of hybrid measures for the measurement year: <ul style="list-style-type: none"> <li>• How are hybrid samples generated?</li> <li>• If applicable, how are sample sizes reduced using the prior year's hybrid rate or this year's administrative rates?</li> <li>• How are data obtained through medical record review integrated back into the administrative data for HEDIS measure calculation?</li> <li>• Describe any system or data limitation that precludes full implementation of HEDIS sampling requirements as specified.</li> </ul>	
<b>5.10E</b>	What tests and checks are performed to validate the accuracy and completeness of: <ul style="list-style-type: none"> <li>• Measure-specific rates?</li> <li>• Measure-specific denominators (i.e., eligible member population)?</li> <li>• Member-month calculations?</li> </ul>	

## System Security or Back-Ups

**Table 5.11: Claim or encounter, membership systems and P4P repository.**

Question		Description
<b>5.11A</b>	How does your organization back up its data or systems?	
<b>5.11B</b>	How is data-access authorization assigned?	
<b>5.11C</b>	What type of physical security is in place, including fire protection and UPS?	
<b>5.11D</b>	Did your organization experience any unexpected or unplanned system downtime during the measurement year? If so, explain and describe how data integrity and completeness were validated.	
<b>5.11E</b>	Did your organization restore data from back-up files during the measurement year? If so, explain and describe how data integrity and completeness were validated.	
<b>5.11F</b>	Did your organization experience data loss during the measurement year? If so, explain and describe how data integrity and completeness were validated.	

**Table 5.12: Internal HEDIS repository, data warehouse or vendor HEDIS repository data processing systems.**

Question		Description
<b>5.12A</b>	How are data or systems backed up?	
<b>5.12B</b>	How is data-access authorization assigned?	
<b>5.12C</b>	What type of physical security is in place, including fire protection and UPS?	
<b>5.12D</b>	Did your organization experience any unexpected or unplanned system downtime during the measurement year? If so, explain and describe how data integrity and completeness were validated.	
<b>5.12E</b>	Did your organization restore data from back-up files during the measurement year? If so, explain and describe how data integrity and completeness were validated.	
<b>5.12F</b>	Did your organization experience data loss during the measurement year? If so, explain and describe how data integrity and completeness were validated.	

### Requested Supporting Documentation

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

Document	Details	Label
<b>Data integration flow chart</b>	Provide 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 P4P reporting.	<b>5.1</b>
<b>P4P repository file structure (if applicable)</b>	Provide a complete file structure, file format and field definitions for your P4Prepository.	<b>5.2</b>
<b>Vendor mapping documents (if using NCQA-certified software)</b>	Provide a mapping document of the organization's data elements to the NCQA-Certified Software's file structure	<b>5.3</b>
<b>Mapping of nonstandard codes (if applicable)</b>	If your organization uses nonstandard codes for producing measures, provide the mapping scheme used to translate codes to standard codes for reporting	<b>5.4</b>
<b>Source code development assignments (if non-certified source code is used)</b>	Provide a list of measures and the programmer assigned to its source code development.	<b>5.5</b>
<b>Disaster recovery or routine back-up processes</b>	Provide 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.	<b>5.6</b>

**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	_____