

Managed Care Organization

Reports Companion Guide

3/15/2013

South Carolina Dept of Health and Human Services

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MCO REPORTS TO SCDHHS

This reports companion guide is specifically designated for reporting formats that are required by the division of managed care. There are other agency required reports that are not specifically addressed within this guide. These reports include GME, FQHC, RHC, wrap encounter data, and Third Party Liability (TPL) reporting and are all examples of reports that the plans submit directly to other areas of SCDHHS. The requirements for these types of reports are contained within P&P if you have questions about reporting formats please contact your program manager and they will direct you to the correct area for follow up.

Model Attestation Letter

To be attached to all reports

(Company Letter Head)
Attestation for Reports

Date _____

I, _____, as (Title) for (Name of Company), do hereby attest, based upon my best knowledge, information and belief, that the data provided in the _____ Report(s) is accurate, true, and complete.

I understand that should SCDHHS determine the submitted information is inaccurate, untrue, or incomplete, (Name of company) may be subject to liquidated damages as outlined in Section 13.3 of the contract or sanctions and/or fines as outlined in Section 13 of the contract.

Signature/Title

Date

**New County or Validation of County Network
Frequency –As Needed (Please see section 2-11 of the P&P guide)**

NETWORK PROVIDER AND SUBCONTRACTOR LISTING SPREADSHEET		
SERVICE	STATUS	SCDHHS COMMENTS
ANCILLARY SERVICES:		
Ambulance Services	3	
Durable Medical Equipment	1	
Orthotics/Prosthetics	1	
Home Health	1	
Infusion Therapy**	1	Follow proximity guidelines for specialists
Laboratory/X-Ray	1	
Pharmacies*	1	Follow proximity guidelines for Primary Care Providers
Hospitals	1	Follow proximity guidelines for specialists
PRIMARY CARE PROVIDERS:		
Family/General Practice	1	
Internal Medicine	1	
RHC's/FQHC's	2	Not required but may be utilized as a PCP provider
Pediatrics	1	
OB/GYN	1	Serving as PCP for pregnant women, follow Proximity Guidelines for Primary Care Providers
SPECIALISTS		
Allergy/Immunology	1	
Anesthesiology	3	
Audiology	3	
Cardiology	1	
Chiropractic	3	
Dental	4	
Dermatology	1	
Emergency Medical	3	
Endocrinology and Metab	1	
Gastroenterology	1	
NETWORK PROVIDER AND SUBCONTRACTOR LISTING SPREADSHEET		

SERVICE		
SPECIALISTS		
Hematology/Oncology	1	
Infectious Diseases	1	
Licensed Independent Social Worker	1	
Licensed Professional Counselor	1	
Licensed Marriage & Family Therapist	1	
Neonatology	3	
Nephrology	1	
Neurology	1	
Nuclear Medicine	3	
OB/GYN	1	
Ophthalmology	1	
Optician	4	
Optometry	1	
Orthopedics	1	
Otorhinolaryngology	1	
Pathology	3	
Pediatrics, Allergy	3	
Pediatrics, Cardiology	3	
Podiatry	3	
Psychiatry (private)	1	
Psychologist	1	
Pulmonary Medicine	1	
Radiology, Diagnostic	3	
Radiology, Therapeutic	3	
Rheumatology	1	
Surgery - General	1	
Surgery - Thoracic	3	
Surgery - Cardiovascular	3	
Surgery - Colon and Rectal	3	
Surgery - Neurological	3	

NETWORK PROVIDER AND SUBCONTRACTOR LISTING SPREADSHEET

SERVICE		
SPECIALISTS		
Surgery - Pediatric	3	
Surgery - Plastic	3	
Urology	1	
Private Physical Therapy	1	
Private Speech Therapy	1	
Private Occupational Therapy	1	
Hospital Based Physical Therapy***	1	
Hospital Based Speech Therapy***	1	
Hospital Based Occupational Therapy***	1	
Long-Term Care	3	MCO responsibility begins once the Medicaid MCO Member has been approved for, and admitted to the LTC facility. If the Medicaid MCO Member stays in the facility for 90 consecutive days, the Medicaid MCO Member will be disenrolled from the MCO at the earliest opportunity by SCDHHS. The MCO financial responsibility will not exceed 120 days total.
Status	1 = Required 2 = Not required unless serving as PCP for the county 3 = Attestation 4 = Attest, if offered	
Proximity Guidelines		
*Primary Care Providers should be within a maximum of 30 miles of the Medicaid MCO Member's place of residence		
**Specialty Care Providers should be within a maximum of 50 miles of the Medicaid MCO Member's place of residence		
SCDHHS considers all the facts and circumstances in reviewing Subcontracts and networks. SCDHHS may grant exceptions to its' stated criteria on case-by-case basis.		
***Therapies are in-patient or out-patient based.		

New County or Validation of County Network Continued Frequency –As Needed (Please see section 2-11 of the P&P guide)

SERVICES	STATUS	NAME (or Attest) if no contract	GROUP OR PRACTICE NAME	STREET ADDRESS	ADDRESS 2	CITY	COUNTY	STATE	ZIP	TELEPHONE NUMBER(S)	MEDICAID #	ACCEPTING NEW CLIENTS Y/N	AGE LIMITS	DAYS OF OPERATION	HOURS OF OPERATION	CONTRACT DATES (START- END)
OB/GYN	1															
Ophthalmology	1															
Optician	4															
Optometry	1															
Orthopedics	1															
Otorhinolaryngology	1															
Pathology	3															
Pediatrics, Allergy	3															
Pediatrics, Cardiology	3															
Podiatry	3															
Psychiatry (private)	1															
Psychologists	1															
Pulmonary Medicine	1															
Radiology, Diagnostic	3															
Radiology, Therapeutic	3															
Rheumatology	1															
Surgery - General	1															
Surgery - Thoracic	3															
Surgery - Cardiovascular	3															
Surgery - Colon and Rectal	3															
Surgery - Neurological	3															
Surgery - Pediatric	3															
Surgery - Plastic	3															
Urology	1															
Private Physical Therapy	1															
Private Speech Therapy	1															
Private Occupational Therapy	1															
Hospital Based Physical Therapy ***	1															
Hospital Based Speech Therapy ***	1															
Hospital Based Occupational Therapy	1															
Long Term Care	3															
1 = Required																
2 = Not required unless serving as PCP for the county																
3 = Attestation																
4 = Attestation, if offered																
Attestation - The MCU attests that the service will be arranged and provided through any necessary means, including out-of-network providers																
*** Therapies are in-patient or out-patient based																

Network Provider and MCO Listing Spreadsheet Requirements

Frequency – Monthly

Provide the following information regarding all network physician providers:

1. Practitioner Last Name, First Name and Title - For types of service such as primary care providers and specialist, list the practitioner's name and practitioner title such as MD, NP (Nurse Practitioner), PA (Physician Assistant), etc.
2. Practice Name/Provider Name - Indicate the name of the provider. For practitioners indicate the professional association/group name, if applicable.
3. Street Address, City, County, State, Zip Code, Telephone Number of Practice/Provider
4. Office hours- the hours the physician is actually available to see the MCO Member (i.e. 8-5)
5. Days of Operation-state what day the physician is actually in the office. (i.e. Monday through –Friday or Tuesday and Thursday , or any variations etc)
6. License Number - Indicate the provider/practitioner license number, if appropriate.
7. NPI National Provider ID – Indicated the provider/practitioner's Medicaid provider number, if they are a Medicaid provider.
8. Restrictions - Indicate any restrictions or limitations of a provider's scope of service. For instance, for a physician who only sees patients up to age 18, indicate < 18; Should an OB/GYN not accept high risk patients, indicate this clearly in a short descriptive narrative.
9. County Served – Indicate which county or counties the provider serves. Do so by listing all alphabetically

On separate tabs to the spreadsheet, please provide listings of all 1) new 2) terminated and 3) Current network providers for the month. New providers are defined as those that are newly contracted in the first month of participation. Terminated providers are those who are no longer contracted in the month. The second month that the provider has been terminated they would no longer be reported on the file. Current providers are those that are ongoing and contracted any new providers in their second month of contracting would be reported on this tab. For these tabs, please provide the information requested in items 1-9 above.

Worksheet Tab 3- Current Network

Primary Care Physicians: Family/General Practice													
Last Name	First Name	License Number	Credential	Practice Name	Address	City	Zip	Phone Number	Provider County	Age Restrictions	Hospital Affiliation	Office Hours	Days Of Operation
Primary Care Physicians: Internal Medicine													
Last Name	First Name	License Number	Credential	Practice Name	Address	City	Zip	Phone Number	Provider County	Age Restrictions	Hospital Affiliation	Office Hours	Days Of Operation
Primary Care Physicians: Pediatrics													
Last Name	First Name	License Number	Credential	Practice Name	Address	City	Zip	Phone Number	Provider County	Age Restrictions	Hospital Affiliation	Office Hours	Days Of Operation

|

Provide the following information regarding all hospital providers:

1. Name – Hospital Name
2. Street Address, City, Zip Code, Telephone Number
3. County Served – Indicate which county or counties the provider serves. Do so by listing all alphabetically

On separate tabs to the spreadsheet, please provide listings of all 1) new 2) terminated and 3) Current network providers for the month. New providers are defined as those that are newly contracted in the first month of participation. Terminated providers are those who are no longer contracted in the month. The second month that the provider has been terminated they would no longer be reported on the file. Current providers are those that are ongoing and contracted any new providers in their second month of contracting would be reported on this tab. For these tabs, please provide the information requested in items 1-3 above.

Excel Spreadsheet Worksheet Tab 1- New Inpatient Services

Hospital					
Name	Address	City	Zip	Phone Number	Provider County
Hospital Pediatric Beds					
Name	Address	City	Zip	Phone Number	Provider County
Emergency Services and Emergency Services Facilities					
Name	Address	City	Zip	Phone Number	Provider County
Birth Delivery Facility/Hospital with birth delivery facilities					
Name	Address	City	Zip	Phone Number	Provider County
Birthing Center					
Name	Address	City	Zip	Phone Number	Provider County
RPICC					
Name	Address	City	Zip	Phone Number	Provider County
NICU Level 3					
Name	Address	City	Zip	Phone Number	Provider County

Excel Spreadsheet Worksheet Tab 2- Terminated Inpatient Services

Hospital					
Name	Address	City	Zip	Phone Number	Provider County
Hospital Pediatric Beds					
Name	Address	City	Zip	Phone Number	Provider County
Emergency Services and Emergency Services Facilities					
Name	Address	City	Zip	Phone Number	Provider County
Birth Delivery Facility/Hospital with birth delivery facilities					
Name	Address	City	Zip	Phone Number	Provider County
Birthing Center					
Name	Address	City	Zip	Phone Number	Provider County
RPICC					
Name	Address	City	Zip	Phone Number	Provider County
NICU Level 3					
Name	Address	City	Zip	Phone Number	Provider County

Excel Spreadsheet Worksheet Tab 3- Current Inpatient Services

Hospital					
Name	Address	City	Zip	Phone Number	Provider County
Hospital Pedatric Beds					
Name	Address	City	Zip	Phone Number	Provider County
Emergency Services and Emergency Services Facilities					
Name	Address	City	Zip	Phone Number	Provider County
Birth Delivery Facility/Hospital with birth delivery facilities					
Name	Address	City	Zip	Phone Number	Provider County
Birthing Center					
Name	Address	City	Zip	Phone Number	Provider County
RPICC					
Name	Address	City	Zip	Phone Number	Provider County
NICU Level 3					
Name	Address	City	Zip	Phone Number	Provider County

Provide the following information regarding all ancillary providers:

1. Provider Name – Name of provider
2. Street Address, City, Zip Code, Telephone Number
3. County Served – Indicate which county or counties the provider serves. Do so by listing all alphabetically

On separate tabs to the spreadsheet, please provide listings of all 1) new 2) terminated and 3) Current network providers for the month. New providers are defined as those that are newly contracted in the first month of participation. Terminated providers are those who are no longer contracted in the month. The second month that the provider has been terminated they would no longer be reported on the file. Current providers are those that are ongoing and contracted any new providers in their second month of contracting would be reported on this tab. For these tabs, please provide the information requested in items 1-3 above.

Excel Spreadsheet Tab 1- New Ancillary Providers

Durable Medical Equipment				
Provider Name	Address	Zip	Phone Number	Provider County
Home Health Services				
Provider Name	Address	Zip	Phone Number	Provider County
Laboratory Services				
Provider Name	Address	Zip	Phone Number	Provider County
Licensed Pharmacy/Pharmacist				
Provider Name	Address	Zip	Phone Number	Provider County
Portable X-ray Services				
Provider Name	Address	Zip	Phone Number	Provider County
Freestanding Dialysis Center				
Provider Name	Address	Zip	Phone Number	Provider County
Dental Services				
Provider Name	Address	Zip	Phone Number	Provider County
Hearing Services				
Provider Name	Address	Zip	Phone Number	Provider County
Vision Services				
Provider Name	Address	Zip	Phone Number	Provider County
Transportation				
Provider Name	Address	Zip	Phone Number	Provider County
School-based Services (In counties in which school-based services exist)				
School Name	Address	Zip	Phone Number	Provider County
County Public Health Departments				
Provider Name	Address	Zip	Phone Number	Provider County

Excel Spreadsheet Tab 2- Terminated Ancillary Providers

Durable Medical Equipment				
Provider Name	Address	Zip	Phone Number	Provider County
Home Health Services				
Provider Name	Address	Zip	Phone Number	Provider County
Laboratory Services				
Provider Name	Address	Zip	Phone Number	Provider County
Licensed Pharmacy/Pharmacist				
Provider Name	Address	Zip	Phone Number	Provider County
Portable X-ray Services				
Provider Name	Address	Zip	Phone Number	Provider County
Freestanding Dialysis Center				
Provider Name	Address	Zip	Phone Number	Provider County
Dental Services				
Provider Name	Address	Zip	Phone Number	Provider County
Hearing Services				
Provider Name	Address	Zip	Phone Number	Provider County
Vision Services				
Provider Name	Address	Zip	Phone Number	Provider County
Transportation				
Provider Name	Address	Zip	Phone Number	Provider County
School-based Services (In counties in which school-based services exist)				
School Name	Address	Zip	Phone Number	Provider County
County Public Health Departments				
Provider Name	Address	Zip	Phone Number	Provider County

Excel Spreadsheet Tab 3- Current Ancillary Providers

Durable Medical Equipment				
Provider Name	Address	Zip	Phone Number	Provider County
Home Health Services				
Provider Name	Address	Zip	Phone Number	Provider County
Laboratory Services				
Provider Name	Address	Zip	Phone Number	Provider County
Licensed Pharmacy/Pharmacist				
Provider Name	Address	Zip	Phone Number	Provider County
Portable X-ray Services				
Provider Name	Address	Zip	Phone Number	Provider County
Freestanding Dialysis Center				
Provider Name	Address	Zip	Phone Number	Provider County
Dental Services				
Provider Name	Address	Zip	Phone Number	Provider County
Hearing Services				
Provider Name	Address	Zip	Phone Number	Provider County
Vision Services				
Provider Name	Address	Zip	Phone Number	Provider County
Transportation				
Provider Name	Address	Zip	Phone Number	Provider County
School-based Services (In counties in which school-based services exist)				
School Name	Address	Zip	Phone Number	Provider County
County Public Health Departments				
Provider Name	Address	Zip	Phone Number	Provider County

Subcontract Update Report

Frequency: Monthly (Please see section 2-8 of the P&P guide for explanation)

1. **Original Date of Contract: The date of the original executed contract.**
2. **Name of Contract: Name of the Contract**
3. **Address: Primary address of subcontractor**
4. **City: City of subcontractor**
5. **County: Counties the subcontractor services**
6. **Date Mailed: Mailing date to subcontractor.**
7. **Status: Please indicate if the contract is complete or incomplete**
8. **Comments: Next steps to complete process with the subcontractor.**
9. **Completed or Signed: Date that the contract was executed between contractor and subcontractor.**

Worksheet Tab 1- 2011

Original Date of Contract	Name of Contract	Address	City	County	Date Mailed	Status	Comments	Completed or Signed

Worksheet Tab 2- 2012

Original Date of Contract	Name of Contract	Address	City	County	Date Mailed	Status	Comments	Completed or Signed

Worksheet Tab 3- 2013

Original Date of Contract	Name of Contract	Address	City	County	Date Mailed	Status	Comments	Completed or Signed

Worksheet Tab 4- 2014

Original Date of Contract	Name of Contract	Address	City	County	Date Mailed	Status	Comments	Completed or Signed

Worksheet Tab 5- 2015

Adjustment Maternity Kicker Notification Payment Log Definitions

Frequency: As Needed

SCDHHS automated the maternity kicker process in 2010. If the MCO finds that a maternity kicker has not been processed through automated adjustments within the fourth month after the birth (birth month is month one) then the MCO must submit the form below to their program manager. After the fourth month the MCO shall submit any maternity kickers that they are seeking manual adjustments for within six months of the child's birth. SCDHHS at its discretion may consider circumstances beyond this timeframe. Stillborn births do not require a waiting period to be reported since no Medicaid ID number is assigned to a stillborn. The baby must be alive at the time of birth to be Medicaid eligible. Indicate with an "X" for multiple births. Otherwise, do not fill in this column.

Count: Numerical count of lines reported - 1, 2, 3....

Newborns Date of Birth: date of birth of newborn format – 00/00/00

Mother's Last Name: Add the mothers last name

Mother's First Name: Add the mother first name

Mother's Medicaid ID Number: Mother's Medicaid ID number – 10 digits

Newborn's Last Name: Add the newborn's last name. If name is not known, use "Baby Boy" or "Baby Girl"

Newborn's First Name: Add the newborn's first name. Not applicable if name is not known

Newborn's Sex: Use M for male, F for female

Multiple Births: Please place an "X" in this column for any multiple birth situations. Regardless of how many births you will only be reimbursed for one maternity kicker.

* These columns reserved for SCDHHS use

Adjustment Maternity Kicker Payment Notification Log

Frequency – Monthly

MCO Name (MCO Number)											
Maternity Kicker Payment Notification Log											
Date (Unpaid Through Date)											
		Mother's Information			Newborn's Information				Reserved for SCDHHS use		
Count	Newborn's DOB (mm/dd/yy)	Last Name	First Name	Mother's Medicaid ID	Last Name	First Name	Child's Medicaid ID	NB Sex (M/F)	Multiple Birth? (X=Yes)	Y/N	\$ amt
									Total		\$0.00
Stillborn Deliveries Below This Line											

Appeals Log with Summary Information

Collected Monthly, Reported Quarterly

For each appeal, utilize the following to report information:

Month/Year: Indicate reporting month and year.

Date Filed: Enter the exact month, day and year the appeal was received by the MCO.

Member Name and Number: Indicate the member's name and the member's Medicaid number. These should be listed exactly as they appear on the member listing report supplied to the MCO by SCDHHS.

Summary of Appeal: Give a brief description of the member's appeal. Include enough information to provide SCDHHS with an understanding of the member's appeal.

Current Status: Indicate the current status of the appeal at the time of reporting; i.e., number of contacts with the member, what actions have been taken to resolve the matter, etc..

Resolution/Response Given: Indicate the resolution, the response given to the member., Include enough information to provide SCDHHS with an understanding of how the appeal was resolved. . If the grievance is pharmaceutical in nature, please provide the name of the medication and the date the prescription was filled by the member.

Resulting Corrective Action: Specify any corrective actions being taken by the MCO as a result of the appeal.

Date of Resolution: The date the resolution was achieved.

Plan Name (Medicaid Number)

Appeals Log

Month/Year: _

Date Filed	Member Name	Member Number	Summary of Appeal	Current Status	Resolution/Response Given	Resulting Corrective Action	Date of Resolution

Capitation Rate Calculation Sheet (CRCS) – Composite

Frequency – Quarterly

MCO Name: MCO						
Quarterly Reporting Period: MM/DD/YYYY- MM/DD/YYYY						
Region: Statewide						
Rate Category: Composite						
Member Months In The Reporting Quarter: XXXX	0					
		A	B	C	D	E
Category of Service	Units	# of Units	Amount Paid	Annual Utilization per 1,000	Cost per Unit	Service Cost PMPM
<i>Inpatient Hospital</i>						
I/P Medical/Surgical/Non-Delivery Maternity	Days	-	\$ - -		\$ -	\$ -
I/P Well Newborn	Days	-	\$ - -		\$ -	\$ -
Mental Health / Substance Abuse	Days	-	\$ - -		\$ -	\$ -
Other Inpatient	Days	-	\$ - -		\$ -	\$ -
<i>Outpatient Hospital</i>						

Surgical (Type 1)	Encounters	-	\$	-	-	\$	-	\$	-
Non-Surgical Emergency Room (Type 5)	Encounters	-	\$	-	-	\$	-	\$	-
Non-Surgical-All Other (Type 5)	Encounters	-	\$	-	-	\$	-	\$	-
Observation Room (Type 1 and Type 5)	Encounters	-	\$	-	-	\$	-	\$	-
Treatment/Therapy/Testing (Type 4)	Encounters	-	\$	-	-	\$	-	\$	-
All Other Outpatient	Encounters	-	\$	-	-	\$	-	\$	-
Pharmacy									
Prescription Drugs	Scripts	-	\$	-	-	\$	-	\$	-
Ancillaries									
Ambulance	Runs	-	\$	-	-	\$	-	\$	-
Prosthetic/DME	Units	-	\$	-	-	\$	-	\$	-
Other Ancillaries	Units	-	\$	-	-	\$	-	\$	-
Physician									
Surgery - I/P and O/P	Procedures	-	\$	-	-	\$	-	\$	-
Surgery - I/P and O/P - Anesthesia	Procedures	-	\$	-	-	\$	-	\$	-
Maternity – Non-Delivery	Cases	-	\$	-	-	\$	-	\$	-
Hospital Visits	Visits	-	\$	-	-	\$	-	\$	-
Office Visits	Visits	-	\$	-	-	\$	-	\$	-
Hospital Inpatient Visits	Visits	-	\$	-	-	\$	-	\$	-

Immunizations	Services	-	\$	-	-	\$	-	\$	-
Radiology	Procedures	-	\$	-	-	\$	-	\$	-
Pathology	Procedures	-	\$	-	-	\$	-	\$	-
Mental Health / Substance Abuse	Visits	-	\$	-	-	\$	-	\$	-
Other Professional	Procedures	-	\$	-	-	\$	-	\$	-
SUM OF COVERED SERVICES		-	\$	-	-	\$	-	\$	-

Capitation Rate Calculation Sheet (CRCS) – Maternity

Frequency – July 15, January 15, June 14, October 12

MCO Name: MCO						
Quarterly Reporting Period: MM/DD/YYYY - MM/DD/YYYY						
Region: Statewide						
Rate Category: Maternity						
Number of Deliveries for the Reporting Quarter:	0					
		A	B	C	D	E
Category of Service	Units	# of Units	Amount Paid	Annual Utilization per Delivery	Cost per Unit	Service Cost per Delivery
<i>Inpatient Hospital</i>						
Inpatient Maternity Delivery	Days	-	\$ -	-	\$ -	\$ -
<i>Outpatient Hospital</i>						
Outpatient Hospital - Maternity	Cases	-	\$ -	-	\$ -	\$ -
<i>Physician</i>						
Maternity – Delivery	Cases	-	\$ -	-	\$ -	\$ -
Maternity – Delivery - Anesthesia	Procedures	-	\$ -	-	\$ -	\$ -

SUM OF COVERED SERVICES		-	\$	-	-	\$	-	\$	-
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Capitation Rate Calculation Sheet – Data Element Summary

MCO Name: Plan Name

Quarterly Reporting Period: Identify the beginning and ending period for the submitted report. The reporting period is on an incurred date of service basis without adjustment for completion factors.

Region: Statewide

Rate Category: Separate Reports for each Capitation Rate Category

Member Months or Deliveries: This field represents the number of member months or deliveries for the reporting period.

of Units (Column A): This field represents the total number of units allowed from the health plan paid claim experience. The definition of units has been defined in the “Units” Column.

Amount Paid (Column B): This field represents the net amount paid for the service.

Annual Utilization per 1,000 (Column C): This is a calculated field using the following formula:

$$(\text{Column A} \div \text{Member Months}) \times 12 \times 1,000$$

Utilization per Delivery (Column C): This is a calculated field using the following formula:

$$(\text{Column A} \div \text{Deliveries}) \times 1,000$$

Cost per Unit (Column D): This is a calculated field using the formula: $(\text{Column B} \div \text{Column A})$

Service Cost PMPM or Per Delivery (Column E): This is a calculated field using one of the following formulas:

If Non-Maternity = $\text{Column B} \div \text{Member Months}$, or,

If Maternity = $\text{Column B} \div \text{Number of Deliveries}$

CRCS Capitation Rate Calculation Sheet

Category of Service	Medicare DRGs	Other Information	Unit Measure
<i>Inpatient Hospital</i>			
IP Medical/Surgical/Non - Delivery Maternity	0001-0003, 0006-0019, 0021-0023, 0026-0106, 0108, 0110-0111, 0113-0114, 0117-0147, 0149-0153, 0155-0208, 0210-0213, 0216-0220, 0223-0230, 0232-0369, 0376-0377, 0385-0390, 0392-0399, 0401-0414, 0417-0424, 0439-0455, 0461-0468, 0471, 0473, 0476-0477, 0479-0482, 0484-0513, 0515, 0518-0520, 0524-0525, 0528-0579		Days
IP Well Newborn	0391		Days
Mental Health / Substance Abuse	0425 – 0433, 0521-0523		Days
Other Inpatient	0004-0005, 0020, 0024-0025, 0107, 0109, 0112, 0115-0116, 0148, 0154, 0209, 0214-0215, 0221-0222, 0231, 0400, 0415-0416, 0434-0438, 0456-0460, 0469-0470, 0472, 0474-0475, 0478, 0483, 0514, 0516-0517, 0526-0527	Any services provided by Inpatient Hospital Providers and not assigned by DRG methodology.	Days

			Unit Measure
<i>Outpatient Hospital</i>			
			Claims
			Claims
			Units
			Units
			Units

Type of Service	FFS Methodology and Revenue Codes	Unit Measure
-----------------	-----------------------------------	--------------

Outpatient Hospital			
-Surgical (Type 1) -Non-Surgical Emergency Room (Type 5) -Non-Surgical – All Other (Type 5) -Observation Room (Type 1 and Type 5) - Treatment/Therapy/Testing (Type 4) -All Other Outpatient	The Fee for Service methodology and revenue codes for the types of service can be found in the SCDHHS Hospital Provider Manual, Section 4, Billing Codes- http://www.scdhhs.gov/internet/pdf/manuals/Hospital/SECTION %204.pdf Pages 4-1 to 4-18. For this section, Encounter = Visit		Encounters Encounters Encounters Encounters Encounters Encounters
Type of Service	CPT – 4 / HCPCS Code	Other Information	Unit Measure
Pharmacy			
Prescription Drugs	All Prescription Drugs Dispensed		Line Items
Ancillaries			
Ambulance	A0001-A0999, Q3019-Q3020, S0207-S0215	*Note: Removed provider logic	Line Items
Prosthetic/DME	A4206-A4265, A4270-A4640, A4648-A8004, A9155, A9274-A9284, A9900-A9999, B4000-B9999, D5985-D5988, E0100-E9999, J7602-J7799, K0000-K0899, L0100-L9999, Q0480-Q0505, Q1001-Q1005, Q4001-Q4051, Q4093-Q4094, S0142-S0143, S0515, S1015-S1016, S1030-S1031, S1040, S5560-S5571, S8095-S8101, S8120-S8490, S8999-S9007, S9061, V2600-V2632, V2788, V5335-V5336 *Note: moved S8004 to Other Professional	*Note: Removed provider logic	Units
Other Ancillaries	92325-92326, 92340-92342, 92370, 92390-92392, 92396, 99500-99602, G0151-G0156, Q5001, S0270-S0274, S0345-S0347, S0500-S0514, S0516-S0590, S0595, S5035-S5036, S5108-S5116, S5180-S5181, S5497-S5523, S9097-S9098, S9122-S9131, S9208-S9590, S9810, V2020-V2599, V2700-V2787, V5011-V5298	*Note: Removed provider logic	Units

Type of Service	CPT – 4 / HCPCS Code	Other Information	Unit Measure
Physician			
Surgery - I/P and O/P	10000-36410, 36420-58999, 59525, 60000-69999, 92973-92974, 92980-92998, 93501-93533, 93561-93581	Excludes anesthesiologist services.	Units
Surgery - I/P and O/P - Anesthesia	00100-00849, 00851-00856, 00858-00945, 00947-00954, 00956-01959, 01962-01966, 01969-01999, 99100, 99116, 99135, 99140, 99143-99145, 99148-99150	Or surgery services provided by an anesthesiologist as identified by a modifier. *Note: Removed provider logic	Line Items
ER Visits	99281-99288		Units
Hospital Visits	90816-90829, 99217-99239, 99289-99316, 99356-99357, 99431, 99433-99440, 99460, 99462-99480, G0263-G0264, G0390, S0310		Units
Office Visits	98966-98969, 99050-99060, 99201-99215, 99321-99355, 99358-99359, 99361-99380, 99441-99444, 99499, G0179-G0182, G0337, S0220-S0260, S9083, S9088 *Note: moved 99024 to Other Professional, 99281-99288 to ER		Units
Immunizations	90465-90749, G0008-G0010, J3530, S0195		Units
Radiology	70000-79999, R0070-R0076		Units
Pathology	80000-89999, P2028-P2038, P3000-P3001, P7001		Units
Mental Health/ Substance Abuse	90801-90815, 90845-90899		Units
Other Professional Services		Any services provided by Professional Providers and not assigned by CPT-4 HCPCS methodology. *Note: Removed provider logic	Units

Type of Service	CPT – 4 / HCPCS Code	Other Information	Unit Measure
Physician			
Maternity – Non-Delivery	59000-59399, 59425-59426, 59428, 59430, 59812-59899 *Note: moved 59412, 59414 to delivery		Units

Category of Service	Medicare DRGs	Other Information	Unit Measure
Inpatient Hospital			
Inpatient Maternity Delivery	0370-0375, 0378-0384		Days

Type of Service	Revenue Code	Other Information	Unit Measure
Outpatient Hospital			
Outpatient Hospital Maternity	Hospital Outpatient providers with a primary diagnosis code of v27.0 – v27.9, 650, and 651.01 - 669.92 (with the 5th digit being 1 or 2)		Claims

Type of Service	CPT – 4 / HCPCS Code	Other Information	Unit Measure
Physician			
Maternity – Delivery	59400, 59409-59410, 59412, 59414, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622	*Note: Removed provider logic	Claims
Maternity – Delivery - Anesthesia	00850, 00857, 00946, 00955, 01960-01961, 01967-01968	Or delivery services provided by an anesthesiologist as identified by a modifier. *Note: Removed provider logic	Line Items

October 5, 2012

Mr. Timothy Hartnett
Department of Health and Human Services
State of South Carolina
P.O. Box 8206
1801 Main Street
Columbia, SC 29202-8206

RE: CRCS REPORTING METHODOLOGY DOCUMENTATION – UPDATED (V4)

Dear Tim:

Milliman, Inc. (Milliman) has been retained by the South Carolina Department of Health and Human Services (SCDHHS) to provide actuarial and consulting services related to the Medicaid managed care program. Milliman was requested to assist in the development of an encounter monitoring report that was utilized in the contract between SCDHHS and the managed care organizations. **This letter defines the CRCS category grouping methodology for the CRCS reports beginning with the second incurred quarter of calendar year 2012, and replaces the correspondence dated September 27, 2010 and updated June 18, 2012. The modifications reflect updates to the coding methodology for the CRCS process and review.**

LIMITATIONS

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and SCDHHS approved July 1, 2012.

The information contained in this correspondence, including any enclosures, has been prepared for the SCDHHS, and its consultants and advisors. It is our understanding that a copy of this letter with the enclosures may be shared with the MCOs. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for SCDHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

In performing this analysis, we relied on data and other information provided by SCDHHS and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

REPORTING MODIFICATIONS AND CLARIFICATIONS

The CRCS reporting template has been revised from the version presented in our September 27, 2010 correspondence. The Outpatient Hospital categories are based on the fee-for-service reimbursement methodology, and are defined explicitly in Enclosure 1.

The following updates will be reflected effective with the second quarter 2012 CRCS reporting period:

- Revenue codes 170 and 171 will be included in the Treatment/Therapy/Testing category for outpatient hospital
- CPT codes 99460 and 99462 will be included in the Physician Hospital Visit category

Enclosure 1 identifies the unit count basis for each category of service. Depending upon the category of service, unit counts were determined as: (1) a unit count of one for the entire claim, (2) a unit count of one for each of the line items within a claim or (3) the number of units listed on each line item.

The following documentation details additional clarifications regarding several of the CRCS reporting requirements. This information is repeated from previous correspondence and has not been materially changed. Changes were made to sections (c) (Maternity Delivery Counts), (d) (Zero Day Length of Stay), and (e) (Zero Dollar Paid Amounts and Sub-capitated Amounts). Sections (f) (Outpatient Hospital Claim Category Hierarchy), (g) (APR DRG Inpatient Hospital Category Groupings), and (h) (Reporting Period) are new with this correspondence.

a. Rate Cell Assignment

The assignment of rate cells corresponds with the financial models developed for the capitation rate setting. It appears that several of the health plans may not be assigning newborns into the appropriate rate cells. The following provides further clarification.

Babies are assigned to a rate cell based on their month of birth. For example, a baby born anytime in April 2010 will be assigned to:

- The 0 – 2 month rate cell in April, May and June 2010
- The 3 – 12 month rate cell in July through December 2010 and January through April 2011
- The 1 – 6 year rate cell starting in May 2011
- The 7 – 13 rate cell starting in May 2017

For the older age rate cells, age is determined as the age at the beginning of the month. In this example, the child remains in rate cell 1 – 6 years during their birthday month of turning 7 unless their birthday is on the first day of the month.

b. Provider Type

The initial category of service definition included identification of provider types. It appears from our initial review that provider types are not consistent among the health plans. At this time, we are removing

provider type from the category of service definition. This may be modified over time as this component is clarified.

c. Maternity Delivery Counts

The maternity delivery summary workbook illustrates hospital inpatient maternity services only for delivery inpatient DRGs consistent with costs used to develop the maternity kick payment. The Medicare DRGs for the delivery admissions include 370, 371, 372, and 375. The APR DRGs for the delivery admissions include 540, 541, 542, and 560.

d. Zero Day Length of Stay

In the summarization of the encounter data, Milliman identified several inpatient hospital claims with date of admission equal to date of discharge corresponding to a zero day length of stay. Several of these claims do not have a room and board revenue code (0100 – 0219). For claims which do have room and board revenue codes, we summarize the units from these lines of the claim and assign the total for each claim as days. All other hospital claims are classified as outpatient hospital.

e. Zero Dollar Paid Amounts and Sub-capitated Claims

Milliman identifies sub-capitated encounter claims as those with a reimbursement indicator type of “C”. These claims should be populated by the plans with a proxy paid amount. This proxy may be a reasonable estimation calculated by the plan or a default fee-for-service fee schedule amount. Currently, we assign service category average unit cost to units associated with these claims. We will continue to review encounter data for consistent plan submissions of these amounts, and when the data becomes credible we will use the proxy amounts in the CRCS reporting process.

We will exclude units for all other claims with zero dollar paid amounts in the encounter data.

f. Outpatient hospital claim category hierarchy

We participated in a series of conference calls with SCDHHS and each of the individual health plans to provide and receive feedback related to the CRCS reporting process. The calls facilitated an open discussion between Milliman and the health plans regarding the individual health plan’s current performance in the CRCS reports. The calls also provided an opportunity for both Milliman and the health plans to pose and answer specific questions regarding the process.

The following identifies the update to the CRCS reporting process for outpatient claims.

- The revised methodology assigns all outpatient hospital claims to a subcategory based on the hierarchy below. This is consistent with the methodology applied for Outpatient Surgery and Outpatient Emergency Room claims. The following hierarchy applies to each claim.
 1. Outpatient Surgery
 2. Outpatient Emergency Room
 3. Treatment, Therapy and Testing
 4. Non-surgery Other
 5. Observation Room
 6. Other Outpatient
- The hierarchy assigns an entire claim to a single subcategory following testing of associated UB-92 revenue codes on the claim.

The table below shows the difference between the utilization per thousand and per member per month (PMPM) values for the outpatient claims incurred during the first quarter of 2011 for each methodology:

Category of Service	Old Methodology		New Methodology	
	Annual Utilization per 1,000	Service Cost PMPM	Annual Utilization per 1,000	Service Cost PMPM
Surgery	75.8	\$ 9.81	75.8	\$ 9.81
Non-Surg – Emergency Room	738.1	17.66	738.1	17.66
Non-Surg – Other	218.6	1.33	210.3	1.25
Observation Room	22.8	0.04	2.0	0.02
Treatment/Therapy/Testing	650.7	11.61	726.1	14.08
Other Outpatient	51.2	2.56	5.0	0.19
Sum of Covered Services	1,757.2	\$ 43.01	1,757.2	\$ 43.01

The new methodology does not change the overall annual utilization or service cost PMPMs, however it does change the allocation of these measures by detailed service category within the outpatient services group.

g. APR DRG Inpatient Hospital Category Groupings

SCDHHS is converting their inpatient hospital payment structure to use APR DRGs for reimbursement. Enclosure 1 contains a list of this version of DRGs by service category.

h. Reporting Period

The CRCS data reporting periods will be on a cumulative year-to-date basis instead of the previously utilized quarter by quarter methodology. For example, the fourth quarter of calendar year 2012 will be incurred claims and membership information for the entire calendar year.

CODING DOCUMENTATION

We were requested to provide documentation of the SAS coding logic which will be applied to future CRCS submissions. The following describes the layout of the CRCS report encounter data processing logic presented in the enclosures.

- Enclosure 2: Processes hospital service claims for CRCS report categories.
- Enclosure 3: Processes professional service claims for CRCS report categories.
- Enclosure 4: Processes pharmacy service claims for CRCS report categories.
- Enclosure 5: Maps appropriate units to CRCS report categories.



Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this report.

If you have any questions regarding the enclosed information, please do not hesitate to contact me at (317) 524-3512.

Sincerely,

Robert M. Damler, FSA, MAAA
Principal and Consulting Actuary

RMD/lrb
Enclosures

ENCLOSURE 1

Category of Service	Medicare DRGs	APR DRGs	Unit Measure
<i>Inpatient Hospital</i>			
IP Medical/Surgical/ Non-Delivery Maternity	001-369, 376-384, 385-390, 0392-0424, 0439-0468, 0471-0520, 0524-0579	001-532, 543-546, 561-625, 630-639, 650-724, 790-912, 930-931	Days
IP Well Newborn	0391	626, 640	Days
Mental Health / Substance Abuse	0425-0438, 0521-0523	740-776	Days
Other Inpatient	0469-0470	950-999	Days

**Note: all claims containing a room and board revenue code (0100-0219) and not containing a DRG listed above are grouped into the Other Inpatient service category.*

Type of Service	Revenue Code	Other Information	Unit Measure
<i>Outpatient Hospital</i>			
Surgery	360-369, 490-499, 790-799, 975		Claims
Non-Surg – Emergency Room	450-451, 981		Claims
Treatment/Therapy/Testing	170-171, 258, 260-261, 300-302*, 304-312*, 314*, 319-324*, 329-330*, 331-332, 333*, 335, 340-343*, 349-352*, 359*, 380-387, 390-391, 400-403*, 410, 412-413, 419-420, 424, 430, 434, 440, 444, 459, 460, 469, 470-472, 479-483, 489, 610-612*, 614-616*, 618-619*, 634-636*, 721, 730-732, 739-740, 749-750, 759, 820-821, 830-831, 840-841, 850-851, 900-901, 910, 914-916, 918, 920-922, 923*, 924, 929, 940, 943	Revenue codes or code ranges marked with a * require the claim to contain a valid HCPCS or CPT-4 procedure code on the claim line	Claims
Observation Room	762, 769		Claims
Non-Surg – Other	510-519, 761		Claims
Other Outpatient		Any services provided by Outpatient Hospital Providers and not assigned by Revenue Code methodology.	Claims

Type of Service	CPT – 4 / HCPCS Code	Other Information	Unit Measure
Pharmacy			
Prescription Drugs	All Prescription Drugs Dispensed		Line Items
Ancillaries			
Ambulance	A0021, A0225-A0999, Q3019-Q3020, S0207-S0215		Line Items
Prosthetic/DME	99070, A4206-A4259, A4262-A4265, A4270-A4640, A4648-A8004, A9155, A9273-A9279, A9283-A9284, A9900-A9999, B4034-B9999, C9351, C9365-C9367, E0100-E8002, K0001-K0899, L0112-L9900, Q0478-Q0506, Q1003-Q1005, Q4001-Q4051, Q4093-Q4094, Q4100-Q4121, S0515, S1015-S1040, S5560-S5571, S8096-S8101, S8120-S8490, S8999-S9007, S9061, T4521-T4543, V2600-V2632, V2788, V5336		Units
Other Ancillaries	92325-92342, 92370, 99500-99602, G0151-G0164, Q5001-Q5010, S0270-S0272, S0345-S0347, S0500-S0514, S0516-S0590, S0595, S5035-S5036, S5100- S5181, S5497-S5523, S9097-S9098, S9122-S9131, S9208-S9381, S9490-S9504, S9537-S9810, V2020-V2599, V2600-V2615, V2700-V2784, V2786-V2787, V5011-V5298		Units

Type of Service	CPT-4 / HCPCS Code	Other Information	Unit Measure
Physician			
Surgery - I/P and O/P	10000-36410, 36420-55920, 56405-58301, 58340-58960, 58999, 59525, 60000-69020, 69100-69990, 92973-92974, 92980-92998, 93451-93462, 93501-93533, 93580-93581, G0127, G0168-G0173, G0251, G0259-G0260, G0267, G0269, G0289-G0291, G0297-G0305, G0339-G0343, G0364, G0392-G0393, G0412-G0419, G0440-G0441, M0301, S0400, S0601, S2053-S2118, S2135-S2152, S2205-S2235, S2270-S2900, S9034	Excludes anesthesiologist services.	Units
Surgery - I/P and O/P - Anesthesia	00100-00840, 00844-01953, 01962-01963, 01969-01999, 99100-99150	Or surgery services provided by an anesthesiologist as identified by a modifier.	Line Items
ER Visits	99217-99220, 99224-99226, 99234-99236, 99281-99288, G0378-G0384		Units
Hospital Visits	90816-90829, 99221-99223, 99231-99233, 99238-99239, 99289-99318, 99356-99357, 99436-99440, 99460, 99462, 99464-99476, 99478-99480 G0390, S0310		Units
Office Visits	98966-98969, 99201-99215, 99324-99355, 99358-99359, 99361-99362,		Units

	99366-99380, 99441-99444, 99499, G0179-G0182, G0337, S0220-S0260, S0273-S0274		
Immunizations	90460-90749, G0008-G0010, G0377, G9141-G9142, J3530, Q2035-Q2039, S0195		Units
Radiology	70000-79999, G0130, G0202-G0235, G0252, G0275-G0278, G0288, G0389, Q0092, R0070-R0076, S8030-S8037, S8042-S8092, S9024		Units
Pathology	36415-36416, 80000-89999, G0027, G0103, G0123-G0124, G0141-G0148, G0265-G0266, G0306-G0307, G0328, G0394, G0430-G0435, G9143, P2028-P7001, Q0091, Q0111-Q0115, Q3031, S2120, S3600-S3890, S9529		Units

Type of Service	CPT – 4 / HCPCS Code	Other Information	Unit Measure
Physician			
Mental Health/ Substance Abuse	90801-90815, 90845-90899, 99408-99409, G0176-G0177, G0396-G0397, G0409-G0411, H0001-H0040, H0046-H0050, H2000-H2013, H2015-H2022, H2027, H2033-H2037, M0064, S3005, S9475, S9480-S9485		Units
Maternity – Non-Delivery	59000-59350, 59425-59430, 59812-59866, 59870-59899		Units
Other Professional Services		Any services provided by professional providers and not assigned by CPT-4 HCPCS methodology.	Units

Delivery Kick Payment Codes

Category of Service	Medicare DRGs	APR DRGs	Unit Measure
<i>Inpatient Hospital</i>			
Inpatient Maternity Delivery	0370-0375	540, 541, 542, 560	Days

Type of Service	Revenue Code	Other Information	Unit Measure
<i>Outpatient Hospital</i>			
Outpatient Hospital Maternity	Hospital Outpatient providers with a primary diagnosis code of v27.0 – v27.9, 650, and 651.01 - 669.92 (with the 5th digit being 1 or 2)		Claims

Type of Service	CPT – 4 / HCPCS Code	Other Information	Unit Measure
<i>Physician</i>			
Maternity – Delivery	59400-59414, 59510-59515, 59610-59622		Claims
Maternity – Delivery - Anesthesia	00842, 01958-01961, 01965-01968	Or delivery services provided by an anesthesiologist as identified by a modifier.	Line Items

ENCLOSURE 2

*drg codes will map CRCS groups for inpatient data;
*updated to APR-DRGs by JMN 11/16/11;

proc format;

invalue \$aprdrg

'001'-'006' = 'IP-Med/Surg'
'020'-'026' = 'IP-Med/Surg'
'040'-'058' = 'IP-Med/Surg'
'070'-'073' = 'IP-Med/Surg'
'080'-'082' = 'IP-Med/Surg'
'089'-'098' = 'IP-Med/Surg'
'110'-'115' = 'IP-Med/Surg'
'120'-'122' = 'IP-Med/Surg'
'130'-'144' = 'IP-Med/Surg'
'160'-'180' = 'IP-Med/Surg'
'190'-'207' = 'IP-Med/Surg'
'220'-'229' = 'IP-Med/Surg'
'240'-'254' = 'IP-Med/Surg'
'260'-'264' = 'IP-Med/Surg'
'279'-'284' = 'IP-Med/Surg'
'300'-'321' = 'IP-Med/Surg'
'340'-'351' = 'IP-Med/Surg'
'360'-'364' = 'IP-Med/Surg'
'380'-'385' = 'IP-Med/Surg'
'400'-'405' = 'IP-Med/Surg'
'420'-'425' = 'IP-Med/Surg'
'440'-'447' = 'IP-Med/Surg'
'460'-'468' = 'IP-Med/Surg'
'480'-'484' = 'IP-Med/Surg'
'500'-'501' = 'IP-Med/Surg'
'510'-'519' = 'IP-Med/Surg'
'530'-'532' = 'IP-Med/Surg'
'543'-'546' = 'IP-Med/Surg'
'561'-'566' = 'IP-Med/Surg'
'580'-'583' = 'IP-Med/Surg'
'588'-'593' = 'IP-Med/Surg'
'600'-'603' = 'IP-Med/Surg'
'607'-'614' = 'IP-Med/Surg'
'620'-'625' = 'IP-Med/Surg'
'630'-'639' = 'IP-Med/Surg'
'650'-'651' = 'IP-Med/Surg'
'660'-'664' = 'IP-Med/Surg'
'680'-'683' = 'IP-Med/Surg'
'690'-'694' = 'IP-Med/Surg'
'710'-'711' = 'IP-Med/Surg'
'720'-'724' = 'IP-Med/Surg'
'790'-'792' = 'IP-Med/Surg'
'810'-'816' = 'IP-Med/Surg'
'830'-'833' = 'IP-Med/Surg'
'840'-'844' = 'IP-Med/Surg'

'850' = 'IP-Med/Surg'
'860'-'863' = 'IP-Med/Surg'
'870'-'873' = 'IP-Med/Surg'
'890'-'894' = 'IP-Med/Surg'
'910'-'912' = 'IP-Med/Surg'
'930'-'931' = 'IP-Med/Surg'
'626' = 'IP-WellNB'
'640' = 'IP-WellNB'
'740' = 'IP-MH/SA'
'750'-'760' = 'IP-MH/SA'
'770'-'776' = 'IP-MH/SA'
'950'-'952' = 'IP-Other'
'955'-'956' = 'IP-Other'
'540'-'542' = 'IP-Del'
'560' = 'IP-Del'
'999' = 'IP-Other'

other='ZZZ'

;

*5/18/10 - JLC

updated 9/17/10 to modify TTT logic;

*source: S:\SCM\SCM23\code groupings.xlsx;

*revenue codes will map CRCS groups for outpatient data;

proc format;

invalue \$rev

'0360' - '0369' = 'OP-Surg'

'0450' - '0451' = 'OP-ER'

'0490' - '0499' = 'OP-Surg'

'0510' - '0519' = 'OP-NonSurg'

'0761' = 'OP-NonSurg'

'0762' = 'OP-Obs'

'0769' = 'OP-Obs'

'0790' - '0799' = 'OP-Surg'

'0975' = 'OP-Surg'

'0981' = 'OP-ER'

'0170' = 'OP-TTT'

'0171' = 'OP-TTT'

'0258' = 'OP-TTT'

'0260' = 'OP-TTT'

'0261' = 'OP-TTT'

'0300' = 'OP-TTTP'

'0301' = 'OP-TTTP'

'0302' = 'OP-TTTP'

'0304' = 'OP-TTTP'

'0305' = 'OP-TTTP'

'0306' = 'OP-TTTP'

'0307' = 'OP-TTTP'

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'0480' = 'OP-TTT'
'0481' = 'OP-TTT'
'0482' = 'OP-TTT'
'0483' = 'OP-TTT'
'0489' = 'OP-TTT'
'0610' = 'OP-TTTP'
'0611' = 'OP-TTTP'
'0612' = 'OP-TTTP'
'0614' = 'OP-TTTP'
'0615' = 'OP-TTTP'
'0616' = 'OP-TTTP'
'0618' = 'OP-TTTP'
'0619' = 'OP-TTTP'
'0634' = 'OP-TTTP'

'0635' = 'OP-TTTP'
'0636' = 'OP-TTTP'
'0721' = 'OP-TTT'
'0730' = 'OP-TTT'
'0731' = 'OP-TTT'
'0732' = 'OP-TTT'
'0739' = 'OP-TTT'
'0740' = 'OP-TTT'
'0749' = 'OP-TTT'
'0750' = 'OP-TTT'
'0759' = 'OP-TTT'
'0820' = 'OP-TTT'
'0821' = 'OP-TTT'
'0830' = 'OP-TTT'
'0831' = 'OP-TTT'
'0840' = 'OP-TTT'
'0841' = 'OP-TTT'
'0850' = 'OP-TTT'
'0851' = 'OP-TTT'
'0900' = 'OP-TTT'
'0901' = 'OP-TTT'
'0910' = 'OP-TTT'
'0914' = 'OP-TTT'
'0915' = 'OP-TTT'
'0916' = 'OP-TTT'
'0918' = 'OP-TTT'
'0920' = 'OP-TTT'
'0921' = 'OP-TTT'
'0922' = 'OP-TTT'
'0923' = 'OP-TTTP'
'0924' = 'OP-TTT'
'0929' = 'OP-TTT'
'0940' = 'OP-TTT'
'0943' = 'OP-TTT'

other='ZZZ'
;
run;

*JLC 5/19/10

updated 9/17/10;

*UPDATE BY RAL/JLC - Identify all claims containing Room & Board revenue codes as Inpatient Hospital.;

*outpatient methodology coding based on South Carolina FFS Hospital Reimbursement Provider Manual;

*Summarize hospital (ub form) encounter claims to compare to health plan reported data.

*Note: libnames/format statements and defined variables assigned in _Execute_CRCS file;

*For IP claims with 0 days, determine if room and board rev codes are present on the claim.

Claims that qualify will stay in IP with total R&B units assigned for days. Claims that do not qualify will run through OP logic;

take units from room and board line and assign to the claim;

data rb_lines;

set output.claims_mapped_&CURRQ.;

where revenue_code ge '0100' and revenue_code le '0219';

run;

*sum up units by claim if more than one R&B line. this way we'll count all the days from the claim;

proc summary nway missing data= rb_lines;

class enc_id_no;

var units_of_service;

output out= rb_summ(drop=_type_)sum=;

run;

*make format statement to map units using the room and board units for days;

data day_Format(keep = FmtName Type Start Label);

set rb_summ;

format Start \$16. Label 12. Type \$1. FmtName \$6.;

Start = enc_id_no;

Label = units_of_service;

Type = 'J';

FmtName = 'days';

run;

proc sort nodupkey data=day_Format;

by Start;

run;

proc format cntlin=day_Format;

run;

```

*first make distinction for ip vs op on ub92 claims;
data map_ip op;
set output.claims_mapped_&CURRQ.;
where enc_doc_type eq 'Z';
format RB_flag $1. CRCS_cat $12. days 12. M_units 12.;

*assign a flag if there is a room & board revenue code on a claim. this indicates it is IP;
if input(enc_id_no,$days.) ne enc_id_no then RB_flag = 'Y';
    else RB_flag = 'N';

*calculate LOS;
days = datepart(TO_DATE) - datepart(DATE_OF_SERVICE);

*re-assign days if there isn't an original day count;
if days eq 0 and RB_flag eq 'Y' then days = input(enc_id_no,$days.);

*if 0 days and don't have room and board, then let it go to op;
if days eq 0 and RB_flag eq 'N' then output op;

*now we run the IP logic on the claims;
else do;

    CRCS_cat = input(drg,$aprdrg.);

    *count deliveries based on delivery drgs. ;
    if drg in ('540','541','542','560') then del_flag = M_claimcnt;
    else del_flag = 0;

    *if there isn't a valid drg on the claim, then send them to op, if there is one, then run through ip
logic;
    if CRCS_cat in ('ZZZ','IP-Other') and input(enc_id_no,$days.) eq enc_id_no then output op;

    else do;
        *only count units/claims for the header line of the ip claim;
        if ENC_DETAIL_LINE_NO eq 1 then do;
            M_mult = 1;
            M_paid = TOTAL_AMT_PAID;
            M_units = days;
        end;
        else do;
            M_mult = 0;
            M_units = 0;
            M_paid = 0;
        end;
        if CRCS_cat eq 'ZZZ' then CRCS_cat = 'IP-Other';

        *zero out voids and 0 paid;
        if void_flag eq 'V' or (M_paid eq 0 and reimburse_method ne 'C') then do;
            M_mult = 0;
            M_units = 0;
            M_paid = 0;
        end;
    end;
end;

```

```

                M_claimnt = 0;
                del_flag = 0; *Update by RAL 10-20-2011 - zero out deliveries on voided
claims;
                end;
                output map_ip;
        end;
end;
run;

```

*Label entire claim depending on revenue code (surg, ER, TTT, TTTP, non-surg, or Obs Room).

The order of importance is taken into account across a few steps;

*make format statement to identify claim number of Surg claims;

```
data Surg_Format(keep = FmtName Type Start Label);
```

```
set op;
```

```
where input(revenue_code,$rev.) eq 'OP-Surg';
```

```
format Start $16. Label $10. Type $1. FmtName $6.;
```

```
Start = enc_id_no;
```

```
Label = 'OP-Surg';
```

```
Type = 'J';
```

```
FmtName = 'Srgclm';
```

```
run;
```

```
proc sort nodupkey data=Surg_Format;
```

```
by Start;
```

```
run;
```

```
proc format cntlin=Surg_Format;
```

```
run;
```

*make format statement to identify claim number of ER claims;

```
data ER_Format(keep = FmtName Type Start Label);
```

```
set op;
```

```
where input(revenue_code,$rev.) eq 'OP-ER';
```

```
format Start $16. Label $10. Type $1. FmtName $6.;
```

```
Start = enc_id_no;
```

```
Label = 'OP-ER';
```

```
Type = 'J';
```

```
FmtName = 'ERclm';
```

```
run;
```

```
proc sort nodupkey data=ER_Format;
```

```
by Start;
```

```
run;
```

```
proc format cntlin=ER_Format;
```

```
run;
```

*make format statement to identify claim number of TTT claims;

```
data TTT_Format(keep = FmtName Type Start Label);
```

```
set op;
```

```
where input(revenue_code,$rev.) eq 'OP-TTT' or (input(revenue_code,$rev.) eq 'OP-TTTP' and
input(procedure_code,$vproc.) eq 'Y');
```

```
format Start $16. Label $10. Type $1. FmtName $6.;
```

```

Start = enc_id_no;
Label = 'OP-TTT';
Type = 'J';
FmtName = 'TTTclm';
run;
proc sort nodupkey data=TTT_Format;
by Start;
run;
proc format cntlin=TTT_Format;
run;

*make format statement to identify claim number of TTTP claims;
data TTTP_Format(keep = FmtName Type Start Label);
set op;
where input(revenue_code,$rev.) eq 'OP-TTTP' and input(procedure_code,$vproc.) ne 'Y';
format Start $16. Label $10. Type $1. FmtName $6.;
Start = enc_id_no;
Label = 'OP-TTTP';
Type = 'J';
FmtName = 'TTTP';
run;
proc sort nodupkey data=TTTP_Format;
by Start;
run;
proc format cntlin=TTTP_Format;
run;

*make format statement to identify claim number of Non-Surgery Other claims;
data nonsurg_Format(keep = FmtName Type Start Label);
set op;
where input(revenue_code,$rev.) eq 'OP-NonSurg';
format Start $16. Label $10. Type $1. FmtName $6.;
Start = enc_id_no;
Label = 'OP-NonSurg';
Type = 'J';
FmtName = 'nonsur';
run;
proc sort nodupkey data=nonsurg_Format;
by Start;
run;
proc format cntlin=nonsurg_Format;
run;

*make format statement to identify claim number of Observation Room claims;
data obs_Format(keep = FmtName Type Start Label);
set op;
where input(revenue_code,$rev.) eq 'OP-Obs';
format Start $16. Label $10. Type $1. FmtName $6.;
Start = enc_id_no;
Label = 'OP-Obs';
Type = 'J';

```

```

FmtName = 'Obsclm';
run;
proc sort nodupkey data=obs_Format;
by Start;
run;
proc format cntlin=obs_Format;
run;

*pull outpatient claims out of hospital types;
data map_op;
set op;
format CRCS_cat $12.;

CRCS_cat = input(revenue_code,$rev.);

*assign outpatient delivery claims per primary diagnosis code;
if substr(PRIM_DIAG_CODE,1,4) eq ' V27' then CRCS_cat = 'OP-Del';
else if PRIM_DIAG_CODE eq ' 650' then CRCS_cat = 'OP-Del';
else if (PRIM_DIAG_CODE ge ' 65101') and (PRIM_DIAG_CODE le ' 66992') and
substr(PRIM_DIAG_CODE,6,1) in ('1','2') then CRCS_cat = 'OP-Del';

M_mult = 1;
M_units = units_of_service;
M_paid = TOTAL_AMT_PAID;

*if it's other, then we'll bucket ip vs op based on whether the health plan assigned it a DRG and if there
aren't any days on it;
*yep, this technically means there will be "IP" claims in my "OP" file... but that shouldn't matter in the
end;
if CRCS_cat in ('ZZZ','OP-Other') and DRG_value ne " and days ne 0 then do;
    CRCS_cat = 'IP-Other';
    if ENC_DETAIL_LINE_NO eq 1 then do;
        M_mult = 1;
        M_units = days;
        M_paid = TOTAL_AMT_PAID;
    end;
end;

```

```

else do;
    M_mult = 0;
    M_units = 0;
    M_paid = 0;
    M_claimcnt = 0;
end;
end;

else if CRCS_cat eq 'ZZZ' then CRCS_cat = 'OP-Other';

*We need the entire claim to be classified here. Map using claim ID format;
*Surg claims have priority if multiple are present. Order of priority is: surg, ER, TTT, TTTP, non-surg,
obs room, other;
*divide treatment/therapy/testing into TTT and other based on proc presence;
if CRCS_cat = 'OP-Del' then CRCS_cat = 'OP-Del';
else if input(enc_id_no,$Srgclm.) eq 'OP-Surg' then CRCS_cat = 'OP-Surg';
else if input(enc_id_no,$ERclm.) eq 'OP-ER' then CRCS_cat = 'OP-ER';
else if input(enc_id_no,$TTTclm.) eq 'OP-TTT' then CRCS_cat = 'OP-TTT';
else if input(enc_id_no,$TTTP.) eq 'OP-TTTP' then CRCS_cat = 'OP-Other';
else if input(enc_id_no,$nonsur.) eq 'OP-NonSurg' then CRCS_cat = 'OP-NonSurg';
else if input(enc_id_no,$Obsclm.) eq 'OP-Obs' then CRCS_cat = 'OP-Obs';
else CRCS_cat = 'OP-Other';

*zero out voids and 0 paid;
if void_flag eq 'V' or (M_paid eq 0 and reimburse_method ne 'C') then do;
    M_mult = 0;
    M_units = 0;
    M_paid = 0;
    M_claimcnt = 0;
end;

*make sure observation claims get a claim count and paid amt;
if revenue_code in ('0762','0769') then do;
    M_ClaimCnt = 1;
    M_Mult = 1;
    M_Units = units_of_service;
    M_paid = TOTAL_AMT_PAID;
end;
run;

*create and output data summaries for excel;
proc summary nway missing data= map_ip;
class M_Indiv_no year_mo M_PROD_ID M_rategrp CRCS_cat reimburse_method;
var M_ClaimCnt M_mult M_units M_paid del_flag;
output out = output.IP_Summ_&CURRQ.(drop=_type_ _freq_)sum=;
run;

```

```
proc summary nway missing data= map_op;
class M_Indiv_no year_mo M_PROD_ID M_rategrp CRCS_cat reimburse_method;
var M_ClaimCnt M_mult M_units M_paid;
output out = output.OP_Summ_&CURRQ.(drop=_type_ _freq_)sum=;
run;
```

ENCLOSURE 3

*5/18/10 - JLC;
*source: S:\SCM\SCM61\code groupings.xlsx;
*procedure codes will map CRCS groups for professional data;
*updated to reflect 2012 CPT codes 5/15/12 - JMN;

proc format;

invalue \$cpt

/*ancillary*/

'A0021' = 'Anc-Amb'
'A0225'-'A0999' = 'Anc-Amb'
'Q3019'-'Q3020' = 'Anc-Amb'
'S0207'-'S0215' = 'Anc-Amb'
'99070' = 'Anc-DME'
'A4206'-'A4259' = 'Anc-DME'
'A4262'-'A4265' = 'Anc-DME'
'A4270'-'A4640' = 'Anc-DME'
'A4648'-'A8004' = 'Anc-DME'
'A9155' = 'Anc-DME'
'A9273'-'A9279' = 'Anc-DME'
'A9283'-'A9284' = 'Anc-DME'
'A9900'-'A9999' = 'Anc-DME'
'B4034'-'B9999' = 'Anc-DME'
'C9351' = 'Anc-DME'
'C9365'-'C9367' = 'Anc-DME'
'E0100'-'E8002' = 'Anc-DME'
'K0001'-'K0899' = 'Anc-DME'
'L0112'-'L9900' = 'Anc-DME'
'Q0478'-'Q0506' = 'Anc-DME'
'Q1003'-'Q1005' = 'Anc-DME'
'Q4001'-'Q4051' = 'Anc-DME'
'Q4093'-'Q4094' = 'Anc-DME'
'Q4100'-'Q4121' = 'Anc-DME'
'S0515' = 'Anc-DME'
'S1015'-'S1040' = 'Anc-DME'
'S5560'-'S5571' = 'Anc-DME'
'S8096'-'S8101' = 'Anc-DME'
'S8120'-'S8490' = 'Anc-DME'
'S8999'-'S9007' = 'Anc-DME'
'S9061' = 'Anc-DME'
'T4521'-'T4543' = 'Anc-DME'
'V2600'-'V2632' = 'Anc-DME'
'V2788' = 'Anc-DME'
'V5336' = 'Anc-DME'
'92325'-'92342' = 'Anc-Other'
'92370' = 'Anc-Other'
'99500'-'99602' = 'Anc-Other'
'G0151'-'G0164' = 'Anc-Other'
'Q5001'-'Q5010' = 'Anc-Other'
'S0270'-'S0272' = 'Anc-Other'

'S0345'-'S0347' = 'Anc-Other'
'S0500'-'S0514' = 'Anc-Other'
'S0516'-'S0590' = 'Anc-Other'
'S0595' = 'Anc-Other'
'S5035'-'S5036' = 'Anc-Other'
'S5100'-'S5181' = 'Anc-Other'
'S5497'-'S5523' = 'Anc-Other'
'S9097'-'S9098' = 'Anc-Other'
'S9122'-'S9131' = 'Anc-Other'
'S9208'-'S9381' = 'Anc-Other'
'S9490'-'S9504' = 'Anc-Other'
'S9537'-'S9810' = 'Anc-Other'
'V2020'-'V2599' = 'Anc-Other'
'V2600'-'V2615' = 'Anc-Other'
'V2700'-'V2784' = 'Anc-Other'
'V2786'-'V2787' = 'Anc-Other'
'V5011'-'V5298' = 'Anc-Other'

/*physician*/

'00100'-'00840' = 'Phys-Anes'
'00844'-'01953' = 'Phys-Anes'
'01962'-'01963' = 'Phys-Anes'
'01969'-'01999' = 'Phys-Anes'
'99100'-'99150' = 'Phys-Anes'

'99217'-'99220' = 'Phys-ER'
'99224'-'99226' = 'Phys-ER'
'99234'-'99236' = 'Phys-ER'
'99281'-'99288' = 'Phys-ER'
'G0378'-'G0384' = 'Phys-ER'

'90816'-'90829' = 'Phys-Hosp'
'99221'-'99223' = 'Phys-Hosp'
'99231'-'99233' = 'Phys-Hosp'
'99238'-'99239' = 'Phys-Hosp'
'99289'-'99318' = 'Phys-Hosp'
'99356'-'99357' = 'Phys-Hosp'
'99436'-'99440' = 'Phys-Hosp'
'99464'-'99476' = 'Phys-Hosp'
'99460' = 'Phys-Hosp'
'99462' = 'Phys-Hosp'
'99478'-'99480' = 'Phys-Hosp'
'G0390' = 'Phys-Hosp'
'S0310' = 'Phys-Hosp'

'90460'-'90749' = 'Phys-Imm'
'G0008'-'G0010' = 'Phys-Imm'
'G0377' = 'Phys-Imm'
'G9141'-'G9142' = 'Phys-Imm'
'J3530' = 'Phys-Imm'

'Q2035'-'Q2039' = 'Phys-Imm'
'S0195' = 'Phys-Imm'

'90801'-'90815' = 'Phys-MH/SA'
'90845'-'90899' = 'Phys-MH/SA'
'99408'-'99409' = 'Phys-MH/SA'
'G0176'-'G0177' = 'Phys-MH/SA'
'G0396'-'G0397' = 'Phys-MH/SA'
'G0409'-'G0411' = 'Phys-MH/SA'
'H0001'-'H0040' = 'Phys-MH/SA'
'H0046'-'H0050' = 'Phys-MH/SA'
'H2000'-'H2013' = 'Phys-MH/SA'
'H2015'-'H2022' = 'Phys-MH/SA'
'H2027' = 'Phys-MH/SA'
'H2033'-'H2037' = 'Phys-MH/SA'
'M0064' = 'Phys-MH/SA'
'S3005' = 'Phys-MH/SA'
'S9475' = 'Phys-MH/SA'
'S9480'-'S9485' = 'Phys-MH/SA'

'59000'-'59350' = 'Phys-NonDel'
'59425'-'59430' = 'Phys-NonDel'
'59812'-'59866' = 'Phys-NonDel'
'59870'-'59899' = 'Phys-NonDel'

'98966'-'98969' = 'Phys-OV'
'99201'-'99215' = 'Phys-OV'
'99324'-'99355' = 'Phys-OV'
'99358'-'99359' = 'Phys-OV'
'99361'-'99362' = 'Phys-OV'
'99366'-'99380' = 'Phys-OV'
'99441'-'99444' = 'Phys-OV'
'99499' = 'Phys-OV'
'G0179'-'G0182' = 'Phys-OV'
'G0337' = 'Phys-OV'
'S0220'-'S0260' = 'Phys-OV'
'S0273'-'S0274' = 'Phys-OV'

'36415'-'36416' = 'Phys-Path'
'80000'-'89999' = 'Phys-Path'
'G0027' = 'Phys-Path'
'G0103' = 'Phys-Path'
'G0123'-'G0124' = 'Phys-Path'
'G0141'-'G0148' = 'Phys-Path'
'G0265'-'G0266' = 'Phys-Path'
'G0306'-'G0307' = 'Phys-Path'
'G0328' = 'Phys-Path'
'G0394' = 'Phys-Path'
'G0430'-'G0435' = 'Phys-Path'
'G9143' = 'Phys-Path'
'P2028'-'P7001' = 'Phys-Path'

'Q0091' = 'Phys-Path'
'Q0111'-'Q0115' = 'Phys-Path'
'Q3031' = 'Phys-Path'
'S2120' = 'Phys-Path'
'S3600'-'S3890' = 'Phys-Path'
'S9529' = 'Phys-Path'

'70000'-'79999' = 'Phys-Rad'
'G0130' = 'Phys-Rad'
'G0202'-'G0235' = 'Phys-Rad'
'G0252' = 'Phys-Rad'
'G0275'-'G0278' = 'Phys-Rad'
'G0288' = 'Phys-Rad'
'G0389' = 'Phys-Rad'
'Q0092' = 'Phys-Rad'
'R0070'-'R0076' = 'Phys-Rad'
'S8030'-'S8037' = 'Phys-Rad'
'S8042'-'S8092' = 'Phys-Rad'
'S9024' = 'Phys-Rad'

'10000'-'36410' = 'Phys-Surg'
'36420'-'55920' = 'Phys-Surg'
'56405'-'58301' = 'Phys-Surg'
'58340'-'58960' = 'Phys-Surg'
'58999' = 'Phys-Surg'
'59525' = 'Phys-Surg'
'60000'-'69020' = 'Phys-Surg'
'69100'-'69990' = 'Phys-Surg'
'92973'-'92974' = 'Phys-Surg'
'92980'-'92998' = 'Phys-Surg'
'93451'-'93462' = 'Phys-Surg'
'93501'-'93533' = 'Phys-Surg'
'93580'-'93581' = 'Phys-Surg'
'G0127' = 'Phys-Surg'
'G0168'-'G0173' = 'Phys-Surg'
'G0251' = 'Phys-Surg'
'G0259'-'G0260' = 'Phys-Surg'
'G0267' = 'Phys-Surg'
'G0269' = 'Phys-Surg'
'G0289'-'G0291' = 'Phys-Surg'
'G0297'-'G0305' = 'Phys-Surg'
'G0339'-'G0343' = 'Phys-Surg'
'G0364' = 'Phys-Surg'
'G0392'-'G0393' = 'Phys-Surg'
'G0412'-'G0419' = 'Phys-Surg'
'G0440'-'G0441' = 'Phys-Surg'
'M0301' = 'Phys-Surg'
'S0400' = 'Phys-Surg'
'S0601' = 'Phys-Surg'
'S2053'-'S2118' = 'Phys-Surg'
'S2135'-'S2152' = 'Phys-Surg'

'S2205'-'S2235' = 'Phys-Surg'
'S2270'-'S2900' = 'Phys-Surg'
'S9034' = 'Phys-Surg'

/*delivery codes*/

'59400'-'59414' = 'Phys-Del'
'59510'-'59515' = 'Phys-Del'
'59610'-'59622' = 'Phys-Del'

'00842' = 'Phys-AnesDel'
'01958'-'01961' = 'Phys-AnesDel'
'01965'-'01968' = 'Phys-AnesDel'

other = 'Phys-other'

;

run;

*methodology coding documented in on CRCS Methodology Documentation v3.doc for CY 2012;
*summarize professional (HCFA form) encounter claims to compare to health plan reported data;
*JLC 5/19/10;
*Note: libnames/format statements and defined variables assigned in _Execute_CRCS file;

```
data map_prof;  
set output.claims_mapped_&CURRQ.;  
where enc_doc_type in ('A','C');  
format CRCS_cat $12.;
```

*first time around, just map a claim if it has a procedure code on our list;
CRCS_cat = input(procedure_code,\$cpt.);

*now check modifiers/provider types to be sure delivery/anesthesia are on claims;
*anesthesia proc mod codes from HCG code set 20091231-set surgery codes w/ anesthesia mod to be
'phys-anes';
if CRCS_cat eq 'Phys-Surg' and PROC_CODE_MODIFIER in ('23','47','AA','AD','G8','QK','QS')
then CRCS_cat = 'Phys-Anes';

*before we assign anesthesia, we need to throw out delivery codes that had an invalid provider;
if CRCS_cat eq 'Phys-Del' and PROC_CODE_MODIFIER in ('23','47','AA','AD','G8','QK','QS')
then CRCS_cat = 'Phys-AnesDel';

if CRCS_cat eq 'ZZZ' then CRCS_cat = 'Phys-Other';

*zero out voids;
if void_flag eq 'V' or (TOTAL_AMT_PAID eq 0 and reimburse_method ne 'C') then do;
M_mult = 0;
M_units = 0;
M_paid = 0;
M_claimnt = 0;
end;
*map units otherwise;
else do;
M_mult = 1;
M_units = units_of_service;
M_paid = TOTAL_AMT_PAID;
end;
run;

*create and output data summaries for excel;
proc summary nway missing data= map_prof;
class M_Indiv_no year_mo M_PROD_ID M_rategrp CRCS_cat reimburse_method;
var M_ClaimCnt M_mult M_units M_paid;
output out = output.Prof_Summ_&CURRQ.(drop=_type_ _freq_)sum=;
run;

ENCLOSURE 4

```
*methodology coding based on Encounter Utilization Report v5 - Enc 2.doc;
*summarize RX encounter claims to compare to health plan reported data;
*JLC 5/19/10;
*Note: libnames/format statements and defined variables assigned in _Execute_CRCS file;
```

```
*pull out Rx claims;
data map_rx;
set output.claims_mapped_&CURRQ.;
where enc_doc_type eq 'D';
format CRCS_cat $12.;
```

```
CRCS_cat = 'Rx';
```

```
*zero out voids;
if void_flag eq 'V' or TOTAL_AMT_PAID eq 0 then do;
    M_mult = 0;
    M_units = 0;
    M_paid = 0;
```

```
end;
```

```
*map units otherwise;
```

```
else do;
```

```
M_mult = 1;
```

```
M_units = 1; *count each line item (script) as 1 unit;
```

```
M_paid = TOTAL_AMT_PAID;
```

```
end;
```

```
run;
```

```
*create and output data summaries for excel;
```

```
proc summary nway missing data= map_rx;
```

```
class M_Indiv_no year_mo M_PROD_ID M_rategrp CRCS_cat ;
```

```
var M_ClaimCnt M_mult M_units M_paid;
```

```
output out = output.RX_Summ_&CURRQ.(drop=_type_ _freq_)sum=;
```

```
run;
```

```
*create detail data for plans;
```

```
data output.forplan_rx_&CURRQ.;
```

```
set map_rx;
```

```
run;
```

FORMS

Universal Medication Prior Authorization Form

I. PROVIDER INFORMATION		II. MEMBER INFORMATION	
Prescriber name	NPI#	Member name	Today's date
Prescriber specialty	Phone	Member plan ID #	Date of birth
Office contact name	Fax	Drug allergies	
Pharmacy name	Pharmacy phone	Plan name and fax for form submission Use the drop down to select the appropriate health plan. ▼	

III. DRUG INFORMATION (ONE DRUG PER REQUEST FORM)				
Drug name	Drug strength	Dosage form	Dosage interval	Quantity per day
Diagnosis relevant to this request				ICD-9 code
Expected length of therapy				Number of refills

IV. DRUG HISTORY FOR THIS DIAGNOSIS																									
A. Is the prescription for a drug to be administered in the office or for the member to take at home? <input type="checkbox"/> office <input type="checkbox"/> home																									
B. Is the member currently treated on this drug? <input type="checkbox"/> Yes: how long? _____ [go to item C] <input type="checkbox"/> No [skip items C and D; go to item E]																									
C. Is this request for continuation of a previous approval? <input type="checkbox"/> Yes [go to item D] <input type="checkbox"/> No [skip item D; go to item E]																									
D. Has strength, dosage or quantity required per day increased or decreased? <input type="checkbox"/> Yes [go to item H] <input type="checkbox"/> No [skip item H; indicate rationale in Section V and submit form]																									
E. Please indicate previous treatments and outcomes with other medications below.																									
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">DRUG NAME</th> <th style="width: 25%;">STRENGTH</th> <th style="width: 25%;">DIRECTIONS</th> <th style="width: 25%;">DATES OF THERAPY</th> <th style="width: 20%;">REASON FOR FAILURE OR DISCONTINUATION</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	DRUG NAME	STRENGTH	DIRECTIONS	DATES OF THERAPY	REASON FOR FAILURE OR DISCONTINUATION																				
DRUG NAME	STRENGTH	DIRECTIONS	DATES OF THERAPY	REASON FOR FAILURE OR DISCONTINUATION																					

V. RATIONALE FOR REQUEST AND PERTINENT CLINICAL INFORMATION (ATTACH ADDITIONAL SHEETS IF MORE SPACE IS NEEDED)		
<p><small>Appropriate clinical information to support the request on the basis of medical necessity must be submitted.</small></p>		
<table style="width: 100%;"> <tr> <td style="width: 75%;">Prescriber/Authorized Representative signature</td> <td style="width: 25%;">Date</td> </tr> </table>	Prescriber/Authorized Representative signature	Date
Prescriber/Authorized Representative signature	Date	

Universal Newborn Prior Authorization Form

Universal Newborn Prior Authorization Form – Pediatric Offices

Out-of-network pediatric providers must provide this information to obtain an authorization for services rendered in the office during the first 60 days after discharge. Authorization should be requested by close of the next business day. For questions, contact the plan at the associated phone number. *Fax the COMPLETED form OR call the plan with the requested information.

<input type="checkbox"/> Absolute Total Care P: 866-433-6041 F: 866-918-4451 www.absolutetotalcare.com	<input type="checkbox"/> BlueChoice HealthPlan P: 866-902-1689 F: 800-823-5520 www.bluechoicescmedicaid.com	<input type="checkbox"/> First Choice by Select Health P: 888-559-1010 F: 866-368-4562 www.selecthealthofsc.com
<input type="checkbox"/> Unison Health Plan P: 800-366-7304 F: 866-841-9336 www.unisonhealthplan.com		

Patient's Name First Middle Last DOB

Address (Street, Apt.#) City/State/Zip

Phone(s) Medicaid Number MCO ID Number

Mom's Name First Middle Last Mom's Medicaid Number

Mom's SSN

Secondary Coverage:
 Plan ID# Group #

Policy Holder DOB Relationship to patient Employer

EPSDT and IMMUNIZATION

99381 (EPSDT New) 99391 (EPSDT Est.) 1 Visit 2 Visits

<input type="checkbox"/> 90471 DOS: <input type="text"/>	Immunization Administered: <input type="text"/>
<input type="checkbox"/> 90472 DOS: <input type="text"/>	Immunization Administered: <input type="text"/>
<input type="checkbox"/> 90473 DOS: <input type="text"/>	Immunization Administered: <input type="text"/>

EIM Non-EPSDT

CPT: Dx: DOS: CPT: Dx: DOS:

LABS **CLIA CERTIFICATE NUMBER**

<input type="checkbox"/> CPT: <input type="text"/> DOS: <input type="text"/>	<input type="checkbox"/> CPT: <input type="text"/> DOS: <input type="text"/>
<input type="checkbox"/> CPT: <input type="text"/> DOS: <input type="text"/>	<input type="checkbox"/> CPT: <input type="text"/> DOS: <input type="text"/>
<input type="checkbox"/> CPT: <input type="text"/> DOS: <input type="text"/>	<input type="checkbox"/> CPT: <input type="text"/> DOS: <input type="text"/>

OTHER

<input type="checkbox"/> 17250 DOS: <input type="text"/>	<input type="checkbox"/> 54160 DOS: <input type="text"/>	<input type="checkbox"/> 98150 DOS: <input type="text"/>
<input type="checkbox"/> 51701 DOS: <input type="text"/>	<input type="checkbox"/> 94640 DOS: <input type="text"/>	<input type="checkbox"/> 98152 DOS: <input type="text"/>
<input type="checkbox"/> 54150 DOS: <input type="text"/>	<input type="checkbox"/> 94760 DOS: <input type="text"/>	<input type="checkbox"/> 97802 DOS: <input type="text"/>
<input type="checkbox"/> CPT: <input type="text"/> DOS: <input type="text"/>	<input type="checkbox"/> CPT: <input type="text"/> DOS: <input type="text"/>	

Practice Name: Practice NPI:

Attending Physician (last name, first name): NPI:

Contact Person: Phone: Fax:

Plan Point of Contact: Date Plan Called: Time of Call:

Plan Reference/Confirmation Number:

FOR MCO USE ONLY:

Approved Denied Authorization # Date of Notification to Pediatric Office:

Reviewer(s) name & title:

Please note that our review applies only to the authorization of medical necessity and benefit coverage. This authorization is not a guarantee of payment unless the member is eligible at the time the services are rendered.

Universal 17-P Authorization Form

Universal 17-P Authorization Form

*Fax the COMPLETED form OR call the plan with the requested information.

Absolute Total Care
 BlueChoice HealthPlan
 First Choice by Select Health
 UnitedHealthcare CommunityPlan
 P: 803-933-3689 P: 866-902-1689 P: 888-559-1010 x55251 P: 800-366-7304
 F: 866-918-4451 F: 800-823-5520 F: 866-533-5493 F: 866-841-9336

Date of Request for Authorization _____

Patient/Member Name _____ DOB _____

First Middle Last

Address (Street, Apt.#) _____ City/State/Zip _____

Phone _____ Medicaid Number _____ MCO ID Number _____

Pregnancy Information and History

G ___ T ___ P ___ A ___ L ___ (Note: A= abortion (spontaneous and medically induced) EDC _____)

Last menstrual period _____ EDD _____ Current Gestational age _____ weeks

Bed Rest Yes No Experiencing Preterm Labor Yes No
(Home administration available if on bed rest)

Singleton Pregnancy Multiple Pregnancy

At least 16 weeks gestation Yes No Major Fetal or Uterine Anomaly Yes No

Patient has a history of prior spontaneous singleton preterm birth between 20-36.6 weeks Yes No

Delivery was due to preterm labor or PPROM even if it resulted in C-section Yes No

Delivery was not due to medical indication, e.g. preeclampsia, abruption, etc. Yes No

Medication Allergies _____ No known drug allergies

Other Pertinent Clinical Information: _____

Pharmacy Information

Ship to patient's home address End Date of Service _____

Ship to provider's address End Date of Service _____

Shipping Preference: Regular Mail Ground Overnight

Ordering Physician's Signature: _____

Provider Information

Ordering Provider Name _____
(Please Print)

Ordering Provider NPI _____ Tax ID _____

Address _____ City/State/Zip _____

Phone _____ Fax _____

Provider Type: OB/GYN Family Medicine MFM/Perinatology Other _____

Practice Name: _____ Practice NPI: _____

Contact Person: _____ Phone: _____ Fax: _____

FOR MCO USE ONLY:

Approved Denied Authorization # _____ Number of Injections _____

Date of Notification to Provider: _____ Reviewer(s) name & title: _____

Please note that our review applies only to the authorization of medical necessity and benefit coverage. This authorization is not a guarantee of payment unless the member is eligible at the time the services are rendered.

Incentive Reporting

Patient Centered Medical Home (PCMH) Form

Completing the PCMH Form:

There are five (5) worksheet tabs to this report. Worksheet one (1) is a review of the instructions, worksheet two (2) is the spreadsheet utilized for providers in the application phase. Worksheet three (3) is utilized for level 1 PCMH providers, worksheet four (4) is for the level 2 PCMH providers, worksheet five (5) is for the level 3 PCMH providers.

PCMH Application:

- a. Please add those providers and their members that are still under application to the worksheet tab labeled Application.
- b. Please include the members Medicaid ID, their last name, first name, date assigned to the PCMH, accredited site, and accredited site address, accredited site phone number and primary care physician first and last name, and the months in the quarter the member was enrolled with the site.
- c. Space has been provided for 75 members on the excel file, if there are more members than this please insert a row or rows for the extra members.
- d. For anyone still in the application process you will need to include with their contracts a copy of the application and a defined timeline with an update provided quarterly. See appendix 5 of the P&P for more details.

[Insert Plan Name] Fiscal Year (insert year) - 1st Quarter (July)															
Record	MedicaidMember Num	FirstName	LastName	DateMember Assigned	Accredited Group NPI #	AccreditedSiteName	AccreditedSiteStreet Address	Accredited SiteCity	Accredited SiteState	Accredited SiteZipcode	Accredited SitePhone	Individual NPI # of Individual Physician	Physician LastName	Physician FirstName	MonthEnrolled
1															
2															
3															
4															
5															
6															

PCMH1 Worksheet:

- a. Please add those providers and their members that are in PCMH1 status to the worksheet tab labeled PCMH1.
- b. Please include the members Medicaid ID, their last name, first name, date assigned to the PCMH, accredited site, and accredited site address, accredited site phone number and primary care physician first and last name, and the months in the quarter the member was enrolled with the site.
- c. Space has been provided for 75 members on the excel file, if there are more members than this please insert a row or rows for the extra members.

Managed Care Organizations Policy and Procedure Guide

[Insert Plan Name] Fiscal Year (insert year) - 1st Quarter (July)															
Record	MedicaidMember Num	FirstName	LastName	DateMember Assigned	Accredited Group NPI #	AccreditedSiteName	AccreditedSiteStreet Address	Accredited SiteCity	Accredited SiteState	Accredited SiteZipcode	Accredited SitePhone	Individual NPI # of Individual Physician	Physician LastName	Physician FirstName	MonthEnrolled
1															
2															
3															
4															
5															
6															

PCMH2 Worksheet:

- a. Please add those providers and their members that are in PCMH2 status to the worksheet tab labeled PCMH2.
- b. Please include the members Medicaid ID, their last name, first name, date assigned to the PCMH, accredited site, and accredited site address, accredited site phone number and primary care physician first and last name, and the months in the quarter the member was enrolled with the site.
- c. Space has been provided for 75 members on the excel file, if there are more members than this please insert a row or rows for the extra members.

[Insert Plan Name] Fiscal Year (insert year) - 1st Quarter (July)															
Record	MedicaidMember Num	FirstName	LastName	DateMember Assigned	Accredited Group NPI #	AccreditedSiteName	AccreditedSiteStreet Address	Accredited SiteCity	Accredited SiteState	Accredited SiteZipcode	Accredited SitePhone	Individual NPI # of Individual Physician	Physician LastName	Physician FirstName	MonthEnrolled
1															
2															
3															
4															
5															
6															

PCMH3 Worksheet:

- a. Please add those providers and their members that are in PCMH3 status to the worksheet tab labeled PCMH3.
- b. Please include the members Medicaid ID, their last name, first name, date assigned to the PCMH, accredited site, and accredited site address, accredited site phone number and primary care physician first and last name, and the months in the quarter the member was enrolled with the site.
- c. Space has been provided for 75 members on the excel file, if there are more members than this please insert a row or rows for the extra members.

Managed Care Organizations Policy and Procedure Guide

[Insert Plan Name] Fiscal Year (<i>insert year</i>)- 1st Quarter (July)															
Record	MedicaidMember Num	FirstName	LastName	DateMember Assigned	Accredited Group NPI #	AccreditedSiteName	AccreditedSiteStreet Address	Accredited SiteCity	Accredited SiteState	Accredited SiteZipcode	Accredited SitePhone	Individual NPI # of Individual Physician	Physician LastName	Physician FirstName	MonthEnrolled
1															
2															
3															
4															
5															
6															

Centering Program

There are two worksheets within this form. Worksheet 1 contains the instructions and the second worksheet is available for adding Centering Program providers.

- a. Please include the members Medicaid ID, their last name, first name, date assigned to the PCMH, accredited site, and accredited site address, accredited site phone number and primary care physician first and last name, and the months in the quarter the member was enrolled with the site.
- c. Space has been provided for 75 members on the excel file, if there are more members than this please insert a row or rows for the extra members.
- d. The MCO will need to provide a copy of the contract that includes a certificate from the Centering Healthcare Institute. In addition the MCO must attach a copy of the signed logs showing their members have attended at least five (5) sessions. A one-time payment will be made for members that have attended at five or more centering sessions.

Centering Program Form

[Insert Plan Name] Fiscal Year (insert year) - 1st Quarter (July)															
Record	MedicaidMember Num	FirstName	LastName	DateMember Assigned	Accredited Group NPI #	AccreditedSiteName	AccreditedSiteStreet Address	Accredited SiteCity	Accredited SiteState	Accredited SiteZipcode	Accredited SitePhone	Individual NPI # of Individual Physician	Physician LastName	Physician FirstName	MonthEnrolled
1															
2															
3															
4															
5															
6															