

Data Reporting Compliance Manual

As of June 30, 2009

The FY 2010 Grant Agreement between the Bureau for Behavioral Health and Health Facilities and the various comprehensive behavioral health providers contains language regarding a data verification process and fines and penalties for the reporting of data.

Data Verification Process

On time Data:

Data must be submitted for each day of services by the 25th of the month following the month of service.

Care Connections © must be submitted at initial intake, annually thereafter, at a critical juncture, or discharge. A Federal Reporting form must accompany any Care Connection © form for patients with a disability group which contains substance abuse.

Data Accuracy

Items to be validated:

1. All dates must fit with in the Gregorian calendar. No more than 12 months and the date must fit within the maximum number of days for the month. No future service dates or birthdates will be accepted. No service dates before birthdates will be accepted.
2. Clients with an age of 100 years or more or less than one year of age, except for MR/DD Waiver, will be validated back with agency.
3. Providers must use valid service codes and modifiers which will be validated against our Service Code Table. See <http://www.wvdhhr.org/bhhf/resources.asp> for the most recent version.
4. Provider must submit valid diagnostic codes which will be validated against our diagnostic code table. See <http://www.wvdhhr.org/bhhf/resources.asp> for the most recent version.
5. If no service data has been submitted for an individual for 180 days then a discharge record must be submitted.

6. Only one gender change will be accepted for a consumer.
7. All service dates must fall within the eligibility period established for the individual.

Due Dates

Daily consumer and service data (CSDR) are due in the prescribed format by the 25th of the following month. The information shall be reported by date of service and not aggregated across days. Reports will be accepted daily however; any reports received after the 25th of the following month are considered late and subject to a fine.

Semi-annual cost report due within 60 days after the end of the reporting period. The reporting periods are July 1 – December 30 and January 1 – June 30 of each fiscal year. Reports received after the due date is subject to a fine as discussed in Exhibit K.

Data Auditing:

The CSDR information for each comprehensive mental health center will be audited no less than every twelve months.

All providers will submit a list of BHHF consumers from which to draw a sample.

If there are individuals on the list for whom there is no CSDR material, a fine may be assessed under the data submission clause.

Exhibit K

Fines Which May be Assessed for Non Reporting

Grantee not filing consumer and service data; budget report; quarterly financial reports; semi-annual cost report; and annual audit as required within the prescribed period, or any approved extended period, shall be fined \$250 per day which shall be invoiced for the amount of the fine or reduced from the Grantee's allocation and/or the Grantee shall not receive payment from the Department until such time as all reporting requirements have been fulfilled.

Fines Which May be Assessed for Poor Data Quality

Beginning January 1, 2009 data quality errors with a cumulative error rate of 2% or greater per month for the following fields, a fine of \$100 per error will be assessed. The fields are Social Security Number, date of birth, gender, invalid DSM-IV, and invalid program codes.

Data must be aggregated for each day (rather than monthly). The Program Code on the CSDR will be used for federal reporting to determine when a level of care changes. Because of the significance of this field, the program code will be validated and subject to a fine for incorrect reporting.

Agencies must collect and report on the military status of each consumer. Given the increase in the number of individuals seeking treatment related to their military service, additional information is needed to identify the individuals and family members. This information is to be reported electronically to APS Healthcare in the same manner as the SA Federal Reporting Form.

Contained in this Manual are the following documents

- A crosswalk of the old BH codes to current HCPCS codes. Please note BH codes and W codes will no longer be accepted.
- A list of valid program codes used with the CSDR and Federal Reporting.
- A list of optional modifiers which may be used for CSDR reporting.
- The Military Status Supplemental Report file layout.
- A file layout for CSDR reporting identifying valid responses for each of the fields.

Clarification Regarding Fines

The submission of CareConnections for non-Medicaid or non-BHHF consumers is optional but encouraged. Even though a CareConnection may not be submitted for a non-Medicaid or non-BHHF consumers, services must still be reported on the CSDR.

The Grant Agreement specifies if there is no service activity for 180 days as reported on the CSDR a discharge must be submitted. Federal reporting requirements are the basis for this requirement. As with the submission of CareConnections, only Tiers two and three will be analyzed to determine compliance with this requirement.

Any services which do not need to be authorized by APS Healthcare, such as T1002 – RN services, will be considered Tier one services. Waiver requirements will not be used in this determination.

Discharges do not need to be submitted for Tier one individuals as long as they continue to receive services within a twelve month period even though they may be outside the 180 day cutoff for the other two tiers. A discharge is required for Tier One when the individual is no longer receiving any services during a twelve month period.

When the data quality errors exceed 2%, only the number of records which exceed the 2% cap will be subject to determining the amount of the fine. Social security number, date of birth and gender will be compared to existing information to determine the quality of the data. The 2 % error rate over which a fine will be assessed allows for a minimal number of consumers or family members to provide incorrect information without a fine resulting. Responses which are blank or filled with all of one number, such as all 9 or all 8, will be considered an error.

One of the reviews the Bureau will make is to compare the service date with the eligibility period established by APS Healthcare for BHHF consumers. APS Healthcare does not issue medical authorizations for BHHF consumers, they will only determine the eligibility period for this population.

Consumer Service Data report (CSDR)

The CSDRs must be received by Medicaid's ASO contractor (APS Healthcare) within 25 days of the end of the month. No exceptions will be given when the 25th falls on a weekend or holiday. Any CSDRs received on or after the 26th of each month will be considered late and subject to a fine of \$250 per day. Each CSDR can be submitted separate from the other days or be submitted in a batch with services for other days in the month identifiable by date of service.

The BH codes and W codes will no longer be accepted. All of the BH codes have been cross walked to HCPCS codes and modifier, when necessary. The crosswalk is attached. **No substitute for BH999 can be found.** Any services which cannot be cross-walked to a HCPCS code is **not** to be reported on the CSDR. Only recognized HCPCS codes are to be reported.

BHHF is not requiring the use of modifiers for residential support and socialization support; however, modifiers may be used at your discretion if it facilitates the completion of the Cost Report. The Cost Report will not be modified in FY 2010 to include modifiers for codes not prior authorized by APS Healthcare.

Attached is a list of modifiers which may be submitted on the CSDR. The use of the modifiers is optional at this time. BHHF would like the LR modifier be used for any commitment related services the provider will be reporting and TG for people receiving care coordination services.

Date

Date of service

Agency ID

Same agency ID assigned by OHFLAC for licensing purposes.

Consumer ID

Use the consumer id used by the agency to identify the person.

Payor Code

The payor codes have been modified. Payor codes 09, 11, 12, 13 and 15 have been deleted because of non use. Payor code 09 was combined with Payor code 07 since non-BHHF charity care is the same as self-pay.

- 01 - BHHF Service
- 02 - Bureau of Children & Families
- 03 - Medicare
- 04 - Medicaid
- 05 - Workers Compensation
- 06 - Other Government Payments
- 07 - Self Pay, Non-BHHF Charity Services
- 08 - Targeted Funds
- ~~09 - Charity Services~~
- 10 - Private Insurance (BC/BS, HMO, etc.)
- ~~11 - Blue Cross / Blue Shield~~
- ~~12 - HMO~~
- ~~13 - Other (Champus)~~
- 14 - Other
- ~~15 - Maternal and Child Health~~

The payor code to be reported is the **initial expected payor**. If the initial payor does not pay, it is at the provider's discretion as to whether or not a revised CSDR will be submitted.

Program Code

The Program Code reported on the Federal Reporting Form will be used for federal reporting purposes as well as compliance with the Grant Agreement as discussed in the section Fines Which May be Assessed for Poor Data Quality. The program code uniquely identifies each substance abuse treatment site and is provided to BHHF by SAMHSA as your NDATUS number. The program code is used for all reporting regarding substance abuse services. The CSDR will be used to determine the beginning date and ending date of services for each NDATUS number and reported to SAMHSA.

Fund Source Code

The following codes remain in effect.

AA	Partnership for Care
BB	PI Services
CC	SA Adolescent RYS/MOP
DD	DD Targeted Services
FF	SA Adult Residential Treatment
GG	Family Support
HH	MI Child Home-Based Care
H1	MI Child Care Parent Education
H2	MI Child Respite Care
H3	MI Child School Based Services
H4	MI Child Treatment
H5	MI Child Collaborative
JJ	Mental Illness Child Case Management
KK	Mental Illness Child Crisis Service
MM	SA Women
PP	Path Homeless Grant
QQ	SA Adolescent Residential Services
RR	Mental Illness-Adult CSS Development Services
SS	Substance Abuse Outpatient Services
TT	SA Adolescent Intensive Outpatient Services
XX	No Targeted Funding Source

Service Code

BH Codes and W codes may no longer be used. Please refer to the crosswalk for the correct HCPCS code to use. The crosswalk is attached to this document.

Service Code Modifiers

Up to three modifiers may be reported on the CSDR. Please refer to the list of potential modifiers attached to this document. With few exceptions, modifiers are not required except when needed for billing purposes such as for Waiver billing or required for cost report purposes. The one requirement is the modifier LR is to be used when providing commitment related services.

Minutes

The provision of services is to be reported on a time basis. All services are to be reported in terms of minutes except for the transportation codes which will be reported either in miles or number of trips whichever is applicable.

Military Status Supplemental Report

The behavioral health systems are beginning to experience an increase in the number of people having served in the Middle East theatres of engagements. BHHF wants to identify those individuals who have served in any conflicts as well as their spouse and other dependent family members. It is not unreasonable to expect people in this vulnerable population to continue to seek or receive services well into the future.

The file layout is attached to this document. The file should be uploaded to APS Healthcare in the same manner as the SA Federal reporting Form. **This report is to be submitted each time the CareConnection is submitted.**

The information is to be collected on active duty personnel or veterans, their spouses and dependent family members. Military service includes the National Guard. Please be aware **multiple DD-214 can be issued** by the regular military, reserves and National Guard to the same individual.

Date

Date submitted by the agency

Agency ID

Same agency ID used with the CSDR

Report Status

New – the first time the information has been submitted

Update – a change in the data previously submitted. Please be aware the disability determination decision may occur some time after the person received the DD-214.

Consumer ID

Use the same consumer ID identifying the person as used on the CSDR.

Military Status

Yes/No never been in the military.

Yes/No a spouse or dependent child of someone currently serving or a veteran.

Currently serving in:

Yes/No Regular military

Yes/No Reserves

Yes/No National Guard

The DD-214 was/were issued by
Yes/No Regular military
Yes/No Reserves
Yes/No National Guard

When the military status is yes, have they served in any of these conflicts?
If they have served in theatre of engagements not listed check "Other."

Respond yes to all that apply.

Yes/No None
Yes/No World War II 1941 - 1945
Yes/No Korean Conflict 1950 – 1953
Yes/No Vietnam War 1959 – 1975
Yes/No Operation Just Cause (Panama) 1989 – 1990
Yes/No Persian Gulf War 1991
(Operation Desert Shield, Operation Desert Storm)
Yes/No Bosnian/Croatian conflicts 1993 - 1995
Yes/No Operation Enduring Freedom – Afghanistan 2001 – current
Yes/No Second Persian Gulf War 2003 – Current
(Operation Iraqi Freedom)
Yes/No Other

Service Connected Disability

Yes/No Did the person incur a disability related to military service?

Modifiers For Use With CSDR Reporting

Up to 3 modifiers may be reported on the CSDR. A list of possible modifiers is attached to this document. With a few exceptions the reporting of modifiers is optional. The modifiers must be included for Waiver services and LR must be used when reported commitment related services. **For individuals receiving care coordination services, please use modifier TG at least once during the month.** If at any time the Cost Report requires the use of modifiers, those HCPCS codes on the Cost Report affected by the decision must also have the modifiers included on the CSDR. Until such time, the use of modifiers is optional except for LR and TG. Codes BH999 and CC750 will no longer be accepted.

Program Codes For Use on The Federal Reporting Form and CSDR

SAMHSA assigns a program code for each level of treatment and location of substance abuse services. These codes are your NDATUS identifiers which BHHF uses for reporting to SAMHSA. BHHF must report each time the NDATUS number changes, at admission or upon discharge. SAMHSA publishes an aggregation of the demographic data as well as identifying episodes of care and readmission rates. BHHF substance abuse block grant funding is dependent upon the reporting of these data. When an NDATUS number is incorrect, the

service information connected to the incorrect NDATUS number can not be reported. This has resulted in a substantial under reporting by BHHF of at least 30% of the number served to SAMHSA. For your agency to receive credit for serving individuals with a substance abuse disorder, the provider must use the correct NDATUS numbers assign to your agency. Data to SAMHSA are submitted with the NDATUS number included.

IMPORTANT - If the individual receiving services has a co-occurring mental health/substance abuse illness but they are receiving services only for the mental health illness, do **not** use the NDATUS code. Use the code for mental health services.

The NDATUS numbers are attached to this document.

Fine Appeal Process

A monthly list of every event which results in a fine being assessed will be provided to each provider. If the provider disagrees with any items, they have 10 days from the date of the fine notification letter to notify BHHF in writing of their disagreement and include any relevant documentation.

For example, 15 social security numbers are not reported on the CareConnections which results in a fine. If it is documented in the charts that these individuals refused to provide their social security number, there will be no fine if the provider submits supporting documentation with the response.

An individual comes in twice a year for med checks. They miss their second regularly scheduled appointment but attend a makeup appoint scheduled for the 194th day. There has been no CSDR activity in the interim. No fine will be assessed because the individual is Tier one and no discharge and readmission is necessary.

Payment of the Fine

If a provider submits a CSDR late the provider will be fined a \$250 per day late fine. If the Cost Report is late, the daily fine will be applied. Providers will be invoiced monthly based on their performance.