



## **Section 8.1**      **Encounter Validation Studies**

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### **8.1.1**      **Introduction**

The Centers for Medicare and Medicaid Services (CMS) requires the Arizona Health Care Cost Containment System (AHCCCS) to conduct encounter validation studies as a condition for receiving Federal Medicaid funding. The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) requires the Regional Behavioral Health Authorities (RBHAs) to conduct encounter validation studies of their providers. For guidelines on the RBHA encounter data validation process, see the Office of Program Support Operations and Procedures Manual.

The purpose of encounter validation studies is to compare recorded utilization information from a clinical record or other source with submitted encounter data. The review “validates” or confirms that covered services are encountered timely, correctly and completely.

The purpose of this section is to:

- Inform providers that encounter validation studies may be performed by AHCCCS, RBHAs and/or ADHS/DBHS staff; and
- Convey ADHS/DBHS’ expectation that providers cooperate fully with any encounter validation review that AHCCCS, the RBHAs and/or ADHS/DBHS may conduct.

### **8.1.2**      **Procedures**

#### **8.1.2-A. Criteria used in encounter validation studies**

The criteria include timeliness, correctness, and omission of encounters, in addition to encountering for services not documented in the medical record. These criteria are defined as follows:

- **Timeliness**-The time elapsed between the date of service and the date that the encounter is received;
- **Correctness**- A correct encounter contains a complete and accurate description of a covered behavioral health service provided to a person. Correctness errors frequently identified include, but are not limited to, invalid procedure or revenue codes and ICD-9 diagnoses not reported to the correct level of specificity; and
- **Omission**- Provider documentation shows a service was provided, however, an encounter was not submitted.
- **Lack of Documentation**. A description of adequate documentation is referenced in: Section 4.2 – Behavioral Health Medical Record Standards, section 4.2.7-F, “Adequacy and availability of documentation.”

In addition, assessment compliance must be monitored by the RBHA in accordance with [NARBHA Policy 3.9, Assessment and Service Planning](#).



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NARBHA conducts quarterly encounter validation studies for subcontracted providers. Each quarter, NARBHA will perform data validation reviews on its providers for omission, correctness and timeliness errors. All encounters will be reviewed to verify that documentation and claims are consistent with requirements in the ADHS/DBHS Covered Behavioral Health Services Guide, the Provider Manual, and applicable licensure requirements. NARBHA conducts an exit interview with the provider and communicates any patterns of errors found during the review and provides technical assistance as necessary. NARBHA also provides each provider with a written summary following each data validation review. Improvement activities for subcontracted providers may include, but are not limited to, more frequent data validation monitoring; mandatory training; changes to documentation, service delivery and/or billing practices; recoupments; and financial sanctions.

NARBHA's Data Validation Unit may also perform a review when notified of concerning claiming patterns. Concerns can be brought to the Data Validation Unit's attention by the Claims Unit, the Corporate Compliance Office, NARBHA Care Management or any other concerned NARBHA staff. If a request is made for the Data Validation Unit to perform a focused audit the results are then given to unit/person who requested the audit, the Clinical Documentation and Review Manager and the Quality Management Administrator. Once the results are distributed the appropriate action can be decided. The provider can be turned over to the Performance Improvement Unit and/or have a full data validation audit performed. Claiming patterns are reviewed by NARBHA's Data Validation Unit each quarter using a claims stratification process. Stratification of data including number of units, service code type, and/or claim reimbursement can identify claims outliers that are then reviewed for accuracy.

If fraud or abuse is suspected at any time during encounter validation, the suspected fraud or abuse will be reported to the NARBHA Corporate Compliance Officer. A provider may be considered to be submitting fraudulent or abusive claims if NARBHA has given the provider written feedback or technical assistance about a pattern of errors and the provider continues the same practice after feedback is received.

In order to ensure technical assistance NARBHA Encounter Data Validation studies are aggregated for the statewide error report (see OPS Manual) and are evaluated as follows:

- The total number of encounters/claims are determined based on the total number of encounters/claims submitted.
- Audits results for individuals not found to be in full compliance (95%) are assigned as follows:
  - Error rate of 6%-25%: the provider needs correction. The provider will correct and rebill, or otherwise have encounters with errors voided/replaced. Technical assistance will be provided as-needed.
    - Because random samples are selected by member rather than by claim, a single error (such as a diagnosis code error) may replicate across every sampled claim for that member when it would not have appeared in a random sample, compromising statistical reliability. To control for this, on a quarterly basis, NARBHA uses the Data Validation Findings Summary which is produced as a deliverable to ADHS/DBHS. This deliverable measures the overall encounter error rate for NARBHA's service area.
    - If the overall Data Validation Findings Summary indicates an overall encounter validation error rate above 5%, NARBHA performs a root-



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cause analysis and will conduct additional technical assistance and/or performance improvement with providers substantially contributing to the error rate. This ensures conformance to a 95% minimum performance standard and the accuracy of that measurement.

- Error rate of 26%-49% the provider needs improvement. A formal technical assistance memo will be issued identifying focused technical assistance needs. A formal training may or may not accompany the technical assistance memo. The provider will be audited again within six (6) months.
- Error rate of 50% or greater: the provider does not meet expectations. There will be a mandatory technical assistance memo along with mandatory focused training, and performance improvement activities. The provider will be audited quarterly until at least reaching the “needs improvement” audit level.

Regardless of the percentage of errors found on audit, those that are able to be corrected must be corrected within the timeframe described below.

NARBHA requires all encounter validation errors be corrected by the provider within 21 calendar days after the date of the NARBHA data validation audit findings letter. Encounter/claim adjustments necessary to correct data validation results must be processed by the provider through NARBHA’s claim system with the void and/or void/replace transaction. Electronic replacement claims must use frequency code 7. Electronic void claims must use frequency code 8. Providers billing paper claims must submit a replacement claim with the corrected information, including the initial claim’s ICN Number in field #19 for CMS 1500 claims and Field #64 for UB04 claims. For paper claims, NARBHA will void and recoup claims internally if the claim cannot be rebilled. NARBHA will notify the provider in writing when adjustment transactions are complete. The provider will submit final corrected claims and any omissions to NARBHA within 21 days after the audit findings letter date. If a provider does not correct data validation errors within this time frame, NARBHA may consider a sanction for each incorrect claim, day of delay, or other sanction in NARBHA’s discretion. (See [NARBHA Policy 10.1 Financial Management and Reporting](#))

### **8.1.2-B. Provider responsibilities**

- Providers must deliver covered services in accordance with the [ADHS/DBHS Covered Behavioral Health Services Guide](#). Providers must document adequate information in the clinical record and submit encounters in accordance with [NARBHA Policy 6.2, Submitting Claims and Encounters to the RBHA](#). Any data validation findings that indicate suspected fraud and/or program abuse must be reported to the DBHS Bureau of Corporate Compliance and the AHCCCS Office of Inspector General as required. If fraud or abuse is suspected at any time during encounter validation, the suspected fraud or abuse will be reported to the NARBHA Corporate Compliance Officer. A provider may be considered to be submitting fraudulent or abusive claims if NARBHA has given the provider written feedback or technical assistance about a pattern of errors and the provider continues the same practice after feedback is received.

A determination of overpayment as the result of a data validation study will result in a recovery of the related funds/voiding of related encounters as required, pursuant to the Affordable Care Act.

### **8.1.2-C. Encounter validation study findings**

RBHAs are required to report the data validation findings to the provider.



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AHCCCS encounter validation study findings – Written preliminary results of all Title XIX/XXI encounter validation studies are sent to ADHS/DBHS for review and comment. ADHS/DBHS has a maximum of 30 days to review results and provide AHCCCS with additional documentation that may affect the final calculation of error rates and sanctions. Behavioral health providers may be requested to assist ADHS/DBHS or the RBHA in reviewing encounter study results and/or, if appropriate, challenging any sanctions assessed.

ADHS/DBHS encounter validation study findings – ADHS/DBHS conducts a quarterly encounter validation study with each RBHA. Medical records are independently reviewed and coded by at least two ADHS/DBHS staff members, with at least one person being a Certified Professional Coder. The results of the independent review are compared to the findings of the RBHA staff. ADHS/DBHS staff then compares the mutually agreed upon medical record review results with encounters on file in the Client Information System (CIS) computer system to determine if the claims have been submitted and to verify that there are no discrepancies between the service codes, number of units, and diagnosis codes documented in the medical record and the encounter data. Within seven business days after completion of the data validation study conduction by the ADHS/DBHS Data Validation Unit, a summary report is issued to the RBHA which includes the number of records reviewed, the number of errors found, a training issues identified, and if required, requests for corrective action.

### **8.1.2.-D AHCCCS Encounter Data Validation**

AHCCCS performs periodic data validation studies. All AHCCCS contractors and subcontractors are contractually required to participate in this process. In addition, the data validation studies enable AHCCCS to monitor and improve the quality of encounter data. Information regarding AHCCCS Encounter Data Validation Study procedures can be found in the Office of Program Support Operations and Procedures Manual.

### **8.1.3 References**

The following citations can serve as additional resources for this content area:

[AHCCCS/ADHS Contract](#)

[ADHS/RBHA Contracts](#)

[NARBHA Policy 3.9 Assessment and Service Planning](#)

[NARBHA Policy 3.13 Covered Behavioral Health Services](#)

[NARBHA Policy 4.2 Medical Record Standards](#)

[NARBHA Policy 6.2 Submitting Claims and Encounters to the RBHA](#)

[NARBHA Policy 7.1 Fraud and Program Abuse Reporting](#)

[ADHS/DBHS Covered Behavioral Health Services Guide](#)

[Office of Program Support Operations and Procedures Manual](#)

[The Affordable Care Act, Title VI. Transparency and Program Integrity](#)



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Signature on file 12/01/14

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Mary Jo Gregory Date  
President and Chief Executive Officer

Signature on file 12/01/14

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Teresa Bertsch, MD Date  
Chief Medical Officer

Reference [ADHS/DBHS Policy 1704](#)