First Health Services Corporation®
A Coventry Health Care Company

Quality Assurance

VaMMIS Procedure Manual

Version 1.0

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HIPAA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] provides protection for personal health information. The regulations became effective April 14, 2003. First Health Services developed HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandated.

Protected health information (PHI) includes any health information whether verbal, written, or electronic, that is created, received, or maintained by First Health Services Corporation. It is health care data plus identifying information that allows someone using the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

The Privacy Rule permits a covered entity to use and disclose PHI, within certain limits and providing certain protections, for treatment, payment, and health care operations activities. It also permits covered entities to disclose PHI without authorization for certain public health and workers' compensation purposes, and other specifically identified activities.

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

Revision History

Document Version	Date	Name	Comments
1.0	02/04/2008	Mae McClendon, Documentation Mgmt. Team	Creation of document

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Preface

The Procedures Manual for the Virginia Medicaid Management Information System (VaMMIS) is a product of First Health Services Corporation. Individual manuals comprise the series of documents developed for the operational areas of the VaMMIS project. Each document includes an introduction, a functional overview of the operations area, workflow diagrams illustrating the processing required to accomplish each task, and descriptions of relevant inputs and outputs. Where appropriate, decision tables, lists, equipment operating instructions, etc. are presented as exhibits, which can be photocopied and posted at unit workstations. Relevant appendices containing information too complex and/or lengthy to be presented within a document section are included at the end of the document.

Use and Maintenance of this Manual

The procedures contained in this manual define day-to-day tasks and activities for the specified operations area(s). These procedures are based on First Health's basic MMIS Operating System modified by the specific constraints and requirements of the Virginia MMIS operating environment. They can be used for training as well as a source of reference for resolution of daily problems and issues encountered.

The unit manager is responsible for maintaining the manual such that its contents are current and useful at all times. A hardcopy of the manual is retained in the unit for reference and documentation purposes. The manual is also available on-line for quick reference, and users are encouraged to use the on-line manual. Both management and supervisory staff are responsible for ensuring that all operating personnel adhere to the policies and procedures outlined in this manual.

Manual Revisions

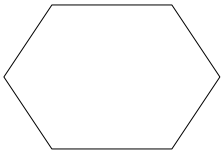
The unit manager and supervisory staff review the manual once each quarter. Review results are recorded on the Manual Review and Update Log maintained in this section of the document. Based on this review, the unit manager and supervisory staff determine what changes, if any, are necessary. The unit manager makes revisions as applicable, and submits them to the Executive Account Manager for review and approval. All changes must be approved by the Executive Account Manager prior to insertion in the manual. When the changes have been approved, the changes are incorporated into the on-line manual. Revised material will be noted as such to the left of the affected section of the documentation, and the effective date of the change will appear directly below. A hardcopy of the revised pages are inserted into the unit manual, and copies of the revised pages are forwarded to all personnel listed on the Manual Distribution List maintained in this section of the manual.

Flowchart Standards

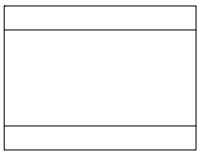
The workflow diagrams included in this document were generated through the flowcharting software product Visio Professional. Descriptions of the basic flowcharting symbols used in the VaMMIS documentation are presented below.

Large Processing Function

Manual Process. No automated processes are used; e.g., clerical function.

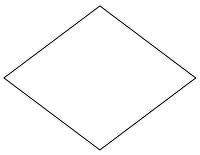


Data Preparation Processing; e.g., mailroom, computer operations, etc.

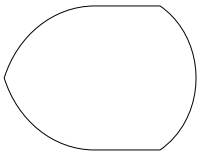


Create a Request

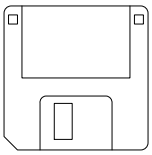
Data maintained in a master datastore.



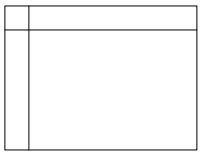
Decision



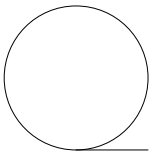
Information entered or displayed on-line.



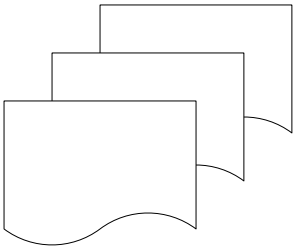
Data stored on diskette media.



On-line Storage; e.g., CD-ROM, microform, imaged data, etc.

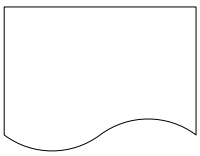


Input or Output Tape



Multiple Outputs; e.g., letters, reports

Communication Link



Single Output; e.g., letter, report, form, etc.

External Entity. Source of entry or exit from a process.

Off-page Connector

1.0 Overview of the Virginia Medical Assistance Program

The Commonwealth of Virginia State Plan under Title XIX of the Social Security Act sets forth the Commonwealth's plan for managing the Virginia Medical Assistance Program (VMAP). It defines and describes the provisions for: administration of Medical Assistance services; covered groups and agencies responsible for eligibility determination; conditions of and requirements for eligibility; the amount, duration, and scope of services; the standards established and methods used for utilization control, the methods and standards for establishing payments, procedures for eligibility appeals; and waivered services.

1.1 Standard Abbreviations for Subsystem Components

For brevity, subsystem components will use these abbreviations as part of their nomenclature.

Abbreviation	Subsystem
AM	Automated Mailing
AS	Assessment (Financial Subsystem)
CP	Claims Processing
DA	Drug Application
EP	EPSDT (Early Periodic Screening, Diagnosis, and Treatment)
FN	Financial Subsystem
MC	Managed Care (Financial Subsystem)
MR	MARs (Management and Reporting)
POS	Point of Sale (Drug Application)
PS	Provider
RF	Reference
RS	Recipient
SU	SURS (Surveillance Utilization and Review)
TP	TPL (Financial Subsystem)

1.2 Covered Services

The Virginia Medical Assistance Program covers all services required by Federal legislation and provides certain optional benefits, as well. Services are offered to Medicaid Categorically Needy and Medically Needy clients. In addition, certain services are provided to eligibles of the State and Local Hospitalization (SLH) program and the Indigent Health Care (IHC) Trust Fund. SLH, Temporary Detention Orders (TDO), and IHC are State and locally funded programs with no Federal matching funds. SLH is a program for persons who are poor, but not eligible for Medicaid in Virginia, which is funded by the Commonwealth and local counties.

Services and supplies that are reimbursable under Medicaid include, but are not limited to:

- Inpatient acute hospital
- Outpatient hospital
- Inpatient mental health
- Nursing facility
- Skilled nursing facility (SNF) for patients under 21 years of age
- Intermediate care facilities for the mentally retarded (ICF-MR)
- Hospice
- Physician
- Pharmacy
- Laboratory and X-ray
- Clinic
- Community mental health
- Dental
- Podiatry
- Nurse practitioner
- Nurse midwife
- Optometry
- Home health
- Durable medical equipment (DME)
- Medical supplies
- Medical transportation
- Ambulatory surgical center.

Many of the services provided by DMAS require a co-payment to be paid by the recipient. This payment differs by type of service being billed, according to the State Plan. Payment made to providers is the net of this amount.

General exclusions from the Medicaid Program benefits include all services, which are experimental in nature, cosmetic procedures, acupuncture, autopsy examination, and missed appointments. In addition, there are benefit limitations for specific service categories that must be enforced during payment request processing.

1.3 Waivers and Special Programs

In addition to the standard Medicaid benefit package, the Commonwealth has several Federal waivers in effect which provide additional services not ordinarily covered by Medicaid, as well as special programs for pregnant women and poor children. The programs include:

- **Elderly and Disabled** is a Home and Community Based Care (HCBC) waiver program covering individuals who meet the nursing facility level-of-care criteria and who are at risk for institutionalization. In order to forestall institutional placement, coverage is provided for:
  - ❒ Personal Care (implemented 1982)
  - ❒ Adult Day Health Care (implemented 1989)
  - ❒ Respite Care (implemented 1989)
- **Technology Assisted Waiver for Ventilator Dependent Children** is a HCBC waiver implemented in 1988 to provide in-home care for persons under 21, who are dependent upon technological support and need substantial ongoing nursing care, and would otherwise require hospitalization. The program has since been expanded to provide services to individuals over age 21.
- **Mental Retardation Waiver** includes two HCBC waivers that were implemented in 1991 for the provision of home and community based care to mentally retarded clients. They include an OBRA waiver for persons coming from a nursing facility who would otherwise be placed in an ICF/MR, and a community waiver for persons coming from an ICF/MR or community. The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) updates the eligibility file for Mental Retardation Waivers.
- **AIDS/HIV Waiver** is a HCBC waiver implemented in 1991 that provides for home and community based care to individuals with AIDS, or who are HIV positive, and at risk for institutionalization.
- **Assisted Living Services** include two levels of payment, regular and intensive. Regular assisted living payments (per day per eligible recipient) are made from state funds. Intensive assisted living payments (per day per eligible recipient) are covered under an HCBC waiver and are made from a combination of state and federal funds.
- **Adult Care Resident Annual Reassessment and Targeted Case Management** provides for re-authorization and/or follow-up for individuals residing in assisted living facilities. The program includes a short assessment process for individuals who are assessed at the residential level, and a full assessment for individuals who are assessed at the regular or intensive assisted living level. The targeted case management is provided to individuals who need assistance with the coordination of services at a level which exceeds that provided by the facility staff.

- **PACE/Pre-PACE Programs** provide coordination and continuity of preventive health services and other medical care, including acute care, long term care and emergency care under a capitated rate.
- **Consumer-Directed Personal Attendant Services** is a HCBC waiver that serves individuals who are in need of a cost-effective alternative to nursing facility placement and who have the cognitive ability to manage their own care and caregiver.
- **MEDALLION Managed Care Waiver** is a primary care physician case management program. Each recipient is assigned a primary care physician who is responsible for managing all patient care, provides primary care, and makes referrals. The primary care physician receives fees for the services provided plus a monthly case management fee per patient.
- **MEDALLION II Managed Care Waiver** is a fully capitated, mandatory managed care program operating in various regions of the State. Recipients choose among participating HMOs, which provide all medical care, with a few exceptions.
- ***Options*** is an alternative to MEDALLION where services are provided through network providers, and the participating HMOs receive a monthly rate based on estimated Medicaid expenditures.
- **Client Medical Management (CMM)** is the recipient "lock-in" program for recipients who have been identified as over utilizing services or otherwise abusing the Program. These recipients may be restricted to specific physicians and pharmacies. A provider who is not the designated physician or pharmacy can be reimbursed for services only in case of an emergency, written referral from the designated physician, or other services not included with CMM restrictions. The need for continued monitoring is reviewed every eighteen (18) months. The services not applicable to CMM are renal dialysis, routine vision care, Baby Care, waivers, mental health services, and prosthetics.
- **Baby Care Program** provides case management, prenatal group patient education, nutrition counseling services, and homemaker services for pregnant women, and care coordination for high risk pregnant women and infants up to age two.

1.4 Eligibility

Medicaid services are to be provided by eligible providers to eligible recipients. Eligible recipients are those who have applied for and have been determined to meet the income and other requirements for the Department of Medical Assistance Services (DMAS) services under Medicaid. Virginia also allows certain Social Security Income (SSI) recipients to “spend down” their income to Medicaid eligibility levels by making periodic payments to providers.

Virginia is a Section 209(b) state, meaning that the DMAS administers Medicaid eligibility for SSI eligibles and State supplement recipients locally through the Department of Social Services (DSS). DSS administers eligibility determination at its local offices and is responsible for determining Medicaid eligibility of Temporary Assistance to Needy Families with Children (TANF), Low-Income Families with Children (LIFC), and the aged. DSS also determines financial eligibility of blind and disabled applicants. In addition, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) administers recipient eligibility for Mental Retardation Waivers. The Department of Visually Handicapped (DVH) and the Department of Rehabilitative Services (DRS) are responsible for determining the degree of blindness of an applicant and the determination of medical necessity, respectively.

Three categories of individuals are eligible for services under the VMAP: Mandatory Categorically Needy, Optionally Categorically Needy, and Optionally Medically Needy. In addition, DMAS operates two other indigent healthcare financing programs, the State and Local Hospitalization (SLH) and the Indigent Health Care (IHC) Trust Fund.

1.5 Eligible Providers and Reimbursement

Qualified providers enroll with the VMAP by executing a participation agreement with the DMAS prior to billing for any services provided to Medicaid eligibles. Providers must adhere to the conditions of participation outlined in the individual provider agreement. To be reimbursed for services, providers must be approved by the Commonwealth and be carried on the Provider Master File in the MMIS.

DMAS employs a variety of reimbursement methodologies for payment of provider services. Inpatient hospital and long-term care facilities are reimbursed on a per diem prospective rate, which goes into effect up to 180 days after the beginning of the rate period to allow for retroactive payment adjustments. Settlement is based on a blend of the per diem rate and the APG/DRG Grouper reimbursement methodology. Other providers are reimbursed on a fee-for-service (FFS) basis according to a Geographic Fee File maximum amount allowed. In the FFS methodology, payment is the allowed amount, or the charge, whichever is less; payment is adjusted by co-payment, as well as by any third-party payment. Medicare co-insurance and deductibles received in the crossover system are reduced to the Medicaid allowance when the Medicare payment and the Medicaid co-insurance amount would exceed the Medicaid-allowed amount. In addition to these payment methodologies, the MEDALLION managed care program uses case management fees as well as FSS. MEDALLION II is fully capitated and uses a per member, per month, payment methodology. Health maintenance organizations (HMOs) participating in the Options program are paid a monthly rate based on estimated Medicaid expenditures. Monthly fees are also paid for Client Medical Management (CMM).

2.0 Balance Production Reports

Production reports reflect the day's invoice processing and other file updates. They are balanced by the Quality Assurance (QA) Unit daily. These jobs require QA to perform balancing of the daily claims processing reports. The balancing of the daily claims processing cycle is recorded on balancing spreadsheets. These spreadsheets are stored and are filed after completion for future reference and audits.

Balancing sheets include detailed instructions on the sheet. Many are Excel files with summary and data balancing specific to the cells used.

All daily production jobs are scheduled to run from an automated scheduling package, CA-7 Scheduler. Jobs must be added to the CA-7 database in order to run in production batch cycles.

All jobs requiring manual balancing are viewed from On-Demand and JHSX/PTR. The On-Demand system stores reports within the jobs for a specified time for viewing. The JHS-X/PTR system stores the JCL.

QA uses these reports and control total pages to balance claims activity.

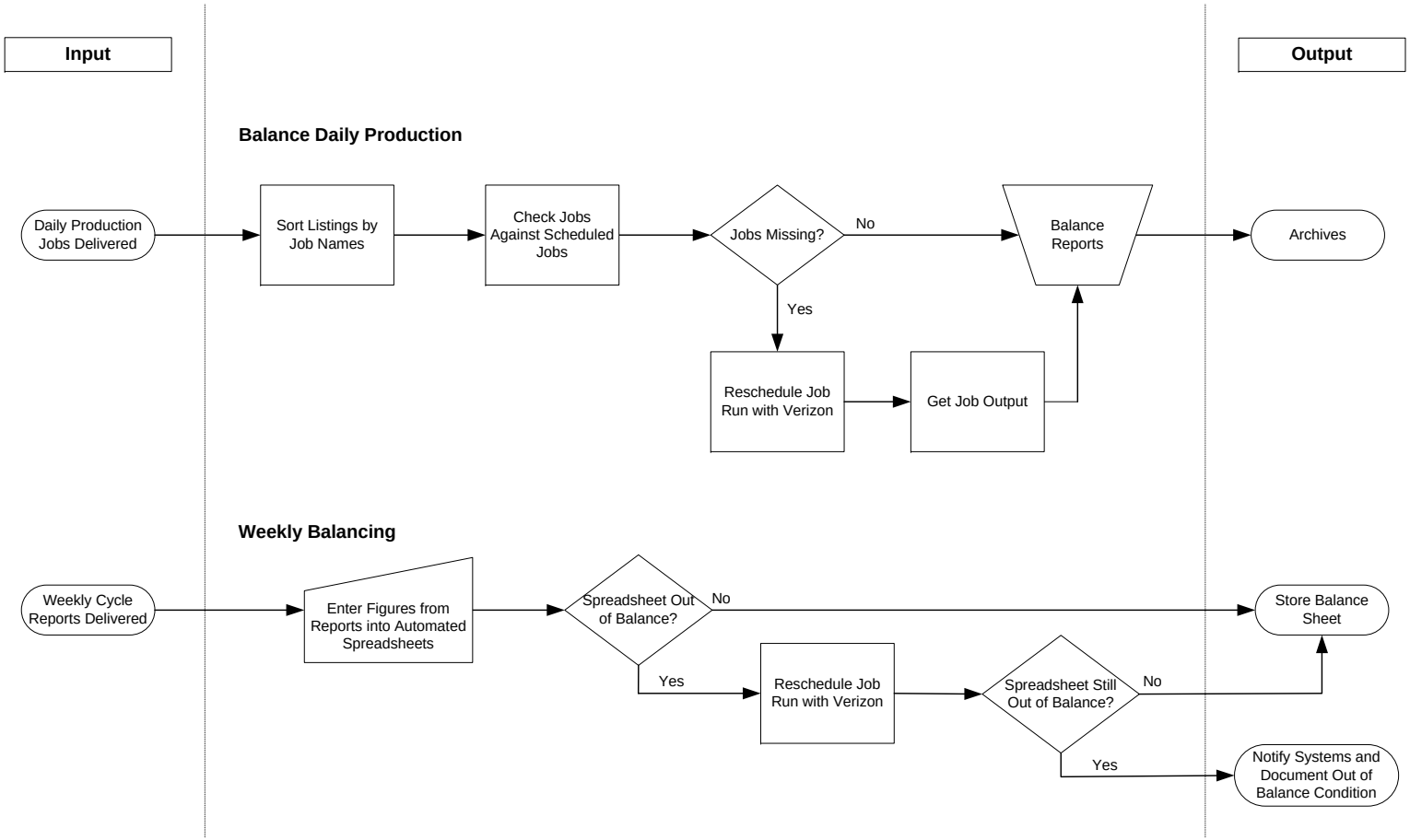
Daily Balancing Reports

Report	Description
Daily Input Summary	**(CP-O-001-03)** Lists total records in and billed charges, by claim type. It reports the results of input of the daily claims to the first program in the daily cycle.
Fee For Service Claims	**(CP-O-010-01)** Shows claim counts and charges for the results of the daily adjudication cycle. This report is used to balance the Approved Claims, Approved Adjustment/Voids counts, the Approved Billed Amount and Adjustment/Voids Billed Amounts. It reports all claim types.
Fee For Service Claims	**(CP-O-010-02)** Shows claim counts and charges for the results of the daily adjudication cycle. The Denied/Pended/Rejected Claim Count and Billed Amounts of each claim type is displayed on this report.
Adjudication Control Totals	**(CP-O-016)** Summary listing of claims that paid, denied, pended, or rejected in an adjudication cycle. It is produced by CPA000, the batch driver, and gives totals by media and by status. The total

Report	Description
	number of claims, the total billed charges, and the total payments are printed.
Daily Claims Input Analysis – Grand Total (All Claims)	**(CP-O-044-10)** Summary of all claims adjudicated in the daily cycle. It reports totals for each claim type by Auto Re-Entry Claims, Manual Reentry Claims, New Claims, and All Claims.
Daily Control Report	**(CP-O-516)** consist of eleven series of reports which displays paper claims processed in the system for daily cycle. The reports displays for daily cycle. The reports displays Claim Type for daily cycle. The reports displays for daily cycle. The reports displays Claim Type, Records Read, Record Written, Record Modified and Records In Errors. The Number Recycles. Other Total fields are also displayed on the reports. The title of the reports are as follows: ▪ Post Adjudication Suspends ▪ Output Totals ▪ Paper Input Totals ▪ HCFA Paper Input Totals ▪ UB92 Paper Input Totals ▪ Assessment Input Totals ▪ Pharmacy Input Totals ▪ TADS Input Totals ▪ ADA Input Totals ▪ ADA PA Input Totals ▪ Xover Input Totals
Daily Error Report	**(CP-O-518)** consist of daily errors that may be a duplicate ICN on the DB and must be resolved or determined by the Data Entry or Systems staff. These claims are usually put back into the system for reprocessing.

WORKFLOW PROCESS

Quality Assurance Procedures: Balance Production Reports



2.1 Balance Data Entry

To do this task, you will have to receive the D/E Export Control Log Report and Medicaid Data Entry Control Log from the Data Entry Console operator. The Medicaid Data Entry Control Log reports the Grand Total Records keyed and transferred by an outside vendor. The logs summarize the total for all paper input claim types processed for the daily cycle. Each day the logs are balanced against the Paper Input Totals (CP-O-516) report. You will place all the totals in the VMAP Daily Contol Balancing Report Speadsheet.

Note: A copy of the VMAP Daily Control Report Balancing spread sheet is in Appendix A. A copy of the CP-O-516 (Paper Input Totals report) is in Appendix B.

Procedure

1. Verify each claim count by each individual claim type:
   - ❖ If there is a discrepancy in the counts, consult with the Data Entry Console Operator. A file could have been transferred from the off-site vendor after data entry work hours.
   - ❖ Verify the next morning if a file was transmitted. You will have to request an updated log showing the extra claims that were processed in the previous night's cycle.
2. Copy or type the totals from the **D/E Log** report into the spread sheet for each line required on the **VMAP Daily Control Report Balancing** spread sheet.

   Enter this data into the spread sheet fields:

On spread sheet…	From log report, do this:
Total # Of Vendor Claims – Off Site Vendors	Total for: HCFA (Grand Total Records) Add: Totals for each Log. *Type into spread sheet.*
Total # Of FHS Internal Data Entry Claims Count	Add: Total for HCFA Total for T18 Total for UB-X Total for UB-92 Total for PHAR Total for PASUPP Total for PREA Total for DADA Total for DADA-PA

On spread sheet…	From log report, do this:
	Total for VADJ Type into spread sheet.
DADA-PA Claim Count	Minus: Total for DADA-PA Type into spread sheet.
PA SUPP Claims	Minus: Total for PA SUPP Type into spread sheet.
PREA Claims	Minus: Total for PREA Type into spread sheet.

3. Move to the spreadsheet's **Total: Data Entry Paper Input Claim Count** field.
4. You see the data total.
5. Get the **CP-O-516** report. Find the total for the **Records Written** column.
6. Enter this total in the spread sheet's next **Total** field.
7. The two counts should match.

2.2 Balance Daily Total Claims Processed Summary Report

You will use the CP-O-001-03 (Daily Input Summary) and the CP-O-044-10 (Daily Claims Input Analysis) reports to balance the total claims processed.

Note: A copy of the Daily Balancing Spread Sheet is in Appendix A. A copy of the CP-O-001-03 (Daily Input Summary) and the CP-O-044-10 (Daily Claims Input Analysis) reports are in Appendix B.

Procedure

1. Get the **CP-O-001-03** and the **CP-O-044-10** reports.
2. From the **CP-O-001-03** report, type the **Total** count under **Grand Total** from the report into the spread sheet.
3. From the **CP-O-044-10** report, copy or type the **New Claims/Total** count for **06 (Pharmacy)** into the spread sheet.
4. From the **CP-O-001-03** report, copy or type the **Grand Total/Records** count for **06 (Pharmacy).** This is the previous day's data entry input.
5. This is the **Total New Claims** being processed in the daily cycle.

If	Then

There are claims reported on the Suspense File,	Add the claim count to the total
There are no claims reported on the Suspense File,	Continue to the Step 6.
There are claims dropped to the Suspense File,	Subtract the claim count from the total.
There are no claims dropped to the Suspense File,	Continue to Step 6.

6. Look at the **CP-O-044-10** report. Copy or type the **Auto Re-Entry Claims/Net/Total** count to the spread sheet.
7. Copy or type the **Manual Re-Entry Claims/Net/Total** count to the spread sheet.
8. Move to the spread sheet's next **Total** field. This **Total** should cross balance to line 9.
9. Look at the **CP-O-044-10** report. Copy or type the **All Claims/Total/Net** count to the spread sheet's next field.
10. Move to the **Out Of Balance** field. You see the amount out of balance.
11. Move to the **Conditions** field and enter a comment or explaination (if necessary) to the field.

2.3 Balance Approved Claims

To do this task, you will use the Daily Control Report (Approved Claims) (CP-O-010-01), the Daily Claims Input Analysis (CP-O-044-10) and the Executive Pend Totals (CP-O-004-01) to balance the Approved Claim totals.

Note: A copy of the Daily Balancing spread sheet is in Appendix A. A copy of the Daily Control Report (Approved Claims) (CP-O-010-01), the Daily Claims Input Analysis (CP-O-044-10), Executive Pend Totals (CP-O-004-01) reports are in Appendix B.

Procedure

1. Get the **CP-O-010-01** and the **CP-O-044-10** reports.
2. From the **CP-O-010-01** report, copy or type the **Approved Total Claims Count/Total** count from the report into the spread sheet field.
3. Copy or type the **Approved Total Claims Count** count for **06 (Pharmacy)** into the spread sheet.
4. Move to the next line of the spread sheet.
5. Move to line D of the spread sheet. From the **CP-O-044-10** report, copy or type the **All Claims/Total/Net** into the spread sheet.
6. Enter the **All Claims/Total** count for **06 (Pharmacy)** into the next into line E of the spread sheet.

7. Move to line F of the spead sheet.
8. Move to line G of the spread sheet. This is the out-of-balance amount.

Is there an out-of-balance amount

Yes! Go to the next step.

No! You are through.

9. Get the **CP-O-004-01** report. Find the count in the **Today's Pends/Mass Adjustments** field and enter it into the spreadsheet field H.
10. From the **CP-O-044-10** report, copy or type the **All Claims/Total** for **15 (Capitation Claims)** into the spread sheet on line I.
11. Move to line J on the spread sheet.
12. The count shown is the out of balance count.

2.4 Balance Denied Claims

You will use the CP-O-010-02 (Daily Control Report-Denied/Pended/Rejected Claims) and the CP-O-044-10 (Daily Claims Input Analysis) reports to balance the Denied claims totals.

Note: A copy of the Daily Balancing Spread Sheet is in Appendix A. A copy of the CP-O-010-02 (Daily Control Report-Denied/Pended/Rejected Claims) and the CP-O-044-10 (Daily Claims Input Analysis) reports are in Appendix B.

Procedure

1. Get the **CP-O-010-02** and **CP-O-044-10** reports.
2. On the **CP-O-010-02** report, find the **Denied Claims Count/Total** count. Type or copy this count into field A of the spread sheet.
3. Find the **Denied Claims Count/Total** count for type **06 (Pharmacy)** claims. Type or copy this count into field B of the spread sheet.
4. Move to line C of the spread sheet.
5. Move to line D of the spread sheet.
6. Look at the **CP-O-044-10** report. Find the **All Claims/Deny/Total/Net** count. Enter it on line D.
7. Find the count for **All Claims/Deny/Total** for **06 (Pharmacy)** claims. Enter it in field E.
8. Move to field F, then to field G. The count shown is out of balance.

Yes! Go to the next step.

No! You are through.

9. Go to the **CP-O-004-01**. Find the count for **Previous Pends/Mass Adjustments.** Enter this count in field H.
10. Go to the CP-O-044-01 report. Find the **All Claims/Deny/Total** for claims type **15 (Capitation).** Type or copy this amount into field I of the spread sheet. Balance the **CP-O-044-10** column under the **All Claims** section.
11. Move to the next field (J). This is the remaining out-of-balance count.

2.5 Balance Pended Claims

You will use the CP-O-010-02 (Daily Control Report-Denied/Pended/Rejected Claims) and the CP-O-044-10 (Daily Claims Input Analysis reports to balance the Pended claims totals.

Note: A copy of the Daily Balancing Spread Sheet is in Appendix A. A copy of the CP-O-010-02 (Daily Control Report-Denied/Pended/Rejected Claims) and the CP-O-044-10 (Daily Claims Input Analysis) reports are in Appendix B.

Procedure

1. Get the **CP-O-010-02** and **CP-O-044-10** reports.
2. On the **CP-O-010-02**, find the **Pended Claims Count/Total** count and enter in field A of the spread sheet.
3. Find the count in **Pended Claims Count** for type **06 (Pharmacy)** claims and enter it into the spread sheet in field B.
4. Move to the field C.
5. Get the **CP-O-044-10** report.
6. Find the count in **All Claims/Pend/Total/Net.** Type or copy this amount into field D of the spread sheet.
7. Find the **All Claims/Pend** count. Enter it into field E of the spread sheet.
8. Move to field F.
9. Move to field G. If the counts are out of balance, you see a count here.

Is there an out-of-balance count?

Yes! Go to the next step.

No! You are through.

10. On the **CP-O-010-02**, find the **Pended Claims Count** for claim type **15**. Type or copy it into field H.
11. On the **CP-O-001-01** report, find the **Previous Pends/Mass Adjustments** count. Type or copy it into field I of the spread sheet.
12. Move to field J. This is the count that is out of balance.

2.6 Balance Rejected Claims

You will use the CP-O-010-02 Daily Control Report (Denied/Pended/Rejected Claims) to balance for this amount.

Note: A copy of the Daily Balancing Spread Sheet is in Appendix A. A copy of the CP-O-010-02 (Daily Control Report-Denied/Pended/Rejected Claims) is in Appendix B.

Procedure

1. Get the **CP-O-010-02** report.
2. Find the **Rejected Claims Count/Total** count. Copy or type it in field A of the spread sheet.
3. Copy or type the **Rejected Claims Count** count for claim type **06 (Pharmacy)** into field B of the spread sheet.
4. Move to field C of the spread sheet.
5. You see the total rejected claim count.

3.0 Conduct Internal Operations Reviews

VMAP conducts Internal Operations Reviews of each operational area. The Quality Control Unit monitors the workflow in all operational areas. The unit works with the manager of each unit to establish and maintain quality control procedures and standards within the work unit.

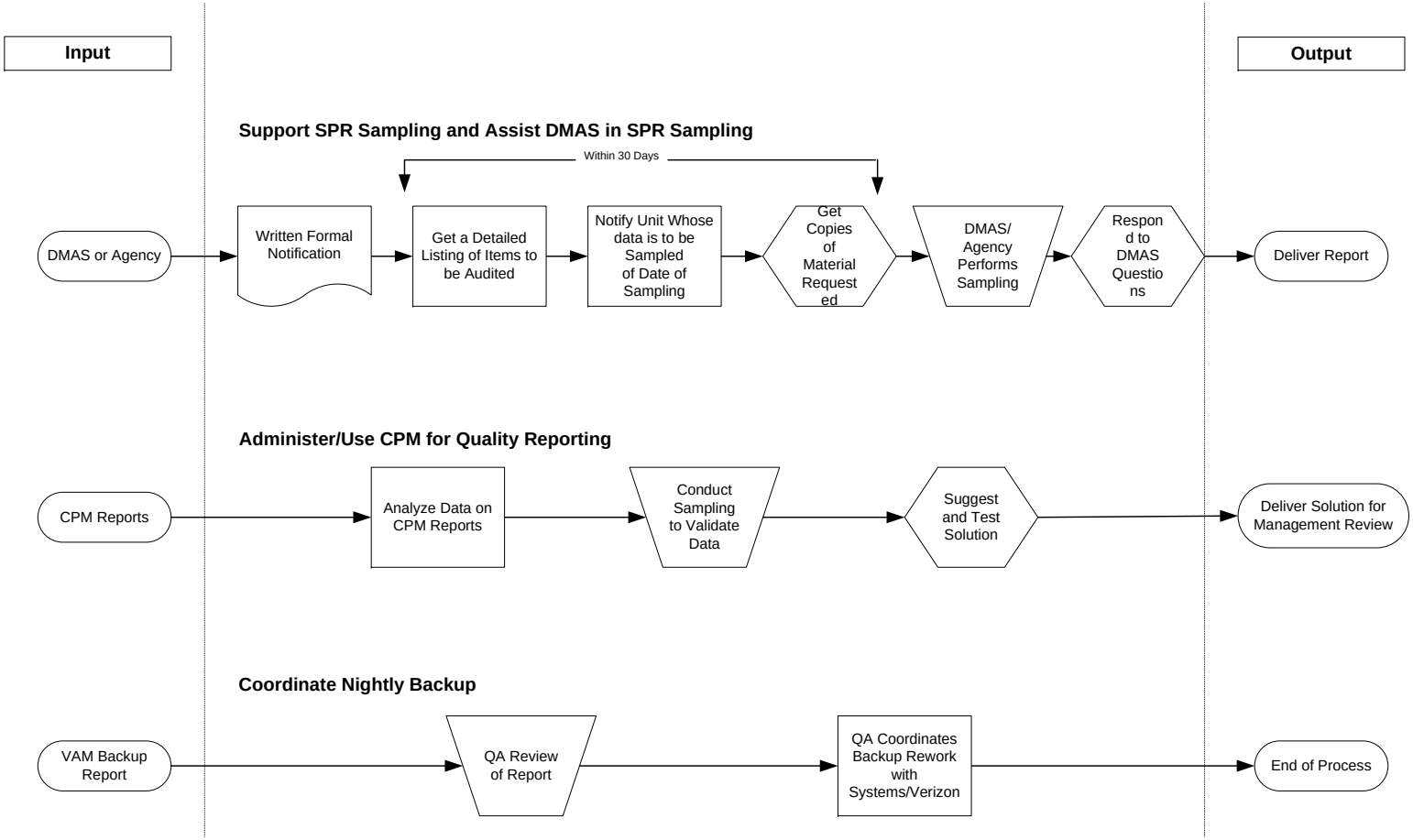
QA performs weekly audits of a statistical sample of adjudicated claims, and monthly audits of the operation using methods similar to those used for SPR sampling. Monthly audits are scheduled so that all activities are reviewed at least twice a year. Discrepancies found during these audits are reported to management so that corrective action can be taken.

On a regular basis, QA audits the procedures and contract policies, and report its findings to the managers and account managers. Reports of these findings will be made to DMAS when requested.

The Quality Control Unit will act as a liaison with DMAS contract monitors, and other DMAS personnel, to ensure that the fiscal agent is kept informed of guidelines and policies.

WORKFLOW PROCESS

Quality Assurance Procedures: Conduct Internal Operations Reviews



3.1 Support SPR Sampling Preparation

DMAS may periodicaly conduct System Performance Reviews (SPRs). VMAP's Quality Control Unit will provide all support requested by DMAS during this review. QA will assit DMAS and CMS in sample selections, documentation and data gathering, then respond to their questions. VMAP is responsible for making all necessary resources available during the on-site review.

Access to all required materials appropriate for review must be provided by Quality Control and Systems within thirty (30) days after written notification from the DMAS Internal Audit Unit.

Procedure

1. Receive formal written notification from agency or DMAS.
2. Notify by telephone or e-mail, the unit manager or supervisor, whose data is to be audited, of the time and date of the audit.
3. Request by telephone, e-mail or memo, all detailed listings of materials needed for the audit from the First Health staff within the units being audited.
4. Gather copies of any material requested from the auditor, such as checks, reconciliation statements, and supporting documentation. These items must be available upon auditor request.
5. Assist DMAS or other agency in selecting and collecting SPR samples.

3.2 Respond to DMAS Questions Relating to SPR

Questions relating to the System Performance Review (SPR) are documented and directed to the VMAP Account Director during and after the review. Usually, Systems and Quality Control units are responsible for responding to CMS and DMAS questions. VMAP follows all guidelines, and meets all requirements outlined in the Federal SPR manual for the specified time frame in which the review is scheduled.

All resources (material and personnel) are made available during preparation of the materials, the walk-through and during the actual on-site review.

A written response to questons concerning the SPR is prepared and forwarded to the auditor, if necessary. Our goal is to resolve all issues during the on-site audit, and leave no unresolved issues.

Procedure

1. Perform research and provide answers to questions that DMAS and CMS auditors have.

2. Request assistance from the Systems staff, if necessary.
3. Provide the requested historical data in the agreed-to format from databases.
4. Assist in responding to questions and resolve issues during and after the audit and within the specified time frames.

3.3 Conduct Internal Quality Sampling

The Quality Control Unit samples data from a variety of different data sources on different platforms. Internal quality sampling is performed and conducted at a level within all units to ensure these contractual duties and activities are covered, and ensures the regularity of audit time/sampling.

VMAP maintains responsive service levels as outlined under Contract Management. QA provides an effective organizational framework, sufficient experience, qualified staff, compliance with DMAS policies, and performance of specific contractual tasks. Some of the features included in the Internal Quality Sampling process are:

- Flexibility for automated sample selection.
- Variety of sampling methodologies.
- Ability for systematic sampling.
- Perform sample analysis.
- Ability to do provider billing sampling.
- Ability to evalutate sample results.
- Eligibility quality control (Recipient and Provider).
- Automated audit worksheets.

Quality Control documents and files each internal audit performance in one centralized location within the Quality Control Unit.

Procedure

1. Plan and execute desk reviews of all internal audits.
2. Conduct audits within each individual unit. Schedule audits that are performed on a weekly or monthly basis around the same target date and time, to ensure audit time/sampling consistency. For example, if performing a mailbag sampling, try to sample all mailbags on the same day of the week, and around the same time of day.
3. Perform weekly audits of adjudicated claims sampling using approved, systematic calculation methodologies.

4. Verify and balance **MARS** and **SURS** reports according to documented balancing procedures. Report discrepancies to the Systems Manager, and supply all necessary documents along with your findings and request for corrections.
5. Report results of the desk reviews of each area sampled in a detailed report to all unit managers.
6. Request a written response (memo) from all unit managers and supervisors with below-standard performance ratings.
7. Maintain internal audit documentation/material in one centralized location within the Quality Control unit for six (6) months to one (1) year.
8. Respond and report all audit results to DMAS upon request.

3.3.1 Determine Items to be Sampled

At the end of each month, a list of items to be sampled and the size for the next month's mailbag samples is prepared and the schedule for pulling the sample is prepared.

The purpose of the mailbag sample is to verify that specific processing activities are being performed in an accurate and timely manner by pulling a sample at the beginning of the process and then reviewing the final results. This review consists of three parts: (1) those activities which are reviewed monthly, (2) those activities which are reviewed quarterly, and (3) those activities which are reviewed semi-annually.

In general, these samples consist of the items described below.

- Monthly Mailbag Sample: Includes verification of front-end processing of claims (i.e., sorting, screening, scanning, Data Entry, etc.) and the proper processing of financial transactions.
- Quarterly Mailbag Sample: Includes verification of Provider file updates, adjustment processing, and provider inquiry activity.
- Semi-Annual Mailbag Sample: Includes verification of mailroom operations, and provider enrollment and verification activities.

The following subsections describe the specific forms and reports needed to complete the reviews and the procedures to be followed in performing the reviews. The last part of this section describes the procedures to be followed in preparing the summary report and the discrepancy reports.

Procedure

1. During the last week of each month, use the **Mailbag Sample Schedule** table at the end of this section to determine which items are to be included in the following month's mailbag sample.
2. Prepare the sample size for each item and the schedule for pulling the sample by completing a **Mailbag Sample Scheduling Form**. (Sample at end of this section.)
3. Enter the sample month in the **Month Of** space.
4. Enter the items to be sampled from the **Mailbag Sample Schedule** table in column 1.
5. Enter the periodicity for each item (Monthly, Quarterly or Semi-AnnuaI) in column 2.
6. Using the chart at the end of this section, determine the sample size for each item and enter it in column 3.
7. Using the chart at the end of this section, determine the schedule for pulling each sample and enter the date in column 4.

Mailbag Sample Schedule	
Monthly Mailbag Sample	
Every Month	▪ Front-End Claims Processing (Hardcopy)
Quarterly Mailbag Sample	
First Month of Quarter (January, April, July, October)	▪ Provider File Updates
Second Month of Quarter (February, May, August, November)	▪ Claims Resolution Telephone Inquiries
Third Month of Quarter (March, June, September, December)	▪ Provider Correspondence
Semi-Annual Mailbag Sample	
Cycle A (January and July)	▪ Mailroom Operations
Cycle B (February and August)	▪ Provider Enrollment
Cycle C (March and September	▪ DARS
Cycle D (April and October	▪ Provider Reverification

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Mailbag Sample Scheduling Form

Month of: _____

Sample Item	Periodicity	Sample Size	Scheduled Pull Date

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Guidelines for Determining Mailbag Sample Size and Schedule			
Monthly Samples			
Front-End Claims Processing	___% of prior month's receipts	1st Tuesday of the month	3rd week of the month
Financial Transaction Processing	___ Financial Transactions per month	Any time during the first three weeks of the month	Monday or Tuesday following receipt
Quarterly Samples			
Provider Files Updates	___ Updates per month	2nd week of the month	3rd week of the month
Claims Resolution	___ Pend listings each month divided among the locations	1st week of the month	3rd week of the month
Telephone Inquiries	___ Inquiries per month	2nd or 3rd week of the month	2nd or 3rd week of the month
Provider Correspondence	___ Inquiries per month	1st week of the month	3rd week of the month
Semi-Annual Samples			
Mailroom Operations	N/A	2nd week of the month	2nd week of the month
DARS	N/A	1st or 2nd week of the month	1st or 2nd week of the month
Provider Enrollment	___ Applications per	1st week of the month	Last week of the month
Provider Reverification	___ Reverifications per	1st week of the month	Last week of the month

3.3.2 Prepare Sampling Control Reports

Once the Mailbag Sample Schedule has been determined, a sampling report form is prepared for each item and filed by week based on the dates scheduled for pulling the sample.

Procedure

1. After the **Mailbag Sample Scheduling Form** has been determined, prepare a **Sampling Control Report** for each item to be sampled that month by completing the **Sample Information** section. (See sample form at the end of this section.)
2. Enter the sample month and year in the **Month Of** space.
3. Enter the type of sample (Mailbag or Product) in the **Type of Sample** space.
4. Enter the periodicity (monthly, quarterly or semi-annually) in the **Periodicity** space.
5. Enter the sample item from the scheduling form in the **Sample Item** space.

6. Enter the sample size from the scheduling form in the **Sample Size** space.
7. Enter the scheduled pull date from the scheduling form in the **Scheduled Pull Date** space.
8. Using the sample size and the schedule chart in the previous section, determine the review date and enter this date in the **Scheduled Review Date** space
9. After a **Sample Control Report** has been completed for each item, sort the reports by the scheduled pull dates and file them with the scheduling form in a tickler file.

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Sampling Control Report

Month of: _____

Sample Information	
Type of Sample:	**Sample Size:**
Periodicity:	**Scheduled Pull Date:**
Sample Item:	**Scheduled Review Date:**
Sample Pull Results	
Date Pulled:	**# Items in Sample:**
Results: ☐ Sample Complete ☐ Sample Incomplete	
Date Pulled:	**# Items in Sample:**
Results: ☐ Sample Complete ☐ Sample Incomplete	
Final Result: ☐ Sample Complete ☐ Sample Incomplete ☐ No Sample Items Found	
Sample Review Results	
Review Date:	**Results:** ☐ Sample Complete ☐ Sample Incomplete
Review Results	
Follow-Up Required	
Follow-Up Completed:	

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3.3.3 Pull and Copy Samples

Each Monday, the schedule is reviewed to determine which mailbag samples are to be pulled, and the Claim Operations Manager is notified to minimize any disruption of mailroom operations occurs. Then the items to be included in the samples are pulled and copied as the mail is being opened, and the items are returned to be processed as normal after they are copied.

Procedure

1. On Monday morning, review the **Mailbag Sample Scheduling Form** to identify which samples are to be pulled during the week.
2. Pull the **Sampling Control Reports** for the scheduled samples and sort them in date sequence.
3. Each morning that a sample is scheduled, call the Claim Operations Manager and notify her that you will be pulling a sample.
4. For samples to be pulled in the mailroom, take the **Sample Control Reports** for the scheduled samples to the mailroom and observe the clerks as the mail is being opened.
5. As the envelopes are being opened in the mailroom, pull the first envelope which contains items to be sampled and each subsequent envelope with items to be sampled until you reach the number of items you need for the sample. For example, if you are sampling provider correspondence, pull the first envelope opened which contains correspondence, then the next envelope which contains correspondence, and so forth until you have the number of envelopes in your sample size. For claims samples, be sure to spread the sample over the different P.O. boxes.
6. After all the samples have been pulled or all the mail is opened, copy the first item in each envelope you pulled for your samples. Be sure that each item copied has enough information on it for you to identify the document (i.e. provider and/or recipient name).
7. After copying the items, return the envelopes to the mailroom immediately so the items can be processed as normal.
8. Return to the Quality Control Unit with the samples and complete the **Sample Pull Results** section of the **Sampling Control Reports**.
9. Enter the current date in the **Date Pulled** space.
10. Enter the number of items you pulled in the **# Items in Sample** space.
11. If the number of items you pulled for the sample equals the **Sample Size** in the **Sample Information** section of the form, check the **Sample Complete** space. If the number of items you pulled is less than the **Sample Size**, check the **Sample Incomplete** space.

12. For all incomplete samples, schedule a pull for later in the same week and repeat steps 2 thru 11, but pull only the additional items you need to complete the sample and record the sample pull information on the second set of lines under **Sample Pull Results**.
13. After the sample pull has been completed, or after the second pull if the sample is still incomplete, check the appropriate space under **Final Result**.
14. If no sample items were found, copy the **Sample Control Report** and place it in the tickler file.
15. Check the tickler file to determine if the previous sample for that item also resulted in no sample. If so, schedule the item for the next month's sample, and if you still find no sample, contact the area supervisor to notify you when they receive the next batch of that item.
16. When the area supervisor notifies you they have received the item(s) needed, go to the area and copy the items for your sample and then complete steps 8 thru 13 above.

3.3.4 Prepare Review Forms

When the samples have been pulled and the sample pull results have been recorded, review forms are prepared for each item in that month's sample.

Procedure

1. Complete the top portion of the appropriate review form for each item in the sample. (See sample review forms at the end of this section.)
2. Attach the document being sampled to the **Mailbag Sample Review Form**.
3. File each sample with its corresponding **Sample Control Report** in a folder in sequence by the scheduled review dates.

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Mailbag Sample Review Form - Front-End Claims Processing (Paper Claims)

Sample Month: _____ **Date Pulled:** _____ (Receipt Date)

Provider Information	Recipient Information
Name:	**Name:**
ID Number:	**ID Number:**

Claim Information		
Invoice Type:	**# Lines:**	**Dates of Service:**

Claim Review Data					
	Yes	**No**		**Yes**	**No**
Screening			**Batching**		
Claim screened correctly	☐	☐	Batched correctly	☐	☐
Returned to Provider	☐	☐	Logged on Control Log	☐	☐
Imaging			**Scanning**		
Claim imaged	☐	☐	All lines scanned	☐	☐
Claim ICNed	☐	☐	All lines scanned correctly	☐	☐
Julian date = receipt date	☐	☐	**Data Entry**		
Correct batch range	☐	☐	All lines keyed	☐	☐
Correct media code	☐	☐	All lines keyed correctly	☐	☐
Attachments imaged	☐	☐	**System Processing**		
Attachments ICNed	☐	☐	Processed through adjudication	☐	☐
Image legible	☐	☐			

Review Results	
Processed Correctly: ☐ Yes ☐ No	
Discrepancies Identified	**Referred To**

_____ Reviewer Signature _____ Review Date

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Mailbag Sample Review Form - Financial Transaction Processing

Sample Month: _____ **Date Pulled:** _____
(Receipt Date)

Transaction Information	
Provider Name:	**Provider Id Number:**
Transaction Amount:	**Transaction Type:**
Authorized Signature: ☐ Yes ☐ No	**Request Completed Correctly:** ☐ Yes ☐ No

Review Data					
	Yes	**No**		**Yes**	**No**
Date Stamped	☐	☐	Correct matching FCN (if applicable)	☐	☐
Logged on Control Log	☐	☐	Entered correctly to Add/Pay File	☐	☐
Correct FCN assigned	☐	☐	Processed through system	☐	☐
Julian date = receipt date	☐	☐	Reported on RA	☐	☐
Correct reason/source code	☐	☐	Reported correctly on financial reports	☐	☐
Correct cost center assigned	☐	☐			

Review Results	
Processed Correctly: ☐ Yes ☐ No	
Discrepancies Identified	**Referred To**

_____ **Reviewer Signature** _____ **Review Date**

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Mailbag Sample Review Form - Provider File Update

Sample Month: _____ **Date Pulled:** _____ (Receipt Date)

Transaction Information			
Provider Name:		**Provider ID Number:**	
Received From:	☐ DMAS ☐ Provider		
Authorized Signature:	☐ Yes ☐ No	**Form Completed Correctly**	☐ Yes ☐ No
Type of Update			
☐ Address Change	☐ Cancellation	☐ Eligibility Change	☐ Provider on review
☐ Rate Change	☐ Reinstate	☐ Other	
Review Data			
Updated Online:	☐ Yes ☐ No	**Appears on Audit Trail:**	☐ Yes ☐ No
Keyed Correctly:	☐ Yes ☐ No	**Appears in Online File:**	☐ Yes ☐ No
Julian Date of Receipt:	**Julian Date of Update:**	**Elapsed Time:**	
Review Results			
Processed Correctly:	☐ Yes ☐ No	**Timeliness Requirements Met:**	☐ Yes ☐ No

Discrepancies Identified	Referred To

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Mailbag Sample Review Form - Claims Resolution

Sample Month: _____ **Date Pulled:** _____ (Receipt Date)

Claim Information			
	Claim ICN	**Provider Name**	**Provider Number**
EOB Code:			
Location:			
Date(s) of Service:		**To be resolved by:**	

Review Data					
	Yes	**No**		**Yes**	**No**
Valid Pend	☐	☐	Correction processed	☐	☐
Resolved correctly	☐	☐	Claim adjudicated	☐	☐
Updated correctly	☐	☐	Appeared on RA	☐	☐

Status after resolution:		
EOB code(s):	**Julian date of update:**	**Julian date of Pend:**
Valid EOB code(s): ☐ Yes ☐ No	**Elapsed time in location:**	

Review Results	
Processed Correctly: ☐ Yes ☐ No	
Discrepancies Identified	**Referred To**

Reviewer Signature _____ **Review Date** _____

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Mailbag Sample Review Form - Telephone Inquiries

Sample Month: _____ **Date Pulled:** _____
(Receipt Date)

Type of Call	Provider Information	Recipient Information	Claim Information
☐ Claim Status ☐ Recipient Eligibility	**Name:**	**Name:**	**Date(s) of Service:**
☐ Denied Claim ☐ Rejected Claim	**Number:**	**Number:**	**Amount Billed:**
☐ Claim Payment ☐ Other:			**Amount Paid:**

Review Data

Clerk Name:	**Time of Call:**

	Yes	No	Comments:
Call answered promptly	☐	☐	
Call put on hold	☐	☐	
Clerk courteous	☐	☐	
Response correct	☐	☐	
Call logged in	☐	☐	

Review Results

Processed correctly: ☐ Yes ☐ No

Discrepancies Identified	Referred To

_____ **Reviewer Signature** _____ **Review Date**

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Mailbag Sample Review Form - Adjustment Processing

Sample Month: _____ **Date Pulled:** _____ (Receipt Date)

Provider Information	Recipient Information
Name:	**Name:**
Number:	**Number:**

Adjustment Information

Original ICN:	Date(s) Of Service:	Reason Of Adjustment:

Check attached: ☐ Yes* ☐ No

*If yes, also complete a Refund Processing Review Form.

Originator

☐ Provider ☐ Provider Services ☐ DMAS ☐ Adjustment/Financial

☐ Other:

Review Data

	Yes	No		Yes	No
Form completed correctly	☐	☐	Image legible	☐	☐
A/V reason coded correctly	☐	☐	Batched correctly	☐	☐
FCN coded correctly (if applicable)	☐	☐	Claim type modifier correct	☐	☐
Screened correctly	☐	☐	Adjustment keyed correctly	☐	☐
Adjustment imaged	☐	☐	Adjustment processed correctly	☐	☐
Adjustment ICNed	☐	☐	Adjustment pended	☐	☐
Julian date = receipt date	☐	☐	Resolved correctly	☐	☐
Correct batch range	☐	☐	Adjustment adjudicated	☐	☐
Attachments imaged	☐	☐	Appears on RA correctly	☐	☐
Attachments ICNed	☐	☐			

Review Results

Processed Correctly: ☐ Yes ☐ No

Discrepancies Identified	Referred To

_____ Reviewer Signature _____ Review Date

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Mailbag Sample Review Form – Refund Processing

Sample Month: _____ **Date Pulled:** _____
(Receipt Date)

Check Information		
Payor Name:		
Check Amount:	**Check Number:**	**Date of Check:**
Reason for Adjustment:		
Check Type: ☐ Personal Check ☐ Returned Check	**Documentation Attached:** ☐ Yes ☐ No	
Claim Specific: ☐ Yes ☐ No *If yes, also complete an Adjustment Processing Review Form.		

Review Data					
	Yes	No		Yes	No
Logged in Data Prep	☐	☐	Transmitted to Fiscal Tech for deposit	☐	☐
Check copied	☐	☐	Entered in recovery suspense	☐	☐
Refund Form prepared	☐	☐	Financial Transaction on RA	☐	☐
Additional information required	☐	☐	Adjustment(s)/disposition prepared	☐	☐
Additional information requested	☐	☐	Adjustment(s)/disposition processed	☐	☐
Additional information received	☐	☐	Adjustment/disposition reported on RA	☐	☐
Correct FCN assigned	☐	☐	Recovery suspense draw down	☐	☐
Julian date = receipt date	☐	☐	Reported on financial reports	☐	☐
Correction effected on 1099	☐	☐		☐	☐

Review Results	
Processed Correctly: ☐ Yes ☐ No	
Discrepancies Identified	**Referred To**

_____ **Reviewer Signature** _____ **Review Date**

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Mailbag Sample Review Form – Provider Correspondence

Sample Month: _____ **Date Pulled:** _____
(Receipt Date)

Inquiry Information	
Provider Name:	**Provider ID Number:**
Nature of Inquiry:	**Form Used:** ☐ Inquiry Form ☐ Letter
Includes all data necessary for research: ☐ Yes ☐ No	

Review Data					
	Yes	**No**		**Yes**	**No**
Logged into PC docs	☐	☐	Response complete and accurate	☐	☐
Control number assigned	☐	☐	Response produced and mailed	☐	☐
Julian date = receipt date	☐	☐	Logged out copy in PC docs	☐	☐
Additional information required	☐	☐	Julian date of receipt:		
Additional information requested	☐	☐	Julian date of response:		
Additional information received	☐	☐	Elapsed time:		
Response prepared	☐	☐			

Review Results	
Processed Correctly: ☐ Yes ☐ No	**Meets Timeliness Requirements:** ☐ Yes ☐ No
Discrepancies Identified	**Referred To**

_____ **Reviewer Signature** _____ **Review Date**

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Mailbag Sample Review Form – Provider Enrollment

Sample Month: _____ **Date Pulled:** _____
(Receipt Date)

Provider Information	
Provider Name:	**Provider Type:**
Provider Address:	

Review Data					
	Yes	No		Yes	No
Request in PC docs	☐	☐	Provider file updated correctly	☐	☐
Enrollment packet mailed	☐	☐	All documents properly loaded in PC docs	☐	☐
Credentials verified	☐	☐	Julian date of receipt:		
All documents received	☐	☐	Julian date of notification:		
Provider ID number assigned	☐	☐	Elapsed time:		
Information packet distributed	☐	☐			

Review Results	
Processed Correctly: ☐ Yes ☐ No	**Timeliness Requirements Met:** ☐ Yes ☐ No
Discrepancies Identified	**Referred To**

_____ **Reviewer Signature** _____ **Review Date**

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Mailbag Sample Review Form – Source Document Management

Sample Month: _____ **Date Pulled:** _____
(Receipt Date)

Review Data				
Document Type	Found		Filed Correctly	
	Yes	No	Yes	No
Hardcopy Claims	☐	☐	☐	☐
Image	☐	☐	☐	☐
DARS	☐	☐	☐	☐
MMIS Reports	☐	☐	☐	☐
Prior Authorizations	☐	☐	☐	☐
Claim Adjustments	☐	☐	☐	☐
Provider Correspondence	☐	☐	☐	☐
Refund/Returned Checks	☐	☐	☐	☐
Financial Transactions	☐	☐	☐	☐
Provider Enrollment Documents	☐	☐	☐	☐
Reverification Documents	☐	☐	☐	☐
Provider File Updates	☐	☐	☐	☐

Review Results	
All Documents Found: ☐ Yes ☐ No	**All Documents Filed Correctly:** ☐ Yes ☐ No
Discrepancies Identified	**Referred To**

_____ _____
Reviewer Signature **Review Date**

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First Health Services Corporation
A Coventry Health Care Company

Mailbag Sample Review Form – DARS

Sample Month: _____ **Date Pulled:** _____
(Receipt Date)

Review Data						
Reports Sampled	Produced On Time		Balanced		Loaded Correctly	
	Yes	No	Yes	No	Yes	No
Reference						
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
Claims						
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
Recipient						
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
Provider						
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
SURS						
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
MARS						
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐

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Review Data						
Reports Sampled	Produced On Time		Balanced		Loaded Correctly	
	Yes	No	Yes	No	Yes	No
EPSDT						
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
Drug						
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
Financial						
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
Remittance Advices						
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐

Review Results

All Reports Process Correctly: ☐ Yes ☐ No

Discrepancies Identified	Referred To

Reviewer Signature

Review Date

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3.3.5 Prepare for and Conduct Review

Each week the Mailbag Sample File is checked to determine which reviews are scheduled for that week. As each review date comes due, the sample is pulled from the file and the apporpriate documentation and reports are gathered in preparation for the review.

After all the required documents have been assembled, the review is conducted using the appropriate documentation manuals as the guideline for how the item under review should have been processed. As each item is reviewed the activity is documented on the appropriate Mailbag Sample Review Form.

Procedure

1. Each Monday morning, review the **Mailbag Sample Scheduling Form** to determine which reviews are scheduled for that week.
2. On the day the review is to be done, pull the sample form from the file and determine which volumes of documentation are required.
3. Assemble the required Detailed System Designs, User Manuals and Operations Procedures Manuals needed for the review.
4. If not completely familiar with the process or activity being reviewed, scan the Operations Procedures Manual to determine which reports are needed to complete the review.
5. Make a list of the reports and remittance advices needed for the review.
6. Go to DARS and print or review the reports and remittance advices needed for the review.
7. For each item in the sample, perform the review by verifying that each activity in the process was completed in accordance with the procedures documented in the appropriate Operations Procedures Manual and that any system processing was done according to the process documented in the appropriate detailed systems design.
8. As each activity is reviewed, check the appropriate space in the **Review Data** section of the **Mailbag Sample Review Form**. (See samples of the review forms at the end of the previous section.)
9. Where the activity must meet specified timeliness requirements, calculate the elapsed time and document the results.
10. To complete the final section of the **Mailbag Sample Review Form**, go to Section 3.3.6 - Document Review Results.

3.3.6 Document Review Results

After completing each review, the results are documented on the **Mailbag Sample Review Form**. Any errors in processing are recorded along with the identification of who caused the error (if applicable), where the error is being referred, and recommended corrective action if necessary.

Procedure

1. For each item reviewed in the sample, document whether the item was processed correctly by checking the appropriate space in the **Review Results** section of the **Mailbag Sample Review Form**.
2. If appropriate, check whether the timeliness requirements were met.
3. For each item on which errors were found, list the error or errors in the **Discrepancies Identified** space at the bottom of the form.
4. If appropriate, identify who caused the error (i.e., FHSC, the provider, or DMAS).
5. Identify to whom the error is being referred for review and/or corrective action.
6. Sign and date the form in the spaces provided.
7. After completing the review of the entire sample, document the results in the **Sample Review Results** space of the **Sampling Control Report**.
8. Enter the date in the **Review Date** space.
9. Check whether the review was completed (i.e., all items in the sample had been processed to completion) or not completed (i.e., some items had not been processed to completion).
10. Summarize the results of the review in the **Review Results** space. List the number of items in the sample which were processed correctly, the number of items for which discrepancies were identified, and the number of items for which the review could not be completed. Then summarize the types of discrepancies identified and the number of discrepancies of each type.
11. If the **Review Not Completed** space was checked, summarize the nature of the items to be completed in the **Follow-Up Required** space.

3.3.7 Prepare Discrepancy Report

After completing the review and documenting the results, Discrepancy Reports are prepared and distributed for errors requiring review and corrective action.

Procedure

1. Follow the procedures in this manual under "Prepare Discrepancy Reports."
2. Attach the sample items to the **Sample Control Report** and file the sample in a "Completed" file until all of that month's mailbag samples have been completed.
3. Sort the **Discrepancy Reports** by the person to whom the report is being referred. Place each set of **Discrepancy Report** in an envelope addressed to the appropriate manager or DMAS person and seal the envelope.
4. Place all envelopes in the "OUT" basket for the next courier pick-up.

3.3.8 Prepare Summary Report

When all mailbag sample reviews for the month have been completed, the Monthly Mailbag Sample Report is prepared.

Procedure

1. After all of the mailbag samples have been completed for the month, prepare the **Monthly Mailbag Sample Summary Report**. (See sample at the end of this section).
2. Pull the completed samples for the month from the file.
3. Enter the sample month in the **Month of** space.
4. Using the data summarized on the **Sampling Control Report** for each sample, complete the six (6) columns for each sample on the first page of the **Summary Report**.
5. Note any unusual circumstances or problems in the **Comments** section on the first page of the **Summary Report**.
6. Using the data summarized on the **Sampling Control Report** and the specific items documented on the **Mailbag Sample Review Forms**, complete the **Error Analysis** and **Discrepancies By Type Of Error** sections on page 2 of the **Summary Report**.
7. File the **Summary Report** for inclusion in the **Monthly Quality Control Report**.
8. File the "completed" QA samples file.
9. File the samples requiring follow-up in a tickler file and identify a scheduled date for review and follow-up.

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Monthly Mailbag Sample Summary Report

Month of: _____

Items Samples	# Items Sampled	# Items Processed Correctly	# Items Requiring Follow-Up	# Items With Discrepancies	# Discrepancies	# Items Referred for Action
Monthly Mailbag Samples						
Front-End Claims Processing (Paper Claims)						
Financial Transactions						
Quarterly Mailbag Samples						
Semi-Annual Mailbag Sample						
Comments:						

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Month of: _____

Error Analysis							
Sample Items	FHSC Errors	Provider Errors	DMAS Errors	Other Errors	Total Errors	Referred to FHSC	Referred to DMAS

Discrepancies by Type of Error					
Sample	Type of Error	Errors	Sample	Type of Error	Errors

3.3.9 Complete Follow-up

Items requiring follow-up are reviewed at the beginning of each week and scheduled items for the week are included in the overall schedule. As the scheduled review dates occur, the reviews are completed and the results are documented on the Follow-up Report.

Procedure

1. Each Monday morning, review the items in the follow-up file and include any items scheduled for the week in that week's review schedule.
2. On the day the review is scheduled, complete the review according to the procedures described under "Conduct Review" in this section of the manual.
3. Document the results on the appropriate review form.
4. Summarize the results on the **Monthly Mailbag Sample Followup Report**.
5. Complete the **Review Results** section of the **Follow-Up Report** for those items which required follow-up only. List the number of items reviewed which were processed correctly and the number of items for which discrepancies were identified. Then summarize the type of discrepancies identified and the number of discrepancies of each type.
6. Attach the **Follow-Up Report** to the front of the sample and file it for inclusion in the monthly **Quality Control Report**.

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Monthly Mailbag Sample Follow-Up Report

Month of: _____

Sample Information
Sample Month:
Sample Outstanding:
Number Items Requiring Follow-Up:
Review Results
Review Date:
Review Results:
Follow-Up Completed:

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3.4 Coordinate and Respond to DMAS Internal Audits

The Quality Control Unit assists in coordinating and responding to DMAS Internal Audits. Audits are usually performed on a 6-month or annual schedule. QA assists DMAS and CMS auditors with gathering all necessary materials needed to conduct an on-site audit. QA usually requests Systems staff to resolve and respond to any questions, discrepancies, or errors found by an auditor. We prefer to provide answers to questions or discrepancies while the auditor is on-site.

The Fiscal Agent must respond to any written request from DMAS or CMS auditors for explanation and/or resolution of discrepancies within ten (10) working days of receiving the request.

Procedure

1. Research questions and provide answers to DMAS and/or CMS auditors in a timely manner.
2. Request the assistance of Systems staff, if needed, to respond appropriately to an auditor's findings.
3. Provide timely historical data from the various databases.
4. Assist in the response to inquiries and issues, during and after the audit, within the specified time frame.
5. Store and file all supporting materials and documentation pertaining to a DMAS internal audit for at least six (6) months to one (1) year. File all documents pertaining to audit in the Quality Control Unit.

3.5 Administer CPM for Quality/Timeliness Reporting

VaMMIS provides the required support for contract project management functions. The system is designed to support all expenditure and budget monitoring; fiscal agent operation monitoring, including compliance with state and Federal requirements; and contractural compliance with DMAS-defined performance levels.

Procedure

The QA group will periodically monitor contract compliance using reports produced from the CPM system as well as responding to DMAS questions and concerns about data on the reports.

For details on the source and input responsibility for the data in the CMS, see the online CPM user manual.

3.6 Coordinate Backup and Recovery with CRD

First Health Services has in place a plan for Disaster Recovery and Planning for each division. The VMAP Disaster Recovery Plan documents First Health's processing capabilities in case of partial or total disaster. For example, partial or total disaster may be the result of fire, water damage, or equipment failure. Backup and recovery are part of the First Health contract with Verizon for computer operations.

Scheduled Backups and Recoveries are performed each night by the Data Center systematically, after the CICS comes down. A report listing all of the requested backup files is produced and sent to the Quality Control Unit on a daily basis. The normal nightly backup includes all computer software and operating programs, databases and systems, operations, and user documentation (in magnetic and non-magnetic form). The same procedures are used for the backup of all monthly files.

Systems staff sometimes co-ordinates special backups of certain files. A request can be submitted by the requestor using the Data Center Work Order form. See Appendix A, Forms, for an example.

Verizon runs a VMS (Valut Management Services) Data Set each night to read the file and list all VMAP applications. Verizon pulls and places in storage containers the magnetic forms which are stored off-site in a secure location. The secure off-site location is within five (5) miles of the Verizon Data Center.

Backup equipment is fully and regularly tested for compatibility and capacity, with any identified shortcomings corrected. The First Health/Verizon Disaster Recovery Plan is developed and maintained in accordance with State Council of Information Management protocol.

Procedure

1. Verify receipt of the VMS report from Verizon and check that all backups were performed with good condition codes.
2. If an out-of-balance condition code is displayed, notify the Systems Manager.

3.7 Maintain/Review SLA Requirements and Performances

Under the direction of the Executive Account Manager, Quality Control Manager will maintain, oversee and review SLA Contract Management procedures. The performances of each requirement is monitored of the Virginia MMIS. The VaMMIS contract is reviewed to insure that we are maintaing our contractual obligations.

Any requirements that are not deliverable is reported to the Account Manager in advance to avoid any penalties. .

The SLA's are requirements stored and listed as part of on the CPM database which store data on system performance and allow a user to choose report parameters. The RFP list the contractor's responsibilities that were aggreed between First Health and DMAS.

Procedure

1. The Executive Account Manager negotiates on behalf of First Health Services for all contractual requirements, activities and duties concerning DMAS.
2. Executive Account Manager delegate duties and activities to responsible staff to perform contractual tasks.
3. The Quality Control Manager oversees all contractual duties and activities of the VMAP contract. Other management staff are asked to review the sections of the RFP and SLA's to make sure that the obligations and the contractual duties are executed.

3.8 Review VaMMIS Operation Procedure Manual Updates

The unit manager and supervisory staff review the manual once each quarter. Review results are recorded on the Manual Review and Update Log maintained in Preface section of each manual. Based on this review, the unit manager and supervisory staff determine what changes, if any, are necessary. The Procedure Manual Owners will make all changes/updates using BLUE font color.

All changes/updates will be sent to DMAS each time they are added to a Procedure Manual. DMAS will have 10 business days to review the changes/updates from the date of receipt.

The First Health Audit Coordinator (Mae McClendon) will coordinate and monitor the Manual update process.She She will ensure all Procedure Manuals and identified internal procedures are reviewed and updated by the 15th day of the last month in each quarter. The Coordinator will also ensure that DMAS is notified of the completion of our review on a Semi Annual basis. This will occur on June 1 and Dec 1. Please note if these dates fall on a weekend, notification will take place by COB Friday before the weekend. The Coordinator will send electronic notification to DMAS verifying manuals have been reviewed and updates applied as required. If no updates are required that information will be reported to DMAS as well.

Once updates are reviewed and approved by DMAS, the Audit Coordinator will ensure they are posted to the N drive. Our Systems resource will post approved manuals to the VaMMIS DED Web site. Once posted the Manual Owner will QC the posted documents to ensure accuracy. Once completed the Manual Owner will notify the Audit Coordinator of the results. If approved,

that status will be updated in the Preface. If a problem exists the Coordinator will work with our Systems resource to correct it.

Procedure

1. Managers/Supervisors review procedure manuals each quarter, make any changes or updates necessary in a shade of BLUE fonts.
2. Reflect the section and page numbers of all changes/Updates in the Preface (Review Log). This will identify the changes for DMAS to review.
3. Submit updates to the First Health Audit Coordinator. She will coordinate any changes with the VaMMIS documentalist and forward the procedures to DMAS.
4. DMAS will review the updates within 10-days and forward any changes they deem necessary to change,
5. Upon approval from DMAS the Audit Coordinator will inform VaMMIS documentalist to make the changes to the on-line system documentation.

Appendix A Quality Assurance Balancing Entry Spreadsheet

Balancing Procedures

```
01/12/2005 EXPORT CONTROL LOG REPORT 15:02:09
Page: 1
Julian Doc Rec
Batch Name Date Time Count Count
==============================================
DAA0501130038 2005012 11:50:37 25 113
DAN0501030177 2005012 11:50:39 50 145
DAN0501030181 2005012 11:50:41 50 118
DAN0501030184 2005012 11:50:43 50 173
DAN0501030185 2005012 11:50:45 50 140
DAN0501030186 2005012 11:50:47 50 150
DAN0501030187 2005012 11:50:49 50 123
DAN0501030188 2005012 11:50:51 50 160
DAN0501030189 2005012 11:50:53 50 172
DAN0501030190 2005012 11:50:55 49 159
DAN0501030191 2005012 11:50:57 50 163
DAN0501030192 2005012 11:50:59 50 143
DAN0501030193 2005012 11:51:01 50 175
DAN0501030194 2005012 11:51:03 50 210
DAN0501030195 2005012 11:51:05 50 121
----- -----
Total For: DADA 1176 3846
DAA0501130038 2005012 11:50:37 8 39
DAN0501130039 2005012 11:51:07 23 24
----- -----
Total For: DADA-PA 31 63
HCA0501010001 2005012 14:08:04 100 110
HCA0501010023 2005012 14:08:11 100 250
HCA0501010025 2005012 14:08:17 100 176
HCA0501010026 2005012 14:08:24 96 203
HCA0501010027 2005012 14:08:30 100 147
```

Export Log (Sample)

Balancing Procedures

	VMAP DAILY CONTROL REPORT BALANCING	
	INSTRUCTIONS: Prepare Daily By Quality Assurance Analyst	
	Complete an explanation of Out-of-Balance Conditions.	
	Julian Date:	
	Date Prepared:	
	Calendar Date:	
	DATA ENTRY (PAPER) INPUT COUNT - EXPORT CONTROL LOG	
A	TOTAL # OF VENDOR CLAIMS - OFF SITE VENDORS	
B	TOTAL # OF FHS INTERNAL DATA ENTRY CLAIMS COUNT	
C	(-) MINUS DADA - PA CLAIM COUNT	
D	(-) MINUS PA SUPP CLAIMS	
E	(-) MINUS PREA CLAIMS	
F	**TOTAL:** DATA ENTRY PAPER INPUT CLAIM COUNT	
G	**TOTAL:** CP-O-516 PAPER INPUT TOTALS REPORT	
H	AMOUNT OUT OF BALANCE (**MUST EQUAL ZERO**)	
	II. DAILY TOTAL CLAIMS PROCESSED SUMMARY REPORT	
A	CP-0-001-03 GRAND TOTAL	
B	(+) NEW CLAIMS (06) PHARMACY COUNT (CP-O-044-01)	
C	(-) MINUS PHARMACY (06) D/E PREVIOUS DAY COUNT CP-O-0	
D	**TOTAL NEW CLAIMS**	
E	**CP-O-044-10** - (AUTO RE-ENTRY CLAIMS) NET TOTAL	
F	**CP-O-044-10** - (MANUAL RE-ENTRY CLAIMS) NET TOTAL	
H	**TOTAL**	
I.	CP-0-044-10 "ALL CLAIMS" NET TOTAL	
J.	**OUT OF BALANCE**	

Balancing Spreadsheet (Sample)

Appendix B Quality Assurance Balancing Reports

Balancing Procedures

```
CPR280                                VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES                REPORT NO:  CP-O-001-03
AS OF MM/DD/CCYY                                   DAILY INPUT SUMMARY                                  PAGE NUMBER   ZZ,ZZ9
RUN DATE: MM/DD/CCYY HH:MM                       FEE FOR SERVICE CLAIMS (1)
(2)     (3)                     ******* DIRECT BILLERS ********  ********* DATA ENTRY **********  ************ TOTAL ************
CL  CLAIM TYPE                  (4) RECORDS  (5) BILLED CHARGES  (6) RECORDS  (7) BILLED CHARGES  (8) RECORDS  (9) BILLED CHARGES
--  ------------------------------ -----------  ----------------- -----------  ----------------- -----------  -----------------
01  UB92 HOSPITAL INPATIENT        ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
02  UB92 NURSING HOME (SNF)        ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
03  UB92 HOSPITAL OUTPATIENT/HOME  ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
04  PERSONAL CARE                  ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
05  PRACTITIONER                   ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
06  PHARMACY                       ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
08  LAB                            ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
09  TITLE-18                       ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
10  UB92 INTERMEDIATE CARE (ICF)   ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
11  DENTAL                         ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
13  TRANSPORTATION                 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
15  CAPITATION PAYMENTS            ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
16  MANAGEMENT FEES                ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
17  ADMINISTRATIVE FEES            ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
96  ASSESSMENTS                    ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
                                   =========== ================== =========== ================== =========== ==================
          TOTAL                    ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
                                   ************ OTHER ************  ********* GRAND TOTAL *********
CL  CLAIM TYPE                  (10) RECORDS (11) BILLED CHARGES (12) RECORDS (13) BILLED CHARGES
--  ------------------------------ -----------  ----------------- -----------  -----------------
01  UB92 HOSPITAL INPATIENT        ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
02  UB92 NURSING HOME (SNF)        ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
03  UB92 HOSPITAL OUTPATIENT/HOME  ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
04  PERSONAL CARE                  ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
05  PRACTITIONER                   ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
06  PHARMACY                       ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
08  LAB                            ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
09  TITLE-18                       ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
10  UB92 INTERMEDIATE CARE (ICF)   ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
11  DENTAL                         ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
13  TRANSPORTATION                 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
15  CAPITATION PAYMENTS            ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
16  MANAGEMENT FEES                ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
17  ADMINISTRATIVE FEES            ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
96  ASSESSMENTS                    ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
                                   =========== ================== =========== ==================
          TOTAL                    ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99 ZZZ,ZZZ,ZZ9  ZZZ,ZZZ,ZZZ,ZZ9.99
                                                *** END OF REPORT ***
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CP-O-001-03

Balancing Procedures

CPR370 VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES REPORT CP-O-516
RUN DATE: MM/DD/CCYY HH:MM DAILY CONTROL REPORT
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(1) CLAIM TYPE	(2) RECORDS READ	(3) RECORDS WRITTEN	(4) RECORDS MODIFIED	(5) RECORDS IN ERROR
XX	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9
XX	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9
XX	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9
XX	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9
XX	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9
XX	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9
XX	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9
XX	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9
XX	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9
XX	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9
OTHER	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZ9
TOTAL	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZZ9	ZZZ,ZZZ,ZZ9	ZZZ,ZZZ,ZZZ9

*** END OF REPORT ***

CP-0-516

Balancing Procedures

CPR271 03/28/2005 05:30:17 VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES REPORT NO: CP-O-004-01
AS OF:03/27/2005 EXECUTIVE PEND TOTALS PAGE NUMBER: 1
RUN DATE: 03/28/2005 04:36

	PREVIOUS PENDS	TODAY'S PENDS	RESOLVED	TRANSFER	CURRENT PENDS	CHANGE
TOTAL PENDS	179,198	8,528	0	45	187,681	8,483
FIRST HEALTH PENDS	27,733	83	0	5	27,811	78
FIRST HEALTH WORKABLE	23,185	83	0	0	23,268	83
FIRST HEALTH PARKED	4,548	0	0	5	4,543	-5
DMAS PENDS	43,051	4	0	21	43,034	-17
DMAS NON-ER PENDS	29,246	4	0	0	29,250	4
DMAS ER PENDS	10,452	0	0	21	10,431	-21
DMAS PARKED PENDS	3,353	0	0	0	3,353	0
RECYCLE PENDS	90,399	8,441	0	19	98,821	8,422
MASS ADJUSTMENTS	18,015	0	0	0	18,015	0

*** END OF REPORT ***

CP-O-004-01

Balancing Procedures

CPR282 03/29/2005 00:34:11 VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES REPORT NO: CP-O-010-01
AS OF:03/28/2005 DAILY CONTROL REPORT (APPROVED CLAIMS) PAGE NUMBER: 1
RUN DATE: 03/29/2005 12:23 AM FEE FOR SERVICE CLAIMS

CLAIM TYPE	APPROVED CLAIMS COUNT	APPROVED BILLED AMOUNT	APPROVED ADJUST/VOID CLAIMS COUNT	APPROVED ADJUST/VOID BILLED AMOUNT	TOTAL APPROVED BILLED AMOUNT	TOTAL APPROVED PAYMENT AMOUNT	TOTAL APPROVED CLAIMS COUNT
01	238	$3,041,861.98	3	$1,897.00	$3,043,758.98	$1,150,317.78	241
02	305	$900,417.24	133	-$1,444.86	$898,972.38	$571,348.50	438
03	916	$883,414.03	13	$887.40	$884,301.43	$219,718.74	929
04	271	$110,133.90	9	-$34.08	$110,099.82	$105,542.10	280
05	17509	$3,057,166.25	61	$6,220.38	$3,063,386.63	$1,729,773.59	17570
06	40019	$3,151,067.02	859	-$75,246.85	$3,075,820.17	$2,197,880.98	40878
08	4686	$305,828.30	54	-$3,929.94	$301,898.36	$64,070.97	4740
09	766	$42,901.41	22	-$1,778.13	$41,123.28	$33,593.01	788
11	314	$27,309.00	0	$0.00	$27,309.00	$17,303.59	314
13	107	$40,321.57	3	$1,117.00	$41,438.57	$9,495.50	110
96	106	$8,235.00	0	$0.00	$8,235.00	$7,460.00	106
TOTAL	65237	$11,568,655.70	1157	-$72,312.08	$11,496,343.62	$6,106,504.76	66394

CP-O-010-01

Balancing Procedures

CPR282 03/29/2005 00:34:11 VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES REPORT NO: CP-O-010-02
AS OF:03/28/2005 DAILY CONTROL REPORT (DENIED/PENDED/REJECTED CLAIMS) PAGE NUMBER: 1
RUN DATE: 03/29/2005 12:23 AM FEE FOR SERVICE CLAIMS

CLAIM TYPE	DENIED CLAIMS COUNT	DENIED CLAIMS BILLED AMOUNT	PENDED CLAIMS COUNT	PENDED CLAIMS BILLED AMOUNT	REJECTED CLAIMS COUNT	REJECTED CLAIMS BILLED AMOUNT	TOTAL BILLED AMT (DENY/PEND/REJECT)	TOTAL CLAIMS COUNT (DENY/PEND/REJECT)
01	142	$3,867,037.77	29	$325,235.64	0	$0.00	$4,192,273.41	171
02	152	$502,975.10	2	$29,496.60	0	$0.00	$532,471.70	154
03	334	$519,621.63	356	$294,513.24	0	$0.00	$814,134.87	690
04	32	$20,287.02	0	$0.00	0	$0.00	$20,287.02	32
05	10475	$1,526,149.74	1457	$343,533.74	0	$0.00	$1,869,683.48	11932
06	9304	$698,473.02	3	$14,349.23	1435	$164,768.31	$877,590.56	10742
08	1765	$105,745.92	127	$8,699.06	0	$0.00	$114,444.98	1892
09	1652	$161,998.20	53	$13,899.81	0	$0.00	$175,898.01	1705
11	283	$19,849.58	34	$2,781.34	0	$0.00	$22,630.92	317
13	118	$62,201.08	30	$55,295.14	0	$0.00	$117,496.22	148
96	0	$0.00	1	$345.00	0	$0.00	$345.00	1
TOTAL	24257	$7,484,339.06	2092	$1,088,148.80	1435	$164,768.31	$8,737,256.17	27784

CP-O-010-02

Balancing Procedures

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CPR380     03/14/2005 19:33:25          VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES                    REPORT NO:    CP-O-518
AS OF:03/14/2005                                        DAILY ERROR REPORT                                    PAGE NUMBER:         1
RUN DATE: 03/14/2005 19:15

TRANS          ICN           PROVIDER        ENROLLEE       PROCEDURE              ERROR MESSAGE
CODE          NUMBER          NUMBER          NUMBER          CODE


                                        ***** NO DATA FOUND FOR THIS REPORT *****

                                           *** END OF REPORT ***

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CP-O-518

Balancing Procedures

CPR281 03/24/2005 00:33:17 VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES REPORT NO: CP-O-044-10
AS OF:03/23/2005 DAILY CLAIMS INPUT ANALYSIS PAGE NUMBER: 1
RUN DATE: 03/24/2005 00:04 GRAND TOTAL
ALL FEE FOR SERVICE CLAIMS

AUTO RE-ENTRY CLAIMS

CT	APPROVED TOTAL	APPROVED PCT	DENY TOTAL	DENY PCT	PEND TOTAL	PEND PCT	REJECT TOTAL	REJECT PCT	TOTAL
01	0	0	5	100	0	0	0	0	5
02	0	0	0	0	0	0	0	0	0
03	430	96	15	3	1	0	0	0	446
04	0	0	0	0	0	0	0	0	0
05	322	10	292	9	2675	81	0	0	3289
06	0	0	0	0	0	0	0	0	0
08	0	0	0	0	0	0	0	0	0
09	24	18	91	70	15	12	0	0	130
10	0	0	0	0	0	0	0	0	0
11	0	0	0	0	0	0	0	0	0
13	0	0	0	0	0	0	0	0	0
15	0	0	0	0	0	0	0	0	0
16	0	0	0	0	0	0	0	0	0
17	0	0	0	0	0	0	0	0	0
96	0	0	0	0	0	0	0	0	0
NET:	776	20	403	10	2691	70	0	0	3870

NEW CLAIMS

CT	APPROVED TOTAL	APPROVED PCT	DENY TOTAL	DENY PCT	PEND TOTAL	PEND PCT	REJECT TOTAL	REJECT PCT	TOTAL
01	803	79	182	18	37	4	0	0	1022
02	1476	84	271	15	3	0	0	0	1750
03	2000	61	713	22	588	18	0	0	3301
04	2252	93	109	5	48	2	0	0	2409
05	21436	71	7563	25	1396	5	0	0	30395
06	29460	78	8296	22	2	0	0	0	37758
08	5226	76	1547	23	91	1	0	0	6864
09	1650	36	2803	62	71	2	0	0	4524
10	21	50	21	50	0	0	0	0	42
11	2298	73	573	18	294	9	0	0	3165
13	39	30	66	52	23	18	0	0	128
15	0	0	0	0	20	100	0	0	20
16	196	50	0	0	196	50	0	0	392
17	0	0	0	0	0	0	0	0	0
96	139	99	0	0	2	1	0	0	141
NET:	66996	73	22144	24	2771	3	0	0	91911

MANUAL RE-ENTRY CLAIMS

CT	APPROVED TOTAL	APPROVED PCT	DENY TOTAL	DENY PCT	PEND TOTAL	PEND PCT	REJECT TOTAL	REJECT PCT	TOTAL
01	135	90	14	9	1	1	0	0	150
02	10	100	0	0	0	0	0	0	10
03	131	70	55	29	2	1	0	0	188
04	0	0	2	100	0	0	0	0	2
05	1306	67	591	30	48	2	0	0	1945
06	0	0	0	0	0	0	0	0	0
08	12	46	14	54	0	0	0	0	26
09	14	67	6	29	1	5	0	0	21
10	0	0	0	0	0	0	0	0	0
11	94	60	62	40	0	0	0	0	156
13	4	50	2	25	2	25	0	0	8
15	0	0	0	0	0	0	0	0	0
16	0	0	0	0	0	0	0	0	0
17	0	0	0	0	0	0	0	0	0
96	0	0	0	0	0	0	0	0	0
NET:	1706	68	746	30	54	2	0	0	2506

ALL CLAIMS

CT	APPROVED TOTAL	APPROVED PCT	DENY TOTAL	DENY PCT	PEND TOTAL	PEND PCT	REJECT TOTAL	REJECT PCT	TOTAL
01	938	80	201	17	38	3	0	0	1177
02	1486	84	271	15	3	0	0	0	1760
03	2561	65	783	20	591	15	0	0	3935
04	2252	93	111	5	48	2	0	0	2411
05	23064	65	8446	24	4119	12	0	0	35629
06	29460	78	8296	22	2	0	0	0	37758
08	5238	76	1561	23	91	1	0	0	6890
09	1688	36	2900	62	87	2	0	0	4675
10	21	50	21	50	0	0	0	0	42
11	2392	72	635	19	294	9	0	0	3321
13	43	32	68	50	25	18	0	0	136
15	0	0	0	0	20	100	0	0	20
16	196	50	0	0	196	50	0	0	392
17	0	0	0	0	0	0	0	0	0
96	139	99	0	0	2	1	0	0	141
NET:	69478	71	23293	24	5516	6	0	0	98287

CP-O-044-10