Addiction and Prevention Services
State Quality Committee

This report shows the detail of how many claims were processed by ValueOptions each month, the timeframe for processing and the percentage of claims processed that denied.

AGGREGATE ANALYSIS REPORT

Final

Reporting Period **FROM:** July 1, 2007 **TO:** June 30, 2008
Annual summary for FY2008

Unit/Team/Department:
PIHP Quality Improvement

Topic/Project:
Claims payment timeliness and accuracy report
Claim Accuracy Audit (VO # 23, Grid Row #16)
Open Claims Inventory and Turn Around Time (VO # 24, Grid Row #17)
Claim Denial Reasons (VO #49, Grid Row #18)

Monitoring Standard:
42 CFR 438.240 Quality Assessment and Performance Improvement Program
42 CFR 438.242 Health information System
42 CFR 438.114 and 438.210 Coverage Rules and payment policies
42 CFR 438.404 Data on claims denials

Goal:
The PIHP will track and report monthly to SRS/AAPS an audit of claims data entry and claims inventory analysis.

Objectives:
To assure the documentation is capturing the audits of claims data to ensure accuracy and compliance with claims payment standards
To evaluate for trends that may require system intervention or education
To allow data to be presented consistently for Committee evaluation and response

Data Collection Activities:
Data was collected from ValueOptions CareConnect System claims. The Claims Accuracy Audit consists of random audits of claims data entry. The Open Claims Inventory and Turn Around Time (TAT) consist of claims inventory analysis that reports claim aging for all open claims. The report includes total counts of claims by each day bucket. The TAT report includes percentage of unclean claims percentage by day buckets. TAT includes detail on total paid, amount billed, denied detail, etc. These reports were listed in RFP as being reported quarterly, but the state has requested that the report is received monthly. This report is not due until 45 days after the close of a quarter.

Results: See Next Page

Medicaid and Block Grant June 2008

Kansas Claims and Audit Statistics (Reporting Requirement # 23 and #24) - Medicaid & Block Grant
Month Ending 6/30/2008

Claims Timeliness Results

Measures the percentage of claims processed within the required turnaround timeframe.
The number reflects the percentage of claims processed and paid/denied within 30, 60 and 90 calendar days.

	Percentage	Number in timeframe/total
Percent Paid in 30 Calendar Days	96.56%	12193/12627
Percent Paid in 60 Calendar Days	99.99%	12626/12627
Percent Paid in 90 Calendar Days	99.99%	12626/12627

Claims Accuracy Results

Audited claims will be categorized and reported by percentages in the following categories:

Financial Accuracy (Payment Errors):
Financial errors are created when incorrect information is entered into the system creating an overpayment, underpayment or non-payment. They are calculated as follows:

Calculation: Overpaid Amount + Underpaid Amount / (divided by) Total paid amount = Financial Error Amount

Mechanical (Statistical) Errors
Mechanical errors are any errors that generate incorrect information, but do not create an overpayment or underpayment. They are calculated as f

Calculation: Number of Claim Elements Correctly Completed / (divided by) Total Number of Claim Elements = Mechanical Error Total

	Percentage
Financial Accuracy	99.28%
Mechanical Accuracy	99.97%

Claims Denial/Paid Results

Claims processed and paid includes all claims that are processed and finalized through the financial system. Dollars reflect paid dollars.
Approved claims represent claims that are finalized and approved for payment. The figures reflect number, percentage and dollars paid.
Denied claims represent claims that are finalized and denied for payment. The figures reflect, number, percent and total paid dollars.

	Claim Count	Percentage	Total Paid
Claims Processed and Paid	14281		
Approved	11210	78.50%	$1,888,431.21
Denied	3071	21.50%	$0.00

Open Inventory

Figures represent number of open claims in each age range, as well as billed dollars associated with those claims,
Explanantion of all claims that exceed 90 days is noted below.

Total Open Inventory

Age	Claim Count	Total Billed
0-7	475	$104,063.76
8-15	250	$64,738.38
16-30	29	$9,055.50
31-45	0	
46-60	0	
61-90	0	
> 90*	0	

Total Open Inventory	754

Conclusions:

June 2008

- 90% of claims paid within 30 days of receipt: the standard was met in the month of June 2008 for Medicaid and AAPS funded (96.56%)

- 99% of claims paid within 60 days of receipt: the standard was met in the month of June 2008 for Medicaid and AAPS funded (99.99%)

- 100% of claims paid within 90 days of receipt: the standard was not met in June 2008 - just below standard at 99.99%

DENIED CLAIMS	PERCENTAGE DENIED
July 2007	14.00 %
August 2007	15.39 %
September 2007	13.27 %
October 2007	19.74 %
November 2007	22.19 %
December 2007	18.18%
January 2008	16.06%
February 2008	5.57%
March 2008	10.21%
April 2008	19.24%
May 2008	20.77%
June 2008	21.50%

- Denied Claims: In June 2008, the percentage of denied claims increased slightly from the previous month (May 2008 = 20.77%, June 2008 = 21.50%).
- In June 2008, there were 28.93% Medicaid claims denied and 18.44% AAPS funded claims denied.
- All claims timeliness standards were met for AAPS funded claims.
- The claims timeliness standards for 30 and 60 days were met for Medicaid claims. The standard for 90 day claims was missed by only .03%,

Denied Claims Reasons: June 2008

Denial Reason	Block Grant	Medicaid
Correct NPI is not in the system	15%	16%
Provider not contracted for this service	13%	13%
Not in the system to provide this service at this location	13%	11%
Provider not contracted at location	13%	11%
Provider organization does not match provider number	13%	7%
Provider capacity field is blank	13%	3%
Provider not in system for this location	13%	3%
Authorization required, not found in CareConnect	3%	13%
Multiple tax id matches	2%	13%
Previously suspended by clinical	2%	10%

Annual Summary (7/1/07-6/30/08)

Claims Timeliness FY2008

Black font = Met standard
Red font = Standard not met

Standard	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	April-08	May-08	Jun-08
90% of claims paid within 30 days of receipt												
Medicaid only	100%	98.88%	95.61%	85.51%	87.89%	90.68%	93.52%	98.83%	92.65%	99.51%	99.87%	99.51%
AAPS funded only	0%	97.95%	81.34%	91.70%	92.99%	95.62%	96.85%	99.62%	99.68%	99.69%	99.73%	95.28%
Medicaid/AAPS funded combined	100%	98.27%	84.58%	89.96%	91.44%	94.00%	95.80%	99.49%	97.78%	99.63%	99.78%	96.56%
99% of claims paid within 60 days of receipt												
Medicaid only	100%	100%	100%	99.03%	98.25%	99.57%	98.08%	99.97%	94.74%	100%	100%	99.97%
AAPS funded only	0%	100%	100%	99.83%	99.16%	99.75%	99.16%	99.99%	99.87%	100%	100%	100%
Medicaid/AAPS funded combined	100%	100%	100%	99.61%	98.88%	99.69%	98.82%	99.99%	98.48%	100%	100%	99.99%
100% of claims paid within 90 days of receipt												
Medicaid only	100%	100%	100%	99.95%	99.92%	99.89%	99.08%	100%	96.04%	100%	100%	99.97%
AAPS funded only	0%	100%	100%	100%	99.98%	99.99%	99.92%	100%	100%	100%	100%	100%
Medicaid/AAPS funded combined	100%	100%	100%	99.99%	99.96%	99.96%	99.65%	100%	98.93%	100%	100%	99.99%

In reference to chart above:

- 90% of claims paid within 30 days of receipt:
  - Medicaid only met standard 10 months of FY2008
  - AAPS funded met standard 11 months of FY2008
  - Medicaid/AAPS funded combined met standard 10 months of FY2008

- 99% of claims paid within 60 days of receipt:

  - Medicaid only met standard 9 months of FY2008
  - AAPS funded met standard every month of FY2008
  - Medicaid/AAPS funded combined met standard 9 months of FY2008
- 100% of claims paid within 90 days of receipt:
  - Medicaid only met standard 9 months of FY2008
  - AAPS funded met standard 11 months of FY2008
  - Medicaid/AAPS funded combined met standard 6 months of FY2008

It was noted in the State Quality Committee that Medicaid data being out of compliance is related to Group II claims.

Preliminary Recommendations to Committee:

- It is recommended to the Committee that data trending continue.
- It is also recommended by the Committee that this aggregate analysis be shared at the Regional QI meeting and posted on the ValueOptions website for public access.
- **It is recommended by the Committee that in the Open Inventory section of the raw report, the header "Age" be changed to "Age of Claim" to clarify the data being reported.**

Date Presented to SQC: 2/5/2009 **BY:** Kim Brown

Recommendations from the Committee for action: Recommendation and changes made by the SQC to the Conclusions and Preliminary Recommendations are noted above in **bold**.

Person Responsible to follow-up and date due: Kim Brown Due: 5/7/2009