

IS System Functional Review
Behavioral Health Information System

Functional Requirements

Each section of the functional requirements describes a software module and contains:

- A request to name the Proposed Product for the module.
- An Overview of the module.
- Software Components within the module that are required by the CBS Coalition members.
- Software Features that are required by the CBS Coalition members.

There are a total of nine modules described in the functional requirements, with 105 components and features.

1.0 Access/Call Center

Proposed Product and/or Program Name for this Module

What is the software product name(s) being proposed for this module?

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Overview

General Requirement:

Initial contact with the PIHP behavioral health systems generally happens in one of three ways: through a centralized 1-800-Access Line; by direct contact with a clinic; or via direct contact with a contracted provider. Clinics and providers may be outpatient office, residential or institutional(Hospital) and contacts may be routine, urgent or emergent. The PIHP desires the ability to deploy call center functionality at each of these contact points and contact types. Staff at these access points need software that supports real-time data checking and data entry while they are on the telephone or face to face with a client, prospective client, or related party.

The system needs to support a seamless handoff of crisis contacts to crisis workers and requests for routine care to outpatient clinics via linkages to these portions of the software. This section contains functionality related to how the “front door” needs to be managed including call logging, provider referral, crisis triage, etc.

Components

1.1 Call Logging

General Requirement:

All calls are logged into a user-defined online form that gathers information on the nature of the call and basic caller data such as date of call, staff receiving call, name, telephone number, language requirement, referring party, etc. If the call is not a

request for service, basic information is collected regarding the type of call and disposition. If the call is about a complaint, compliment or grievance, all relevant data is recorded on the online form. Recording and reporting of disposition is included in all cases. Call logs must be easily retrievable and sortable by client, staff member, date, call type, disposition, etc.

Score: Comments:

<i>Screen Shot:</i>	<i>Please include a representative sample screen shot of a call logging screen.</i>
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1.2 Pre-Registration

General Requirements:

The IS system provides user-defined online pre-registration forms to gather initial client demographic and financial resources information for individuals requesting service. If the client becomes registered for service this information can be forwarded to Registration so that duplicate data entry is not required. If the client is already registered as a client in the system this should be flagged.

Score: Comments:

<i>Screen Shot:</i>	<i>Please include a representative sample screen shot of a pre-registration screen.</i>
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1.3 Intake Screening

General Requirements:

The IS system provides user-defined online client screening forms to assist in the determination of whether the client requires services from the crisis system, hospitalization, referral for outpatient services, or referral to other community resources. Includes access needs information, presenting problems and other relevant clinical information.

Score: Comments:

<i>Screen Shot:</i>	<i>Please include a representative sample screen shot of an intake screen.</i>
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1.4 Referral Management

General Requirements:

The system contains detailed provider profile information for clinicians working at PIHP facilities, independent providers in the provider network, and at contracted provider organizations. Clients can be matched to clinicians based on multiple variables in the Provider Registration Database. This includes information about provider location, specialties, non-English language capability, etc. The system should support the issuance and tracking of service referrals by counties to members of their internal and external provider networks. Users should be able to customize the referral management screens, including the sort and selection criteria, as well as referral letters that can be sent to clients and providers. It should be possible to upload information electronically to the Provider Registration Database. This component is closely linked to the Authorization Management system, described in section 3, when a referral is made and the PIHP is responsible for payment of the services associated with that referral/authorization.

Score: Comments:

1.5 Community Resource Database

General Requirements:

Allows for the uploading or manual entry of community resources into a searchable database that can be filtered based on user criteria. Counties should have the option of storing these entries in the provider referral database in ways that keep these records separate from the listing of network providers, or in a separate table that has the same lookup and tracking capacities of the provider referral database.

Score: Comments:

1.6 Wait List Management

General Requirements:

The system supports the ability to enter prospective clients on a wait list if space is not available for them at a provider that can meet their clinical needs. All wait listed clients will be entered into a user-defined online form that gathers information such as date of entry, referral type, reason for wait list, priority, expected appointment date, etc. The system should be able to track and sort prospective clients by priority to assist in moving individual into service in the proper order. Information on the wait list screen can be updated as additional data is gathered or client circumstances change. The system generates Request for Service logs, which are available to the state and show the status of clients on the wait list at a given point in time.

Score:

Comments:

2.0 Eligibility Verification

Proposed Product or Program Name for this Module

What is the software product name(s) being proposed for this module?

Overview

The PIHP has a history of using automated eligibility processes to ensure that client eligibility is current and accurate. This section describes, in some detail, the expectations that the PIHP has for supporting the first step in the authorization and billing cycle. Eligibility verification is an important module that is used in several other modules including Managed Care and Practice Management.

Components

2.1 Insurance Eligibility Loading

General Requirements:

The system supports monthly loading of the North Carolina Eligibility files from the state. The system assures that all eligible enrollees have a new record added to the PIHP system for Medicaid and State Services eligibility each month, including all retroactive additions to Medicaid. The eligibility system should maintain eligibility records for all PIHP eligibles in the state monthly download file, not just individuals who are enrolled as clients. Similar eligibility loading and processing capabilities should be available for Medicare and any other health plans with whom the PIHP contracts. It is expected that as part of the implementation the PIHP will be compliant with protocols relating to the downloading of Eligibility the Medicaid Health Plan and Enrollment and Disenrollment formats.

Score:

Comments:

2.2 Automated Insurance Eligibility Determination

General Requirements:

Each month, or at a frequency to be determined by the PIHP, the eligibility of registered clients should be evaluated against the downloaded eligibility files and updated as necessary based on a matching algorithm. When the process identifies clients where no prior eligibility had been determined or where the eligibility status has changed, including retro-active updates for clients previously served, users will have the option of updating client insurance records automatically or through computer-assisted manual updates. The process should include assigning or updating the cascade level of insurance plans that have been changed for a client, identifying

clients who have lost their insurance coverage, and determining how previous billings should be adjusted. The system shall also support the manual on-line review and update of insurance records for clients with various special handling conditions including: a partial eligibility match requiring investigation, North Carolina Medicaid Share of Cost responsibility, State eligibility, other state aid codes, Medicare, private insurance, and North Carolina clients with a different responsible county. Changes made through the automated insurance eligibility determination process should be supported with a complete audit trail.

Score:

Comments:

2.3 Real-Time Eligibility Verification

General Requirements:

The system should support a real-time interface to the PIHP and State database for viewing a client's current eligibility status for Medicaid and other included payors. The system should allow a user to poll the system and then easily update a client's eligibility and insurance coverage records if the coverage has changed. For Medicaid clients this includes entry of the North Carolina Eligibility Verification or, in the absence of State data, entering the Primary Service Code and County Code to support the eligibility status. The process also supports easy identification and clearance of a client's Share of Cost obligation, ensuring that those services are not billed to the PIHP.

Score:

Comments:

Features

2.4 Eligibility Lookup Access

General Requirements:

The system supports easy access to a client's eligibility records for eligibility lookup from various components and modules including Call Logging, Appointment Scheduling, Registration, etc.

Score:

Comments:

3.0 Care Management

Proposed Product or Program Name for this Module

What is the software product name(s) being proposed for this module?

Overview

As providers of behavioral health care and Medicaid health plans, PIHP has the responsibility to manage the quality, access, utilization and cost of services that are provided to eligible populations. This section describes the crisis, outpatient, and 24-hour care management requirements of the counties.

Components

3.1 Crisis Plans

General Requirements:

Supports the development of a user-defined online Crisis Management Plan that is generally prepared by the client and their case manager. If a client goes into crisis this plan is easily accessible to provide guidance to staff on the care team and other providers who have contact with the client.

Score:

Comments:

3.2 Crisis Tracking and Management

General Requirements:

Provides user-defined screens for tracking crisis episode data including date and time of first contact, referral source, clinical notes about the crisis including user-defined checklists and text-based crisis notes that allow for the recording of diagnosis, level of functioning and other relevant clinical data. Also tracks and allows easy viewing of the services provided during the crisis episode.

Score:

Comments:

3.3 Authorization Management

General Requirements:

Allows for the creation, approval/deferral/denial, issuance, letter generation, tracking and closing of a variety of authorization types (e.g. acute inpatient, residential, outpatient), which constitute discrete episodes of care, compliant with State mandated Referral Certification and Authorization formats. This includes:

- 1) PIHP-Issued Internal Authorizations for clients served at provider clinics;
- 2) PIHP-Issued External Authorizations for clients referred to providers in the provider network as part of the PIHP’s role as a Medicaid mental health plan; and

- 3) Health Plan-Issued External Authorizations to the PIHP from other health plans and managed care companies, which are approving services to be provided by PIHP staff or contractors.

The system is compatible with multiple payment methods for services provided under an authorization including fee for service, case rate, per diem, etc. The system should support several methods of setting, tracking and providing reminders of service limits for each type of authorization including number of visits or days, number of client or clinician service hours, number of days or weeks, specific service codes, service codes clusters, or specific dollar limits.

The option should exist for linking specific authorization types to insurance plans to aid in the utilization management of those authorizations. As service is provided, actual services are compared with authorized amounts and the system has multiple ways of notifying providers and utilization managers of remaining balances and impending authorization expirations, including during data entry, regular reports and various ticklers.

The authorization system supports user-defined rules for determining whether provider payment for unauthorized services will be pended or paid and whether these services will be billed to a third party payor.

If authorizations are denied because medical necessity has not been met, or if a level of care request is reduced, the system will generate the appropriate Notice of Action letter to the provider and client, alerting them of the denial/reduction and informing them of their due process rights.

Score:

Comments:

<i>Screen Shot:</i>	<i>Please include a representative sample screen shot of an authorization screen.</i>
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3.4 Inpatient Tracking and Management

General Requirements:

Provides user-define screens that meet CMS, State and PIHP requirements for tracking key inpatient data including date of admission, referring provider, inpatient case manager, treating psychiatrist, outpatient authorization type, outpatient case manager, and date of discharge, admit and discharge diagnosis, legal status, etc. The system supports the entry, creation and compliance tracking of the NC Treatment Authorization Requests or similar locally defined authorization or notification forms, which are generated for inpatient admissions and submitted to the State's inpatient fiscal intermediary or similar party. The system also supports the tracking of episodic data during the inpatient stay such as utilization review notes and user-defined checklists and can produce daily census and bed statistics reports for clients being managed by the PIHP.

Score:

Comments:

4.0 Payor/Provider Relations and Management

Proposed Product or Program name for this Module

What is the software product name(s) being proposed for this module?

Overview

The PIHP serves as both provider and a health plan manager. This section describes the provider relations and management functional requirements of the counties as both behavioral health providers and Medicaid health plans, including the ability to process provider claims.

Components

4.1 Provider Registration and Credentialing

General Requirements:

The system should support the development of user-defined screens to register, track and report on Provider Organizations and Individual Clinicians that contract with the PIHP. The system needs to support the ability to manage both contracted clinicians who are part of the external provider network and employee clinicians who staff the case management programs. The system should support the collection of several user-defined clinician characteristics such as location, licensure, language, days and times worked, and specialties. It should also support the credentialing of individual clinicians (internal and external) and the certification of provider facilities. Credentialing and certification data should include effective and expiration dates. When provider organizations and clinicians are registered, the system supports the assignment of providers to specific fee schedules, specific health plans, specific procedure codes, or groupings of these attributes in a manner that is easy to set up and manage on an ongoing basis.

Score: Comments:

4.2 Claims Receipt and Processing

General Requirements:

The system supports the electronic receipt and manual entry of provider submitted Claims or Equivalent Encounter Information. The system automatically adjudicates claims on a per claim basis. Claims are adjudicated based on user-defined rules including payor eligibility, whether other insurance plans are primary, the existence of an appropriate authorization, coverage for the specific service, service by an

authorized provider, covered diagnosis, etc. The system generates electronic and hard copy reports that provide Payment and Remittance Advices.

The system must be able to process claims as a basis for billing the State on a Fee-for-Service bases for services that were provided to eligible persons but were not covered or included in the Capitation payment.

The system can be configured to allow for pending claims for review or to deny the claims if they do not have an appropriate authorization in the system. The user can choose to include or exclude denials and pended claims from Remittance Advice reports and other PIHP-defined electronic transfer files that may be necessary. All claims can be easily viewed via user-defined sort and select options (e.g. by provider, by client, by payor) and view claims display key information including claim status. The system provides appropriate operations reports to support claims receipt and processing including pre-adjudicated batch reports, exception reports, claims ready for payment reports, etc. The Collections Management component described in Section 6.0 can also be used to manage provider claims.

Score:

Comments:

Screen Shot:

Please include a representative sample screen shot of a claims entry screen.

4.3 Claims Payment and Adjustment

General Requirements:

In some cases the PIHP will be using the claims processing module to cut checks to providers and the system should have an accounts payable module to support this activity. In other instances counties will require only the generation of accounts payable invoices for entry or electronic files for transfer to the PIHP accounting system. The system should produce paper and electronic Explanation of Benefits (EOB) and offer flexibility for user-defined letters to accompany EOBs.

The system supports the entry of claim adjustments where claims that have been entered, adjudicated, approved and paid can be reversed and credit balances cleared, while retaining the historical audit trail. These adjustments will also be included in the Remittance Advices for specific providers/facilities. All entries, including reversals, should be maintained in history and viewable and reportable.

The system supports the entry of payment and denial information from providers related to coordination of benefits where the PIHP is not the primary payor; in many cases this is required prior to payment of their secondary or tertiary responsibility.

Score:

Comments:

4.4 Claims Payment History

General Requirements:

History is maintained by the system for all claims processed through the claims processing module. Contract limits can be tracked by vendor and payor source and processed claims can be applied against those limits. Users can view vendor summary and detail information and the system can generate IRS Form 1099 documents each calendar year end. Information is tracked and can be reported by date of service and claims paid date.

Score:

Comments:

Features

4.5 Multiple Contracting Schemes

General Requirements:

In the roles of health plans and managed care entities the PIHP has multiple contracting schemes with organizational and individual members of their provider networks. The system should support multiple contractor agreements that include services funded by multiple payors with differing benefit designs and multiple provider reimbursement systems such as case rate, fee for service, capitation, and fixed fee payments. Different benefit designs will include or exclude certain services based on diagnosis, coverage, or other attributes. A single provider can have multiple fee schedules based on health plan coverage or population served, including enhanced rates for services based on state or PIHP-specific criteria such as language. Fee schedules have start and end dates, with history saved to support proper payment of late claims submitted after the end date of a given fee schedule.

Score:

Comments:

4.6 Provider Communication Management

General requirements:

The system has the ability to record and track communications with provider organizations and individual clinicians including the recording and tracking of notes related to provider requests and complaints as well as contacts initiated by PIHP staff. The system includes a tickler system for ensuring follow-up of outstanding items.

Score:

Comments:

5.0 Practice Management – Administrative Workflows

Proposed Product or Program name for this Module

What is the software product name(s) being proposed for this module?

Overview

The practice management/administrative workflow functions incorporate a variety of activities that are necessary to identify and register new clients; admit, track services and discharge clients from admissions to particular sites. In addition, this functional area includes client and resource scheduling; and gathering basic financial information needed for billing operations.

It is important to recognize that these traditional “practice management” type functions vary far beyond the clinic model where clients make and keep regular appointments. Rather, services are provided in inpatient, residential, day treatment, adult and juvenile criminal justice facilities, schools, and a wide variety of community-based settings. A significant percentage of services are not delivered on a scheduled basis. The system also requires flexibility to accommodate non-traditional mental health services including services related to psycho-social rehabilitation and wraparound services.

The system should allow for the integration of DD/MH/SA information such that data can be organized, based on the registration of unique clients. Each client record should have the ability to contain funder required data and documentation specific to and identifiable by each program. The system should be capable of registering clients to different funding streams while maintaining record security so that confidentiality is maintained for each program.

Components

5.1 Client Lookup/Immediate Inquiry

General Requirements:

The system supports rapid inquiry to determine if a client is new to the system. Inquiries may be made by name, partial name, alias, birth date, social security number, ethnicity, other query criteria or any combination of criteria. The system uses sophisticated identifier matching techniques to identify the client. If the client is new to the system, the client can be added using the registration process. The inquiry process includes the identification of the client’s status, which is user-defined and can include values such as pre-registered, enrolled, wait-listed, discharged, etc. The client status should be automatically updated whenever an event, such as a discharge, occurs.

An easily accessible, user-configurable summary screen displays key “at-a-glance” information for a client including basic registration data, urgent Red Flag

information, language requirements, insurance eligibility, pending appointments and dates of last service.

Score:

Comments:

<i>Screen Shot:</i>	<i>Please include a representative sample screen shot of a client lookup screen.</i>
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5.2 Registration

General Requirements:

- The system support the development of user-defined registration screens, which include federal, state, and local registration fields in addition to the core fields in the IS system.

Score:

Comments:

<i>Screen Shot:</i>	<i>Please include a representative sample screen shot of a standard registration screen.</i>
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5.3 Duplicate Checking & Merge

General Requirements:

When it is determined that a client has erroneously been registered with two identities the system supports a function which will allow a system manager to merge the client data including all services, charges, payments, adjustments and accounts receivable balances. A single ID number will be retained and all data from the incorrect ID number will be merged. A history of past merged records will be retained for system manager inquiry.

Score:

Comments:

5.4 Financial Information

General Requirements:

A financial assessment process collects all standard eligibility information from clients. Authorized users collect information required for Medicaid B and C, Medicare, State and Third Party Insurance. During the financial assessment process, the system makes on-line access to Medicaid eligibility data to determine eligibility. The system collects income, various categories of expense, family size, family member information, and assets to comply with “ability to pay” criteria. The

financial assessment process prompts for and can produce printed forms to be given to clients at the conclusion of the financial assessment.

Score:

Comments:

5.5 Sliding Scales

General Requirements:

The system can be configured to support multiple sliding scales including annual deductible, percentage discount, fixed dollar discount, etc. Financial Information collected in item 5.4 is used to place the client on the appropriate sliding scale and calculate the client and family financial responsibility. Scales consistent with local requirements and state regulations can be configured including the any existing “Ability to Pay” criteria. The system should provide the flexibility to accommodate a change in financial status and sliding scale liability with an effective date of the change.

Score:

Comments:

5.6 NC Medicaid Eligibility Referral Support

General Requirements:

The system provides a financial assessment screening process that collects appropriate information regarding indigent clients who may be potentially Medicaid eligible. Potential eligibility criteria may be configured by the system administrator in support of current North Carolina eligibility criteria. When clients match the potential criteria, the financial interviewer is advised immediately and a potential eligibility referral letter to the local State Social Services Office is prepared by the system.

Score:

Comments:

5.7 Admission – Discharge - Transfer

General Requirements:

Clients may be admitted to and discharged from organizational providers through a user-defined online admission/discharge form, which can be customized for different types of provider organizations. Admission and discharge data can be collected to meet the requirements of the Client and Service Information. The system will allow authorized users to transfer an admission from one organizational provider to another or copy the pertinent information from an existing admission to another to reduce required data entry.

Score: Comments:

Screen Shot:

Please include a representative screen shot of an admission screen.

5.8 Episode Tracking

General Requirements:

The system has the ability to define and track episodes of care for clients based on state and local definitions of episodes. This includes: tracking all of the care provided to an individual within a given service area, by a specific provider, during a given time period (e.g. a client could have mental health and an alcohol drug episodes open at the same time and services would be tracked separately). Separate episodes could be tracked for outpatient services and an admission to an inpatient facility during the same time period, or multiple outpatient episodes may exist concurrently; and episodes could be flagged for closing if a predetermined period of no service occurred. It will also allow for post discharge follow-up and surveys; these clients may be completely closed to the System of care, but will require some level of activity in order to track follow-up activities.

Score: Comments:

5.9 Intake Assessment

General Requirements:

The system offers various standard intake assessment instruments including optional 3rd party licensed assessment tools. The system also supports the creation of user defined intake assessment forms. The intake forms can be designed to display current data in the system, such as demographic items. The intake form can be designed to include various types of data including: free text, multiple choice, and drop down menu items.

Score: Comments:

Screen Shot:

Please include a representative sample screen shot of a standard intake assessment screen.

5.10 Diagnosis Management

General Requirements:

The system accepts either DSM IV or ICD-9 diagnoses as determined by the system administrator. The system supports cross-walk tables to translate the diagnoses from

one classification scheme to another. It can also track multiple diagnoses based on user-defined criteria, such as admission diagnosis and discharge diagnosis.

Score:

Comments:

5.11 Appointment Scheduling

General Requirements:

The system offers a full appointment scheduling system which allows for rapid entry and retrieval of client appointments with staff. The system is designed to support a front-desk environment that is common to busy public sector clinic settings. The system supports common inquiries such as “find first available appointment for Dr. X”. Staff profiles of availability can easily be maintained, noting available and non-available hours. Daily rosters of appointments and “chart pull” lists can be generated on demand. The system should have the flexibility to allow appointment scheduling several months in advance to accommodate medication management and other services that are scheduled in. The system should also have the functionality to allow for entry of recurring appointments. Appointments can be made for clinicians, rooms, other facilities, vehicles, etc. Integration with commonly available appointment scheduling or calendaring software would be desirable.

Score:

Comments:

<i>Screen Shot:</i>	<i>Please include a representative sample screen shot of an appointment scheduling screen.</i>
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6.0 Practice Management – Billing and Accounts Receivable

Proposed Product for this Module

What is the software product name(s) being proposed for this module?

Overview

Over a period of years, the current practice management software used by the PIHP has been tailored to meet the detailed billing and reimbursement requirements of the North Carolina FFA systems and has focused on accurate and timely Medicaid claiming and reimbursement. The new system is expected to meet or exceed these capabilities, provide sophisticated functionality for managing Medicare, private insurance and client billing, and comply with the HIPAA and other requirements.

Components

6.2 North Carolina Billing Rules and

General Requirements:

The system supports the development of a variety of billing rules for specific services and programs. A basic State and local requirement is the availability of billing logic that supports the calculation of charges based on the standard rate per minute multiplied by the number of total therapist minutes (primary and co-therapist(s) totals), divided by the number in group. The system will allow for multiple staff to bill on one client, such as during a case conference, or crisis event. The system supports the entry of Medicaid lock-out matrix that controls what can and cannot be billed, depending on where the client has been admitted. For example, if a client is in an inpatient facility, all outpatient services except case management under certain circumstances cannot be billed. The goal in scripting North Carolina specific billing rules is to provide flexibility in creating the rules as they are required rather than any attempt to identify and support all current rules.

Score:

Comments:

6.3 Electronic Billing and Remittance Advices

General Requirements:

The system has the capability to electronically submit claims or encounters to Medicaid, Medicare, major insurance carriers within the State of North Carolina utilizing health claims or Equivalent Encounter Information and to receive payments electronically. Can produce paper claims for any service transaction on-demand or in a batch mode. This includes claims which are forwarded electronically to the PIHP from contract providers for submission to payors and the corresponding forwarding of remittance advices back to the contract providers.

Score:

Comments:

6.4 Manual Billing and Remittance Advices

General Requirements:

The system has the capability to generate paper-based claims in HCFA-1500, UB-92 and user-defined formats. The system can also support the manual data entry of payments that are not received electronically.

Score:

Comments:

6.5 Authorization System Linkage

General Requirements:

The system should be user-configurable to allow certain authorization types in the Authorization Management component to control whether an entered service is billed to a third party payor. In this instance, if a provided service does not fall within the parameters of an existing authorization for a client (e.g. date range, provider, service code) the claim will be pended and listed on an error report or tickler for follow-up.

Score:

Comments:

6.6 Multiple Payors, Fee Schedules and Reimbursement Methods

General Requirements:

The system supports multiple payors for a client and the tracking and management of benefit limits, deductibles, copays, and covered and non-covered services for specific plans. The system also supports multiple fee schedules by payor including state-specific fee schedules such as NC Medicaid fee-for-service billing for retro-active eligibility or for clients identified with a separate payor source with specific billing/adjust rules for that program. The system supports easy updating of all clients with coverage under a specific plan to address benefit plan changes which may occur. The system also supports the management of multiple reimbursement methods including fee for service, case rates, per diem, capitation and grant-in-aid, and the bundling and unbundling of service codes by payor.

Score:

Comments:

6.7 Retroactive Medicaid Billing

General Requirements:

The system utilizes retroactive enrollment data to produce Medicaid claims for services originally billed to other sources that are now Medicaid eligible and make the proper adjustments to the relevant revenue, receivable and adjustment accounts. The system uses a similar process for Medicare and private insurance companies when coverage changes occur. The system can retroactively bill these plans based on plan-specific retroactivity dates.

Score:

Comments:

6.8 Grant Billing

General Requirements:

The system supports the setup of grant funding sources as quasi-insurance companies where clients who have no other coverage and meet funding sources eligibility requirements can have their services cascade to either a specific grant source (quasi-insurance company) or to a funding source group that may be billable to multiple grant sources. The system is configurable so that these charges can either be posted as outstanding accounts receivables that will be cleared by grantor payments, or automatically written off to a specific adjustment account. The system should be able to track and report on the grant eligibility of all visits provided to individuals who are eligible for these funds.

Score: Comments:

6.9 Client Billing

General Requirements:

The system properly calculates, bills and tracks: client co-pays and deductibles; sliding scale requirements that include billing a pre-calculated monthly total, a pre-calculated per episode total, or per visit charges (depending on service type); other user-defined sliding scales; and the ability to support budget payment plans. The system supports the adjustments to outstanding balances. The system can properly track insured clients, who are currently not subject to copayments and deductibles.

Score: Comments:

6.10 Client Statements

General Requirements:

The system can produce user-defined client statements on demand and on a cycle basis (e.g. every month) and has the capability of disabling the production of statements for any client and the ability to classify clients into categories for which the user will have control over the decision to print statements (e.g. when the cost of billing exceeds the potential revenue to be billed client may not be sent statements, and clients who have State or Medicaid coverage should not receive statements). The system supports the identification of which party should receive statements, such as directly to the client/guarantor, the client's conservator, or both. Client statements production supports the entry of user-defined dunning and thank-you messages based on specific payment or non-payment rules. Statements can be printed in detail or summary format based on user-defined rules.

Score: Comments:

<i>Screen Shot:</i>	<i>Please include a representative sample of a client statement.</i>
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6.11 Revenue Recognition and General Ledger Posting

General Requirements:

The system generates revenue, contractual allowances and sliding scale adjustments for each service from all sources at the time of entry based on the billing rules entered for insurance companies and self-pay clients. All charges are recorded at standard fees and any contractual allowances or sliding scale discounts are recorded as adjustments to the standard fees. These entries can be posted to the PIHP's general ledger via hard copy or electronic posting reports, which can be summarized based on user-defined criteria including subtotals by payor, payor class, program, location, etc. The system supports the entry and proper tracking of multiple adjustment codes including contractual allowances, sliding scale discounts, and bad debt write-offs.

Score:

Comments:

6.12 Payment Posting

General Requirements:

The system supports point of service check-out whereby charges are calculated and added to previous accounts receivable balances, payments can be posted and payment receipts can be issued. Allows the posting of payments to a client account even though there are no corresponding charges and considers these payments as credit balances to be matched with charges at a later date. Also supports easy data entry of hard copy Remittance Advices and electronic posting of payment and remittance advices to client accounts. The system should have sufficient controls to support reconciliation of payments entered to cash receipts.

Score:

Comments:

<i>Screen Shot:</i>	<i>Please include a representative sample screen shot of a remittance advice entry screen.</i>
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6.13 Cascade Billing and Accounts Receivable Management

General Requirements:

The system provides for open item accounting with the default of posting of payments and adjustments to specific charges/invoices. It properly handles the sequential billing of payors (e.g. Medicare 1st, Private Insurance 2nd; Patient 3rd; or Patient 1st and Medicaid 2nd) ensuring that the sequence is based on both the coverage that the client has and the services that are covered by the various plans. When Remittance Advices are posted, outstanding charges are automatically calculated and upon user confirmation, transferred to secondary and tertiary payors and/or client responsibility, and the appropriate electronic and paper claim forms are produced, which include the payments received from the previous payors. Outstanding charges

not confirmed and transferred to the next sequential payor remain as an open receivable. Appropriate audit trails are kept of claims that have been sequentially billed to multiple payors and revenue and accounts receivable balances do not overstate outstanding amounts by reporting balances for multiple payors simultaneously. This process includes automatically crediting contractual allowance and other adjustment accounts during payment posting based on predetermined carrier-specific criteria. This information is tracked and reported via detailed aged accounts receivable reports with user-defined sort and subtotal criteria including payor, provider, client, program, location, etc.

Score: Comments:

6.14 Capitation and Grant-In-Aid Payment Management

General Requirements:

Can compute and automatically write off the positive or negative contractual allowance amounts for bills that are covered by capitated or grant-in-aid funding streams.

Score: Comments:

6.15 Collections Management

General Requirements:

The system produces on-line ledger cards for all client accounts that show the transaction history of all charges, payments, and adjustments for all payors for a specified date range; can be filtered to show the same information for a single payor (including client responsibility). Has the ability to attach notes to any transaction regarding collection calls and can generate tickler reports based on the follow-up dates entered into these notes.

Score: Comments:

<i>Screen Shot:</i>	<i>Please include a representative sample screen shot of a collections management screen.</i>
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2.7 Electronic Clinical Records (ECR)

Proposed Product or Program name for this Module

What is the software product name(s) being proposed for this module?

Overview

Within the PIHP provider network, member agencies and providers are generally not using an electronic clinical record. Some agencies/providers may have developed components of an ECR, while others have purchased free standing clinical applications that are not integrated into their practice management systems. The majority of the PIHP providers do not have any operational clinical software. Their systems remain primarily administrative and are mostly used by support staff to enter data for State or PIHP reporting and billing purposes.

Despite the diversity of their experience, the PIHP may desire to improve system clinical functionality and move towards an electronic clinical record. However, since most providers will be moving from paper charts, they understand that the implementation of this component will require the expert assistance and consultation from an experienced technical staff.

The following components represent standard elements of the ECR that may be considered.

Components

7.1 Clinical History Inquiry

General Requirements:

All clinical information on the history of past diagnoses, treatment plans, services, and medications are available to authorized clinicians. Immediate inquiry of all elements of the ECR is available. Clinical history screens may be customized to accommodate the varying needs of clinicians, case managers and clients. All clinical inquiries are controlled through the user-definable security system described in Section 3.0.

Score:

Comments:

Screen Shot:

Please provide a representative sample of a clinical history screen.

7.2 Clinical Assessment

General Requirements:

A variety of pre-defined assessment forms are available including for example, psycho-social assessments, intake assessments, Addiction Severity Index (ASI), inpatient evaluations, residential placement evaluations. In addition, the system offers a forms development tool set designed to allow locally defined assessment forms to be created. Locally defined forms can capture data as defined by the system administrator. Such forms may also display data collected from “non-clinical” functions (e.g. demographic data, address, current diagnosis). The assessment

function may be configured to generate targeted problems for treatment and such problems can flow to the treatment planning process.

Score:

Comments:

<i>Screen Shot:</i>	<i>Please include a representative sample screen shot of a clinical assessment screen.</i>
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7.3 Treatment Plans

General Requirements:

Clinicians can build treatment plans for various target populations. Using a clinical database of evidence-based practice guidelines, the clinician moves through the diagnoses, problem, goals, objectives and interventions definition. The data set, which offers the various statements describing the key components of the treatment plan, is tailored to the appropriate target population. The practice guidelines are fully customizable in order to respond to various theoretical approaches. Current and past authorizations as well as outcome results are available for review by clinicians. All elements of the clinical guidelines that underlie the treatment planning module may be defined and/or modified by authorized clinical supervisors. A printable version of the treatment plan is available for clients and the system supports the process of obtaining client signatures on treatment plans.

Score:

Comments:

<i>Screen Shot:</i>	<i>Please include a representative sample screen shot of a treatment plan screen.</i>
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7.4 Wellness and Recovery Plans

General Requirements:

The system supports the development of client created action plans. Such plans contain information provided by the client which includes their personal strategy for recovery. The plan may also include crisis contact information, advance medication directions, and advance directives from the consumer. Clients may designate users authorized to view such plans. A printable version of the plan is available for clients.

Score:

Comments:

7.5 Progress Notes

General Requirements:

Progress notes for individuals as well as group progress notes can be captured by the system. Clinical note entry uses standard word processing functions including spell checking. Notes are easily accessible as part of the service entry process. The option is also available to generate service transactions as part of the progress note entry. While writing a progress note, clinicians have ready access to the current authorization information as well as the treatment plan. Each progress note can be linked with key elements of the treatment plan as required by regulatory guidelines. System administrators may attach program specific fields for local data requirements.

Score: Comments:

<i>Screen Shot:</i>	<i>Please include a representative sample screen shot of a progress note screen.</i>
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7.6 Medication History

General Requirements:

The system supports the entry and viewing, on a single screen, information about medications prescribed by PIHP staff (if any), those being taken but prescribed by another provider, drug allergies, and past adverse reactions to particular medications. Information is also readily available about medications that have been tried and considered ineffective and medications that are no longer being taken due to other reasons. The system also supports Tickler Engine reminder rules that estimate and flag when a client's prescribed medication might be running out.

Score: Comments:

<i>Screen Shot:</i>	<i>Please include a representative sample screen shot of a Medication History screen.</i>
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7.17 Outcome Measurement

General Requirements:

Using the system forms development tool described in Section 3.2, a variety of outcome measurement instruments can be created within the system. In addition, third party licensed instruments can be incorporated into the system for authorized use. Locally defined as well as third party licensed scoring protocols can be used to summarize outcome instrument data. Clinical review of outcome score trends over time is available as on-line queries for clinical decision-making.

Score: Comments:

8.0 Data Management and Reporting

Proposed Product for this Module

What is the software product name(s) being proposed for this module?

Overview

Piedmont PIHP is required to develop sophisticated reporting systems for “turning data into information” under its new contract. The Data Management and Reporting section defines the requirements for how data is accessed and reported within the system and how the IS system supports the extraction, management and reporting outside the system.

Components

8.1 Standard Operational Reports

General Requirements:

The system has standard operational reports to support each functional area in this document. The reports allow users to select and filter data by variables such as date range, department, clinician, etc. The user has the option of outputting reports to the screen, printer, standard ASCII file format and PC application formats such as XLS, CSV, PDF, MDB, TXT, DIF, etc. Standard reports can be copied, edited and added to the reports menu with a new report name.

Score:

Comments:

8.2 Standard Management Reports

General Requirements:

The system has standard management reports that provide a variety of views of PIHP operations such as monthly trend reports, clinician comparison reports, etc. The key aspect of these reports is that they provide summarized management-related data that support tactical and strategic decision-making. The user has the option of outputting reports to the screen, printer, standard ASCII file format and PC application formats such as XLS, CSV, PDF, MDB, TXT, DIF, etc. Standard reports can be copied, edited and added to the reports menu with a new report name.

Score:

Comments:

8.3 North Carolina-Mandated Performance Outcome System Reports

General Requirements:

The system supports the collection, compilation, reporting and analysis of the North Carolina -mandated Performance Outcome System (POS) client outcome and satisfaction reports included in the contracts for Medicaid B and C waivers, and other state mandated reporting:

Score:

Comments:

8.4 Quality Management Reports

General Requirements:

The system supports the reporting and data analysis of the PIHP's quality management program including:

Quality Assurance: The development and production of reports based on payor and PIHP identified performance and outcome measures for access, assessment, treatment planning, service delivery, etc. Also aids random chart sampling and review processes.

Quality Improvement: The development and production of reports that track and trend quality measures over time and can support the identification of variation that is material and statistically significant.

Utilization Review: The development and production of reports that track utilization throughout the PIHP and identify specific clients, clinicians, services, and/or programs that are above or below user-designated trigger thresholds.

Score:

Comments:

8.5 Integrated Report Writer

General Requirements:

The system includes an integrated, user-friendly report writer that has the capability of reporting on any combination of data fields in the entire system including user-defined fields; can perform multi-layered sorts and selects; has the ability to utilize wild cards in any data position of a field to select items; has the ability to compute on any field or combination of fields. The report writer generates both ad hoc query-type results and formatted reports whose production can be scheduled, produced and distributed electronically on an ongoing basis. The report writer is integrated such that the running of reports against the production database will not create noticeable degradation in the response time of staff that are entering transactions and using the system's various lookup features. The user has the option of outputting results to the screen, printer, standard ASCII file format and PC application formats such as XLS, CSV, PDF, MDB, TXT, DIF, etc.

Score:

Comments:

Screen Shot:	<i>Please include a representative sample screen shot of a client lookup screen.</i>
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8.6 Alternative Report Writers

General Requirements:

The vendor has experience interfacing other SQL-compliant third-party report writer applications such as Crystal Reports, Microsoft Access, or R&R Report Writer with the system such that the tool can report on any combination of data fields in the entire system including user-defined fields.

Score: Comments:

8.7 Letter Writing/Mail Merge

General Requirements:

The system supports a letter writing/mail merge function where third party word processing programs such as Microsoft Word can be integrated with the system to produce letters to clients, clinicians and other parties. Letter templates can be added to system menus and automatically generated based on rules in the Tickler Engine and the Workflow Management component (both found in Section 3.2). Examples include the generation of a referral letter to clinician and client when a referral is created, and generation of a follow-up letter when an appointment is recorded as a missed appointment.

Score: Comments:

8.8 Data Rectangle Exports

General Requirements:

The system supports the development of standard data rectangles based on predefined views that can be exported to common third party products such as Microsoft Excel and Microsoft Access.

Vendor: Comments:

8.9 Mirrored Database Support

General Requirements:

The vendor has experience and supports the mirroring of the production database to a reporting server, which uses the Integrated Report Writer and/or an Alternative Report Writer to produce user-developed reports and ad hoc queries.

Score:

Comments:

8.10 Data Warehouse/Mart Support

General Requirements:

The IS system supports the extraction, transformation, and loading of all data from the system into a Data Store containing denormalized and summarized data, which is used for data analysis and reporting. Trained PIHP staff will have the ability to maintain and manage the extraction, transformation and loading processes and obtain timely and accurate information from the IS system when they make changes to the system's data dictionary.

Score:

Comments:

Features

8.11 Data Dictionary

General Requirements:

Documentation for the system includes a complete data dictionary and Entity Relationship Diagram of all of the tables, table relationships, fields, and field attributes.

Score:

Comments:

8.12 Drill-Down Capabilities

General Requirements:

The internal or alternative report writer supports the development of drill-down reports that allow users to examine the underlying data behind figures on the report.

Score:

Comments:

8.13 Report Scheduling

General Requirements:

The system allows users to schedule report production requests for regular periodic processing according to specified criteria such as one or more times per day, weekly

on specified day, monthly on first day of month and fiscal period, etc. Specification of data ranges to be included in reports may differ from the scheduled date/time of the execution of the report.

Score:

Comments:

8.14 Predefined Data Views

General Requirements:

The system provides predefined views of data sets that combine files from multiple tables into logical reporting groupings to assist non-technical users in creating new standard, management, and ad hoc reports. Example views include Clients, Clinicians, Services, and Authorizations. The system supports the development of views based on groupings of client attributes such as user-defined population cohorts, geographic clusters of zip codes, groupings of client eligibilities, etc. Views can include core fields as well as any user-defined field added to the system.

Score:

Comments:

9.0 System Interfaces

Proposed Product or Program Name for this Module

What is the software product name(s) being proposed for this module?

Overview

The PIHP currently interface with various external systems. The interfaces to the State systems will require mapping of data to or from the State formats as well as code conversion.

Components

9.1 Interface Engine

General Requirements:

The system has an interface engine that supports the bi-directional transfer of data with state and PIHP systems as well as with other business associates. The interface engine: supports healthcare application-level transaction standards; supports the translation of data sets based on pre-defined translation code tables; supports the development of error-checking routines, flagging via error reports, and the ability to readily resolve non-matching data. The interface engine allows trained PIHP staff to maintain and modify these interfaces in response to specification changes from payors and business associates.

Score:

Comments:

9.2 Financial Accounting System Interface

General Requirements:

The interface engine can be used to generate generally accepted accounting standards (GAAP)-compliant, double-entry uploads of billing and claims transactions into the PIHP’s general ledger and accounts payable systems. The file structure of the data coming out of the system supports a variety of general ledger coding schemes in use by the PIHP’s Great Plains General Ledger system.

Score:

Comments:

9.3 Interfaces with Other Practice Management Systems

General Requirements:

The interface engine can be used to receive and upload, with proper edit checking, client registration, episode, admission, discharge, authorization, and service data from contract providers that utilize a different practice management system.

Score:

Comments: