NEVADA HEALTH AUTHORITY

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Nevada Health Authority
Nevada Medicaid

Fiscal Year 2025 Encounter Data Validation Study Report: Information Systems Review, Comparative Analysis, and Medical/Dental Record Review

November 2025

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

Accurate and complete encounter data are critical to the success of any managed care program. Therefore, Nevada Medicaid, a Division of the Nevada Health Authority (NVHA), requires its contracted managed care organizations (MCOs) and its dental benefit administrator (DBA)/prepaid ambulatory health plan (PAHP), collectively referred to as managed care entities (MCEs), to submit high-quality encounter data. During fiscal year (FY) 2025, Nevada Medicaid contracted Health Services Advisory Group, Inc. (HSAG), to conduct an encounter data validation (EDV) study. The goal of the study was to determine the extent to which professional, institutional, pharmacy, and dental encounters submitted to Nevada Medicaid by its contracted MCEs are complete and accurate. The EDV study included the following four MCOs and one DBA:

- **Anthem Blue Cross and Blue Shield Healthcare Solutions** (**Anthem**)
- **Molina Healthcare of Nevada, Inc.** (**Molina**)
- **SilverSummit Healthplan, Inc.** (**SilverSummit**)
- **UnitedHealthcare Health Plan of Nevada Medicaid** (**UHC HPN**)
- **LIBERTY Dental Plan of Nevada, Inc.** (**LIBERTY**)

Methods

In alignment with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP [Children's Health Insurance Program] Managed Care Plan: An Optional EQR-Related Activity*, February 2023 (CMS EQR Protocol 5),[1] HSAG conducted the following three core evaluation activities designed to evaluate the completeness and accuracy of Nevada Medicaid's encounter data. Together, the MCE-specific activities outlined in the methodology provided a comprehensive assessment of Nevada Medicaid's encounter data submitted by each MCE. The three activities are as follows:

- Information systems (IS) review—assessment of MCEs' information systems and processes. The goal of this activity was to examine the extent to which the MCEs' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 2: Review the Managed Care Plan's (MCP's) Capability in the CMS EQR Protocol 5.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5: Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Sep 12, 2025.

- Comparative analysis—analysis of Nevada Medicaid's electronic encounter data completeness and accuracy through a comparison between Nevada Medicaid's electronic encounter data and the data extracted from the MCEs' data systems. The goal of this activity was to evaluate the extent to which encounter data in Nevada Medicaid's data warehouse are complete and accurate based on corresponding information stored in each MCE's data systems. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in the CMS EQR Protocol 5.
- Medical/dental records review—analysis of Nevada Medicaid's electronic encounter data completeness and accuracy through a review of a sample of Nevada Medicaid's electronic encounter data and the associated medical/dental records. The goal of this activity was to evaluate the extent to which Nevada Medicaid's encounter data are complete and accurate when compared to information contained within the member's medical/dental records. This activity corresponds to the Activity 4: Review Medical Records in the CMS EQR Protocol 5.

HSAG conducted an EDV study including all three activities (i.e., IS review, comparative analysis, and medical record review) for **Anthem** and **UHC HPN** in FY 2018 and **SilverSummit** and **LIBERTY** in FY 2022. Since FY 2025 is the first year HSAG conducted the EDV study for **Molina**, HSAG included the IS review component of the EDV activity for this MCE only. Concurrent with the IS review, HSAG conducted the comparative analysis for all five MCEs to ascertain whether encounter data are complete and are of high quality before proceeding with the medical/dental record review activity.

Table 1-1 shows the core evaluation activities for each MCE.

Table 1-1—Core Evaluation Activities for Each MCE

MCE	IS Review	Comparative Analysis	Medical/Dental Record Review
Anthem	No	Yes	Yes
Molina	Yes	Yes	Yes
SilverSummit	No	Yes	Yes
UHC HPN	No	Yes	Yes
LIBERTY	No	Yes	Yes

Findings

A summary of major findings from the three EDV study components is presented below.

Information Systems Review

The IS review component of the EDV study provided self-reported qualitative information from **Molina** regarding the encounter data processes related to collection, processing, and transmission of encounter data to Nevada Medicaid and below are the key findings:

- Based on the data submission requirements (e.g., companion guides) from Nevada Medicaid, **Molina** demonstrated its capability to collect, process, and transmit encounter data to Nevada Medicaid, as well as develop data review and correction processes that can respond to quality issues identified by Nevada Medicaid.
- While submitting denied lines to Nevada Medicaid with $0 paid at the line level, **Molina** did not submit fully denied claims (i.e., all lines were denied) to Nevada Medicaid.
- While **Molina** and/or its subcontractors evaluated claim volume by submission month, field-level completeness and accuracy, and submission timeliness, it did not note any reports regarding claim volume per member per month (PMPM), reconciliation with financial reports (e.g., clerk disperse journal), or medical record review. In addition, the example report from **Molina** appeared to include vision encounters in the "Professional" category, which may mask the data issues from vision encounters.
- **Molina** did not anticipate any upcoming changes to its encounter data submission process, as it was not facing any internal or external issues.

Comparative Analysis

Throughout the comparative analysis section, lower rates indicate better performance for omission and surplus rates while higher rates indicate better performance for accuracy rates.

Record Completeness

HSAG evaluated the record-level data completeness of Nevada Medicaid's encounter data by investigating the record omission and record surplus rates in Nevada Medicaid's data compared to each MCE's data. Record omission is defined as records present in the MCE-submitted data but not present in Nevada Medicaid's data, and record surplus is defined as records present in Nevada Medicaid's data but not present in the MCE-submitted data. Table 1-2 displays the MCO statewide rates as well as MCEs' performance by encounter type. The left half of each circle in the table represents the record omission rate, and the right half of each circle represents the record surplus rate. The green shading indicates a rate less than 5.0 percent (i.e., better record completeness) while the red shading indicates a rate greater than 5.0 percent (i.e., relatively poor performance).

Table 1-2—Summary for Record Omission and Surplus Rates

Encounter Type	MCO Statewide Record Omission	MCO Statewide Record Surplus	Anthem	Molina	SilverSummit	UHC HPN	LIBERTY
Professional	2.1%	3.7%	+	*	^	^	—
Institutional	2.7%	5.4%	^	*	^	+	—
Pharmacy	0.2%	2.6%	^	^	^	+	—

Encounter Type	MCO Statewide Record Omission	MCO Statewide Record Surplus	Anthem	Molina	SilverSummit	UHC HPN	LIBERTY
Dental	—	—	—	—	—	—	^

^ Both <5.0% + Record Omission <5.0% * Record Surplus <5.0% # Both >5.0%

Note: "—" in the gray shaded cells indicates that the encounter type was not applicable for the MCE.

The overall MCO statewide record omission rates for professional, institutional, and pharmacy encounters were 2.1 percent, 2.7 percent, and 0.2 percent, respectively. Likewise, the overall MCO statewide record surplus rates for professional, institutional, and pharmacy encounters were 3.7 percent, 5.4 percent, and 2.6 percent, respectively. The MCOs' results varied within each encounter type. Additionally, the record omission and surplus rates for **LIBERTY** were 0.2 percent and 1.8 percent, respectively.

Data Element Completeness and Accuracy

For records that could be matched between both data sources, HSAG evaluated the element-level completeness of Nevada Medicaid's encounter data by assessing element omission and element surplus rates for key data elements relevant to each encounter type. Element omission is defined as values present in the MCE-submitted data but not present in Nevada Medicaid's data for a data element, and element surplus is defined as values present in Nevada Medicaid's data but not present in the MCE-submitted data for a data element. Additionally, HSAG evaluated the element-level accuracy of Nevada Medicaid's encounter data by assessing records that were present in both Nevada Medicaid's and the MCEs' data with the same non-missing values for a given data element. Table 1-3 shows the number of data elements evaluated for each encounter type and the number of data elements needing the MCEs' attention since either the element omission or element surplus rate was greater than 5.0 percent, or the element accuracy rate was less than 95.0 percent for a data element, indicating a potential area of concern for element completeness and accuracy.

Table 1-3—Number of Data Elements Evaluated and Number of Elements With Omission, Surplus, or Element-Level Accuracy Rates Needing MCE Attention

Encounter Type	Number of Key Data Elements	Anthem	Molina	SilverSummit	UHC HPN	LIBERTY
Professional	21	2	2	2	0	—
Institutional	25	5	6	3	2	—
Pharmacy	10	0	0	0	0	—
Dental	18	—	—	—	—	0

Note: "—" in the gray shaded cells indicates that the encounter type was not applicable for the MCE.

For professional data, **UHC HPN** had no action items and the other three MCOs had action items for two key data elements. For institutional data, all MCOs require attention to at least two key data elements. For pharmacy and dental data, no MCEs require attention to any key data elements that were evaluated.

All-Element Accuracy

HSAG determined all-element accuracy by evaluating the records present in both data sources with exactly the same values (missing or non-missing) for all data elements relevant to each encounter type. Higher all-element accuracy rates indicate that the values populated in Nevada Medicaid's data warehouse were more accurate and complete for all key data elements.

The MCO statewide all-element accuracy varied across encounter types, showing 56.3 percent for professional encounters, 34.0 percent for institutional encounters, and 96.2 percent for pharmacy encounters, whereas **LIBERTY**'s all-element accuracy for dental encounters was fairly high at 91.0 percent. The low all-element accuracy rates for the MCOs could be caused by element omission, element surplus, and element inaccuracy from any of the key data elements.

Medical/Dental Record Review

Encounter Data Completeness

Table 1-4 displays the medical/dental record omission and encounter data omission rates for each key data element from the medical/dental record review activity. The left half of each circle in the table represents the medical/dental record omission rate, and the right half of each circle represents the encounter data omission rate. The green shading indicates a rate less than 5.0 percent (i.e., better record completeness) while the red shading indicates a rate greater than 5.0 percent (i.e., relatively poor performance).

Table 1-4—Medical/Dental Record Review: Encounter Data Completeness Summary

	MCO						DBA
Data Element	MCO Statewide Medical Record Omission	MCO Statewide Encounter Data Omission	Anthem	Molina	Silver-Summit	UHC HPN	LIBERTY
Date of Service	16.6%	2.3%	*	*	*	*	^
Diagnosis Code	17.9%	1.4%	*	*	*	*	*
Procedure Code	25.5%	1.6%	*	*	*	*	*

	MCO						DBA
Data Element	MCO Statewide Medical Record Omission	MCO Statewide Encounter Data Omission	Anthem	Molina	Silver-Summit	UHC HPN	LIBERTY
Procedure Code Modifier	29.6%	1.7%	*	*	*	*	NA

^ Both <5.0% + Medical/Dental Record Omission <5.0% *Encounter Data Omission <5.0% # Both >5.0

NA indicates that the data element was not applicable for dental record review.

- The data elements *Date of Service* (16.6 percent), *Diagnosis Code* (17.9 percent), *Procedure Code* (25.5 percent), and *Procedure Code Modifier* (29.6 percent) were moderately supported by the medical records at the statewide level. For **LIBERTY**, the data elements *Date of Service* (1.7 percent) and *Procedure Code* (5.2 percent) were generally supported by the members' dental records as evidenced by the dental record omission rates in Table 5-4 and Table 5-6. However, the data element *Diagnosis Code* (13.8 percent) was moderately supported by the dental records in Table 5-5.
- In contrast, the relatively low encounter data omission rates for all key data elements (i.e., *Date of Service, Diagnosis Code, Procedure Code,* and *Procedure Code Modifier*) indicated that these data elements found in the members' medical records were well supported by the electronic encounter data extracted from Nevada Medicaid's data warehouse with MCO statewide rates ranging from 1.4 percent (*Diagnosis Code*) to 2.3 percent (*Date of Service*). Similarly, for **LIBERTY**, all key data elements (i.e., *Date of Service, Diagnosis Code,* and *Procedure Code*) had low encounter data omission rates ranging from 0.4 percent (*Procedure Code*) to 2.1 percent (*Date of Service*) as shown in Table 5-4 through Table 5-6. This indicated the data elements found in the members' dental records were well supported by the data found in Nevada Medicaid's data warehouse.

Encounter Data Accuracy

Table 1-5 displays the element accuracy rates for each key data element and the all-element accuracy rates.

Table 1-5—Encounter Data Accuracy Summary

Data Elements	MCO					DBA
	MCO Statewide	Anthem	Molina	SilverSummit	UHC HPN	LIBERTY
Diagnosis Code	**99.6%**	99.7%	99.2%	99.6%	99.9%	71.6%
Procedure Code	**95.6%**	96.1%	95.7%	94.1%	96.4%	94.1%
Procedure Code Modifier	**99.3%**	98.8%	98.8%	100%	99.2%	NA
All-Element Accuracy	**72.2%**	69.1%	71.2%	71.7%	75.5%	37.6%

NA indicates that the data element was not applicable for dental record review.

Overall, when key data elements were present in both Nevada Medicaid professional data and the medical records and evaluated independently, the data element values were found to be accurate. Among the key data elements evaluated, 99.6 percent of diagnosis codes, 95.6 percent of procedure codes, and 99.3 percent of procedure code modifiers present in both sources were accurate at the MCO statewide level. In comparison to the MCOs, the DBA, **LIBERTY**, had lower accuracy rates for the key data elements *Diagnosis Code* (71.6 percent) and *Procedure Code* (94.1 percent) for dental encounters. The errors affecting the *Diagnosis Code* data element and the *Procedure Code* data element were mostly due to the use of inaccurate codes for both medical and dental records instead of other error types as shown in Table 5-8 and Table 5-9.

More than 72.0 percent of the dates of service present in both data sources contained accurate values for all three key data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) for the MCOs. The relatively low MCO statewide all-element accuracy rates were caused by the medical record omissions, encounter data omissions, and element inaccuracies from all three key data elements, with *Procedure Code* contributing the most and *Diagnosis Code* contributing the least. For **LIBERTY**, 37.6 percent of the dates of service present in both data sources contained accurate values for the data elements *Diagnosis Code* and *Procedure Code*. The low all-element accuracy rate was caused by the dental record omission, encounter data omission, and element inaccuracy for the two data elements, with *Diagnosis Code* contributing the most and *Procedure Code* contributing the least.

Recommendations

To improve the quality of encounter data submissions from the MCEs, HSAG offers the following recommendations for each component of the EDV study to assist Nevada Medicaid and the MCEs in addressing opportunities for improvement:

Information Systems Review

- **Molina** should work with Nevada Medicaid to decide whether the fully denied claims should be submitted to Nevada Medicaid.
- **Molina** should explore the possibility of developing or enhancing monitoring reports to assess the accuracy, completeness, and/or timeliness of the encounters as noted below.
  - **Molina** should develop reports regarding claim volume PMPM or reconciliation with financial reports (e.g., clerk disperse journal).
  - **Molina** should monitor vision encounters separately from other professional encounters.

Comparative Analysis

- The results from the comparative analysis indicated that encounters submitted by the MCEs and maintained in Nevada Medicaid's data warehouse were relatively complete (i.e., low record omission and surplus rates) when compared to data the MCEs submitted to HSAG. However, there

were a few record omission and surplus rates between 5.0 and 9.0 percent. HSAG recommends that Nevada Medicaid work with the MCEs to resolve these issues (i.e., refer to the MCE-specific data discrepancy reports or the MCE-specific appendices in the report). In addition, HSAG recommends that Nevada Medicaid continue its current monitoring efforts to maintain the quality of encounter data submissions and promptly address any identified data issues.

- While many key data elements showed high completeness and accuracy rates, some elements had high element omission/surplus rates or low accuracy rates. HSAG recommends that Nevada Medicaid work with the MCEs to resolve issues related to these data elements (i.e., refer to the MCE-specific data discrepancy reports or the MCE-specific appendices in the report). This involves clarifying the requirements for submitting, collecting, and reporting these data elements to improve the overall data quality.
- **Anthem**, **Molina**, and **SilverSummit** reported system query errors when extracting data for the EDV study. MCEs should review and implement standard quality controls to ensure accurate data extracts from their respective systems. Standardizing data extraction procedures and enhancing quality controls will help reduce errors associated with data extraction.

Medical/Dental Record Review

- The results from the medical/dental record review also indicated that the key data elements (i.e., *Date of Service, Diagnosis Code, Procedure Code, Procedure Code Modifier*) in the encounters submitted by the MCEs and maintained in Nevada Medicaid's data warehouse were generally supported by members' medical and dental records, with a few exceptions. As such, HSAG recommends Nevada Medicaid continue its current efforts in monitoring encounter data submissions and addressing any identified data issues with the MCEs' encounter data submissions.
- Since the results of the medical/dental record review are dependent on the MCEs' submission of complete and accurate supporting documentation, HSAG recommends that Nevada Medicaid consider setting record submission standards to ensure the MCEs and providers are more responsive in procuring requested records. By having the MCEs submit complete and accurate documentation and records, results will be more representative of the actual documentation available.
- The medical record omission rates for *Date of Service, Diagnosis Code, Procedure Code*, and *Procedure Code Modifier* were relatively high across all MCOs. The dental record omission rate for *Diagnosis Code* was relatively high for **LIBERTY**. As such, MCEs should investigate the root causes of these medical/dental record omissions and consider performing periodic medical/dental record reviews of submitted claims to verify appropriate coding and data completeness, where appropriate. Findings from these reviews should be used to provide targeted education and training for providers regarding encounter data submissions, medical/dental record documentation, and coding practices.
- **LIBERTY** should investigate the relatively low accuracy rate for the data element *Diagnosis Code* and implement any changes needed.

2. Overview and Methodology

Overview

Accurate and complete encounter data are critical to the success of any managed care program. State Medicaid agencies rely on the quality of encounter data submissions from contracted MCEs so as to monitor and improve quality of care, establish performance measure rates, generate accurate and reliable reports, and obtain utilization and cost information. The completeness and accuracy of these data are essential in the state's overall management and oversight of its Medicaid managed care program.

Methodology

During FY 2025, Nevada Medicaid contracted HSAG to conduct an EDV study. In alignment with the CMS EQR Protocol 5, HSAG conducted the following three core evaluation activities:

- IS review—assessment of MCEs' information systems and processes.
- Comparative analysis—analysis of Nevada Medicaid's electronic encounter data completeness and accuracy through a comparison between Nevada Medicaid's electronic encounter data and the data extracted from the MCEs' data systems.
- Medical/dental record review—analysis of Nevada Medicaid's electronic encounter data completeness and accuracy through a comparison between Nevada Medicaid's electronic encounter data and the medical/dental records.

During FY 2025, HSAG conducted the EDV study for the following four MCOs and one DBA:

- **Anthem**
- **Molina**
- **SilverSummit**
- **UHC HPN**
- **LIBERTY**

Since FY 2025 is the first year HSAG conducted the EDV study for **Molina**, and HSAG conducted the IS review activity for the other four MCEs either in FY 2018 or in FY 2022, HSAG included the IS review activity for **Molina** only. The IS review evaluated and determined whether **Molina**'s systems can collect and report high quality encounter data. Concurrent with the IS review, HSAG conducted the comparative analysis for all five MCEs to ascertain whether data are complete and are of high quality before proceeding with the medical/dental record review.

Information Systems Review

The IS review seeks to define how each participant in the encounter data process collects and processes encounter data such that the data flow from the MCEs to Nevada Medicaid is understood. The IS review is key to understanding whether the IS infrastructures are likely to produce complete and accurate encounter data. To ensure the collection of critical information, HSAG employed a three-stage review process that included a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members. As noted in the previous section, HSAG conducted this activity for **Molina** only since HSAG had already conducted an IS review for the other MCEs.

Stage 1—Document Review

HSAG initiated the EDV activity with a thorough desk review of documents related to encounter data initiatives/validation activities currently put forth by Nevada Medicaid. Documents requested for review included data dictionaries, process flow charts, data system diagrams, encounter system edits, sample rejection reports, workgroup meeting minutes, and Nevada Medicaid's current encounter data submission requirements, among others. The information obtained from this review was important for developing the targeted questionnaire to address important topics of interest to Nevada Medicaid.

Stage 2—Development and Fielding of Customized Encounter Data Assessment

To conduct a customized encounter data assessment, HSAG developed a questionnaire customized in collaboration with Nevada Medicaid to gather information and specific procedures for data processing, personnel, and data acquisition capabilities. This assessment also included a review of supplemental documentation regarding other data systems, including enrollment and providers. Lastly, this review included specific topics of interest to Nevada Medicaid. For example, the questionnaire assessed how **Molina** monitors encounter data quality for encounters collected by its subcontractors.

Stage 3—Key Informant Interviews

After reviewing the completed assessments, HSAG followed up with key **Molina** information technology (IT) personnel to clarify any questions from the questionnaire responses. Overall, the IS review allowed HSAG to document current processes and develop a thematic process map identifying critical points that impact the submission of quality encounter data. From this analysis, HSAG was able to provide actionable recommendations to the existing encounter data systems on areas for improvement or enhancement.

Comparative Analysis

HSAG conducted the comparative analysis component for all five MCEs. The goal of the comparative analysis was to evaluate the extent to which encounters submitted to Nevada Medicaid by the MCEs are complete and accurate, based on corresponding information stored in each MCE's data systems. This step corresponds to another important validation activity described in the CMS EQR Protocol 5—i.e., analyses of MCE electronic encounter data for accuracy and completeness on reporting. In this activity,

HSAG developed a data requirements document requesting claims/encounter data from both Nevada Medicaid and the MCEs. A follow-up technical assistance session occurred approximately one week after distributing the data requirements document, thereby allowing the MCEs time to review and prepare their questions for the session.

HSAG used data from both Nevada Medicaid and the MCEs with dates of service from January 1, 2023, through December 31, 2023, to evaluate the accuracy and completeness of the encounter data. To ensure that the extracted data from both sources represented the same universe of encounters, the data for the MCOs targeted professional, institutional, and pharmacy encounters submitted to Nevada Medicaid with MCO adjustment/paid dates on or before May 31, 2024, and submitted to Nevada Medicaid on or before June 30, 2024. Similarly, the data for the DBA targeted dental encounters with adjustment/paid dates on or before May 31, 2024, and submitted to Nevada Medicaid on or before June 30, 2024. This anchor date allowed sufficient time for the calendar year (CY) 2023 encounters to be submitted, processed, and available for evaluation in Nevada Medicaid's data warehouse.

Once HSAG received data files from all data sources, the analytic team conducted a preliminary file review to ensure data were sufficient to conduct the evaluation. The preliminary file review included the following basic checks:

- Data extraction—Data were extracted based on the data requirements document.
- Percentage present—Required data fields were present on the file and had values in those fields.
- Percentage of valid values—The values included were the expected values (e.g., valid International Classification of Diseases, 10th Revision [ICD-10] codes in the diagnosis field).
- Evaluation of matching claim numbers—The percentage of claim numbers that matched between the data extracted from Nevada Medicaid's data warehouse and the MCEs' data submitted to HSAG.

Based on the results of the preliminary file review, HSAG generated a report that highlighted major findings requiring Nevada Medicaid and the MCEs to resubmit data, if appropriate.

Once HSAG received and processed the final set of data from Nevada Medicaid and each MCE, HSAG conducted a series of comparative analyses, which were divided into two analytic sections.

First, HSAG assessed record-level data completeness using the following metrics for each encounter data type:

- The number and percentage of records present in the MCEs' submitted files but not in Nevada Medicaid's data warehouse (**record omission**).
- The number and percentage of records present in Nevada Medicaid's data warehouse but not in the MCEs' submitted files (**record surplus**).

Second, based on the number of records present in both data sources, HSAG further examined completeness and accuracy for key data elements listed in Table 2-1. The analyses focused on an element-level comparison for each data element.

Table 2-1—Key Data Elements for Comparative Analysis

Key Data Elements	Professional	Institutional	Pharmacy	Dental
Recipient ID	✓	✓	✓	✓
Date of Service				
Header Service From Date	✓	✓	✓	✓
Header Service To Date	✓	✓		✓
Detail Service From Date	✓	✓		✓
Detail Service To Date	✓	✓		✓
Admission Date		✓		
Discharge Status		✓		
Provider Information				
Billing Provider National Provider Identifier (NPI)	✓	✓	✓	✓
Rendering Provider NPI	✓			✓
Attending Provider NPI		✓		
Prescribing Provider NPI			✓	
Referring Provider NPI	✓	✓		✓
Service Information (e.g., Diagnosis Codes, Procedure Codes, and Drug Information)				
Primary Diagnosis Code	✓	✓		✓
Secondary Diagnosis Code(s)	✓	✓		✓
Procedure Code (CPT/HCPCS/CDT)*	✓	✓		✓
Procedure Code Modifier(s)	✓	✓		
Units of Service	✓	✓		✓
Revenue Code		✓		
Surgical Procedure Code(s)		✓		
Type of Bill (TOB) Code		✓		
Place of Service (POS) Code	✓			✓
National Drug Code (NDC)	✓	✓	✓	
Drug Quantity	✓	✓	✓	
Days of Supply			✓	
Tooth Number				✓
Tooth Surface Codes (1 through 5)				✓

Key Data Elements	Professional	Institutional	Pharmacy	Dental
Oral Cavity Codes (1 through 5)				✓
Payment Information				
Header Paid Amount	✓	✓	✓	✓
Detail Paid Amount	✓	✓		✓
Header Third Party Liability (TPL) Paid Amount	✓	✓	✓	
Detail TPL Paid Amount	✓	✓		
Paid Date	✓	✓	✓	✓

*CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System; CDT = Current Dental Terminology

For records that matched between Nevada Medicaid's and the MCEs' data, HSAG evaluated the element-level completeness based on the following metrics:

- The number and percentage of records with values present in the MCEs' submitted files but not in Nevada Medicaid's data warehouse (**element omission**).
- The number and percentage of records with values present in Nevada Medicaid's data warehouse but not in the MCEs' submitted files (**element surplus**).
- The number and percentage of records with values missing from both Nevada Medicaid's data warehouse and the MCEs' submitted files (**element missing**).

Element-level accuracy was limited to those records with values present in both MCE- and Nevada Medicaid-submitted files. For each key data element, HSAG determined the number and percentage of records with the same values in both MCE- and Nevada Medicaid-submitted files (**element accuracy**).

Finally, for records present in both Nevada Medicaid- and MCE-submitted files, HSAG evaluated the number and percentage of records with the same values for all key data elements relevant to each encounter data type (**all-element accuracy**).

Data Discrepancy Report

As a follow-up to the comparative analysis activity, HSAG provided technical assistance to Nevada Medicaid and the MCEs regarding the issues identified from the comparative analysis via the data discrepancy reports. First, HSAG drafted MCE-specific encounter data discrepancy reports highlighting key areas for investigation. The evaluation metrics that warranted investigation included an omission or surplus rate exceeding 5.0 percent or an accuracy rate falling below 95.0 percent. Second, upon Nevada Medicaid's review and approval, HSAG distributed the discrepancy reports to the MCEs, along with data samples, to assist with their internal investigations. MCEs then investigated the potential root causes of the key issues and provided written responses including action plans. Lastly, once HSAG

reviewed the written responses, it followed up with the MCEs, if appropriate, and worked with Nevada Medicaid to determine whether the issues had been addressed or the action plans were acceptable.

Medical/Dental Record Review

As outlined in the CMS EQR Protocol 5, medical/dental record review is a complex and resource-intensive process. Medical and clinical records are considered the "gold standard" for documenting Medicaid members' access to and quality of healthcare services.

During FY 2025, HSAG evaluated encounter data completeness and accuracy through a review of medical and dental records for physician and dental services, respectively, rendered between January 1, 2023, and December 31, 2023. This study answered the following question:

- *Are the data elements in Table 2-2 found on the professional/dental encounters complete and accurate when compared to information contained within the medical/dental records?*

Table 2-2—Key Data Elements for Medical and Dental Record Review

Medical	Dental
Date of Service	Date of Service
Diagnosis Code	Diagnosis Code
Procedure Code	Procedure Code
Procedure Code Modifier	

To answer the study question, HSAG conducted the following steps:

- Identified the eligible population and generated samples from data extracted from Nevada Medicaid's data warehouse.
- Provided technical assistance to the MCEs to support the procurement of medical/dental records from providers, as appropriate.
- Reviewed medical/dental records against Nevada Medicaid's encounter data.
- Calculated study indicators and submitted study results to Nevada Medicaid.

Study Population

To be eligible for the medical/dental record review, a member had to be continuously enrolled in the same MCE during the study period (i.e., between January 1, 2023, and December 31, 2023) and had to have at least one physician/dental visit during the study period. In addition, members with other insurance coverages were excluded from the eligible population since these members may have received services that were documented in the medical/dental records but not in Nevada Medicaid's encounter data. In this report, HSAG refers to physician and dental services as the services that met all criteria in Table 2-3.

Table 2-3—Criteria for Physician and Dental Services Included in the Study

Data Element	Criteria
Physician Services	
Provider Type	14–Behavioral Health Outpatient Treatment
	20–Physician, M.D., Osteopath, D.O.
	21–Podiatrist
	24–Advanced Practice Registered Nurses
	25–Optometrist
	26–Psychologist
	34–Therapy
	47–Indian Health Services (IHS) and Tribal Clinics
	74–Nurse Midwife
	77–Physician Assistant
	85–Applied Behavior Analysis (ABA)
Place of Service	02–Telehealth Provided Other Than in Patient's Home
	10–Telehealth Provided in Patient's Home
	11–Office
	20–Urgent Care Facility
	23–Emergency Room—Hospital
	49–Independent Clinic
	50–Federally Qualified Health Center
	71–Public Health Clinic
	72–Rural Health Clinic
Procedure Code	If all detail lines for a visit have the following procedure codes, the visit will be excluded from the study since these procedure codes are for services outside the scope of work for this study (e.g., durable medical equipment [DME], dental, and vision): • A procedure code starting with "B', "E", "D", "K", or "V" • Procedure codes between A0021 and A0999 (i.e., codes for transportation services) • Procedure codes between A4206 and A9999 (i.e., codes for medical and surgical supplies, miscellaneous, and investigational procedures) • Procedure codes between T4521 and T4544 (i.e., codes for incontinence supplies) • Procedure codes between L0112 and L4631 (i.e., codes for orthotic devices and procedures)

Data Element	Criteria
	• Procedure codes between L5000 and L9900 (i.e., codes for prosthetic devices and procedures) • Procedure codes with an "F" in the fifth digit • Procedure codes related to blood pressure quality measures (i.e., G8476, G8477, G8752, G8753, G8754, G8755, G8783, G8785, G8950, and G9273)
Dental Services	
Provider Type	Dentist
	Registered Dental Hygienist
	County Health Department
	Federally Qualified Health Center
Place of Service	Same criteria as those listed under the "Physician Services" heading
Taxonomy Classification	Remove providers with Taxonomy Grouping = "Other Service Providers" and Taxonomy Classification = "Specialist"

Sampling Strategy

HSAG used a two-stage sampling technique to select samples based on the member enrollment and encounter data extracted from Nevada Medicaid's data warehouse. HSAG first identified all members who met the study population eligibility criteria and then used random sampling to select 411 members[2] from the eligible population for each of the MCEs. Then, for each selected sampled member, HSAG used the SURVEYSELECT procedure in SAS®,[3] 9.4 to randomly select one professional/dental visit[4] that occurred in the study period (i.e., between January 1, 2023, and December 31, 2023). Additionally, to evaluate whether any of the dates of service were omitted from Nevada Medicaid's data warehouse, HSAG reviewed a second date of service rendered by the same rendering or billing provider during the review period. The providers selected the second date of service, which was closest to the selected date of service, from the medical/dental records for each sampled member. If a sampled member had no second visit with the same provider practice during the review period, HSAG evaluated only one date of service for that member. As such, the final number of services reviewed was between 411 and 822 in total for each MCE.

For the four MCOs, HSAG calculated the MCO statewide rates. Since an equal number of cases were selected from each MCO, to ensure an adequate sample size when reporting rates at the MCO level,

[2] The sample size of 411 is based on a 95 percent confidence level and a margin of error of 5 percent for potential MCE-to-MCE comparisons.

[3] SAS and all other SAS Institute Inc. product or service names are registered trademarks or trademarks of SAS Institute Inc. in the USA and other countries. ® indicates USA registration

[4] To ensure that the medical/dental record review included all services provided on the same date of service, encounters with the same date of service and same rendering provider were consolidated into one visit for sampling purposes.

adjustments were required to calculate the statewide rates to account for population differences among the MCOs. When reporting MCO statewide rates, HSAG weighted each MCO's raw rates based on the volume of physician visits among the eligible population for each MCO. This approach ensured that no MCO was over- or underrepresented in the MCO statewide rates. Since there is only one DBA, there was no need for HSAG to calculate the statewide rates.

Medical/Dental Record Procurement

Upon receiving the final sample list from HSAG, the MCEs were responsible for procuring the sampled members' medical/dental records from their contracted providers for services that occurred during the study period. In addition, the MCEs were responsible for submitting the documentation to HSAG. To improve the procurement rate, HSAG conducted a one-hour technical assistance session with participating MCEs to review the EDV project and the procurement protocols after distributing the sample list. MCEs were instructed to submit medical/dental records electronically via HSAG's Secure Access File Exchange (SAFE) site to ensure that protected health information (PHI) was safeguarded. During the procurement process, HSAG worked with the MCEs to answer questions and monitor the number of medical/dental records submitted. For example, HSAG provided an initial submission update when 40 percent of the records were expected to be submitted and a final submission status update following completion of the procurement period.

All electronic medical/dental records HSAG received were maintained on a secure HSAG network, which allowed HSAG's trained reviewers to validate the cases from a centralized location under supervision and oversight. As with all medical/dental record review and research activities, HSAG implemented a thorough Health Insurance Portability and Accountability Act (HIPAA) compliance and protection program in accordance with federal regulations that included recurring training as well as policies and procedures that addressed physical security, electronic security, and day-to-day operations.

Review of Medical/Dental Records

HSAG's experienced medical/dental record reviewers were responsible for abstracting the medical/dental records. To successfully complete the study, the project lead worked with the case review team (CRT) beginning with the methodology phase. The CRT was involved in the tool design phase as well as in testing the tools to ensure that the abstracted data were complete and accurate. Based on the study methodology, clinical guidelines, and the tool design/testing results, the CRT drafted an abstraction instruction document specific to the study to be used for training. Concurrent with record procurement activities, the CRT trained the medical/dental record reviewers on the specific study protocols and conducted inter-rater reliability (IRR) testing. All medical/dental record reviewers had to achieve a 95 percent accuracy rate for the training/test cases before they could review medical/dental records.

During the medical/dental record review activity, HSAG's trained reviewers collected and documented findings in an HSAG-designed electronic data collection tool. The tool was designed with edits to assist in the accuracy of data collection. The validation included a review of specific data elements identified in the sample cases and compared to corresponding documentation in the medical/dental record. IRR

among reviewers, as well as reviewer accuracy, were evaluated regularly throughout the study. Questions and decisions raised during this evaluation process were documented in the abstraction instruction document and communicated to all reviewers in a timely manner. In addition, HSAG analysts reviewed the export files from the abstraction tool on an ongoing basis to ensure the abstraction results were complete, accurate, and consistent.

The validation of encounter data incorporates a unique two-way approach through which encounters were chosen from both the electronic encounter data and from medical/dental records and were subsequently compared with one another. Claims/encounters chosen from Nevada Medicaid's data system were compared against the medical/dental records and visit records, and the medical/dental records submitted by providers were compared against Nevada Medicaid's encounter data. This process allowed the study to identify services documented in the members' medical/dental records that were missing from Nevada Medicaid's system. It also identified surplus encounters present in Nevada Medicaid's data system that were not documented in the members' medical/dental records. For services in both data sources, an analysis of coding accuracy was completed. Information that existed in both data sources but that contained values that did not match were considered discrepant.

Study Indicators

Once the medical/dental record review was completed, HSAG analysts exported information collected from the electronic tool, reviewed the data, and conducted the analysis. HSAG used the study indicators in Table 2-4 to report the medical/dental record review results.

Table 2-4—Study Indicators

Study Indicator	Denominator	Numerator
Medical/Dental Record Procurement Rate: Percentage of medical/dental records submitted. Additionally, the reasons for missing medical/dental records are presented.	Total number of requested sample cases.	Number of requested sample cases with medical/dental records submitted for either the sampled date of service or the second date of service.
Second Date of Service Submission Rate: Percentage of sample cases with a second date of service submitted in the medical/dental records.	Number of sample cases with medical/dental records submitted.	Number of sample cases with a second date of service submitted in the medical/dental records.
Medical/Dental Record Omission Rate: Percentage of data elements (e.g., *Date of Service*) identified in Nevada Medicaid's data warehouse that are not found in the members' records. HSAG calculated the study indicator for each data element listed in Table 2-2.	Total number of data elements (e.g., *Date of Service*) identified in Nevada Medicaid's data warehouse (i.e., based on the sample dates of service and the second dates of service that are found in Nevada Medicaid's data warehouse).	Number of data elements (e.g., *Date of Service*) in the denominator but not found in the members' records.

Study Indicator	Denominator	Numerator
Encounter Data Omission Rate: Percentage of data elements (e.g., *Date of Service*) identified in members' records but not found in Nevada Medicaid's data warehouse. HSAG calculated the study indicator for each data element listed in Table 2-2.	Total number of data elements (e.g., *Date of Service*) identified in members' records (i.e., based on the service records procured for the sample dates of service and second dates of service).	Number of data elements (e.g., *Date of Service*) in the denominator but not found in Nevada Medicaid's data warehouse.
Diagnosis Code Accuracy: Percentage of diagnosis codes supported by the medical/dental records. Additionally, the frequency count of associated reasons for inaccuracy are presented.	Total number of diagnosis codes that met the following two criteria: • For dates of service (i.e., including both the sample dates of service and the second dates of service) that exist in both Nevada Medicaid's encounter data and the medical/dental records. • Diagnosis codes present for both Nevada Medicaid's encounter data and the medical/dental records.	Number of diagnosis codes supported by the medical/dental records.
Medical/Dental Procedure Code Accuracy: Percentage of procedure codes supported by the medical/dental records. Additionally, the frequency count of associated reasons for inaccuracy are presented.	Total number of procedure codes that met the following two criteria: • For dates of service (i.e., including both the sample dates of service and the second dates of service) that exist in both Nevada Medicaid's encounter data and the medical/dental records. • Procedure codes present for both Nevada Medicaid's encounter data and the medical/dental records.	Number of procedure codes supported by the medical/dental records.
Procedure Code Modifier Accuracy: Percentage of procedure code modifiers supported by the medical records.	Total number of procedure code modifiers that met the following two criteria: • For dates of service (i.e., including both the sample dates of service and the second dates of service) that exist in both Nevada Medicaid's	Number of procedure code modifiers supported by the medical records.

Study Indicator	Denominator	Numerator
	encounter data and the medical records. • Procedure code modifiers present for both Nevada Medicaid's encounter data and the medical records.	
All-Element Accuracy Rate: Percentage of dates of service present in both Nevada Medicaid's encounter data and the medical/dental records, with the same values for all data elements listed in Table 2-2.	Total number of dates of service (i.e., including both the sample dates of service and second dates of service) that are in both Nevada Medicaid's encounter data and the medical/dental records.	• For medical records: The number of dates of service in the denominator with the same diagnosis codes, procedure codes, and procedure code modifiers for a given date of service. • For dental records: The number of dates of service in the denominator with the same diagnosis codes and procedure codes for a given date of service.

3. Information Systems Review Findings

Molina representatives completed the questionnaire approved by Nevada Medicaid and supplied by HSAG. For more details regarding the questionnaire provided, please refer to Appendix A. To support its questionnaire responses, **Molina** submitted documents with varying formats and levels of detail on its professional, institutional, and pharmacy encounters. This section summarizes the findings from **Molina**'s questionnaire responses.

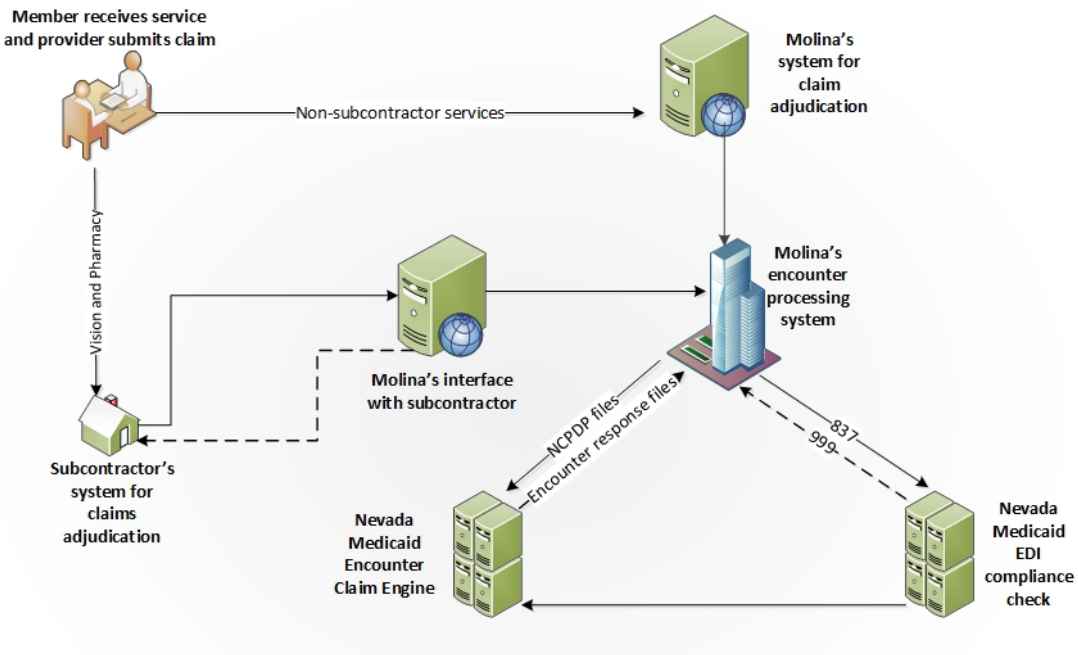
Encounter Data Sources and Systems

This section of the report summarizes data sources used in the claims data to encounter data cycle, the systems in place to process the data, the systematic formatting that occurs prior to submission, and how encounter data are verified from provider and member information.

Claims/Encounter Data Flow

Figure 3-1 shows a high-level general process that outlines the path of **Molina**'s encounter data from the point when a member receives a service (or services) until Nevada Medicaid processes the encounter. The solid lines represent the main transaction paths between each process agent while the dotted lines indicate data transfer feedback loops.

Figure 3-1—Claims/Encounter Data Path From Origin Through Submission to Nevada Medicaid



As shown in Figure 3-1, the claims/encounter process begins when a Nevada Medicaid member receives a healthcare service from a provider. The provider then submits the claim electronically or via paper to a clearinghouse responsible for aggregating and formatting claims for submission to the claim processor, although the provider may also submit the claim directly to **Molina** via its web portal for claims processing. Next, the claim is processed and then submitted to **Molina**'s encounter processing system. For claims collected by **Molina**'s pharmacy and vision subcontractors, **Molina** receives pass-through files from its two subcontractors for submission to Nevada Medicaid. **Molina** and its subcontractors are responsible for ensuring that encounter data are accurate, complete, and formatted correctly for timely submission to Nevada Medicaid, using 837 Professional (837P), 837 Institutional (837I), or National Council for Prescription Drug Programs (NCPDP) D.01 files. After Nevada Medicaid processes the encounter data, it provides a variety of response files to **Molina** so that **Molina** and its subcontractors can identify encounters that Nevada Medicaid does not successfully process or that fail Nevada Medicaid edits.

Information System Infrastructure

Molina received 837P and 837I files directly from its contracted clearinghouse daily. Moreover, **Molina** received pharmacy data from CVS Caremark via the NCPDP D.01 files weekly and received vision data from Vision Service Plan (VSP) via 837P files bi-weekly.

Upon receiving claims from providers, **Molina** and its subcontractors used various software to receive, process, validate, and prepare encounter data files, as shown in Table 3-1. In addition, the software used for Electronic Data Interchange (EDI) compliance checks and the Workgroup for Electronic Data Interchange Strategic National Implementation Process (WEDI SNIP) levels are also included in Table 3-1.

Table 3-1—Primary Software for Encounter Processing and EDI Compliance Checks

Questionnaire Item	Data Source		
	837P and 837I Encounters Collected by Molina	Pharmacy Encounters Collected by CVS	Vision Encounters Collected by VSP
Software used to receive data	EDI, secure file transfer protocol (SFTP)	AS400/CVS proprietary Encounter Management System (EMS)	EDI, SFTP
Software used to validate data	Edifecs	AS400/CVS proprietary EMS	VSP's system that is certified by Optum to generate the X12 EDI 5010 837P files.
Software used to generate encounters for Nevada Medicaid	SQL, a file transfer application called Moveit DMZ	AS400/CVS proprietary EMS	Moveit DMZ

Questionnaire Item	Data Source		
	837P and 837I Encounters Collected by Molina	Pharmacy Encounters Collected by CVS	Vision Encounters Collected by VSP
Software for EDI compliance check	**Molina**'s custom code	Not applicable	Optum Transaction Integrity. Version: v24.4.7 software
WEDI SNIP level	BizTalk handled SNIP levels 1 and 2 and **Molina**'s custom code handled all other SNIP levels (3 to 7).	Not applicable	SNIP levels 1 to 7

Modifications, Validation, and Field Mapping

When preparing the encounter data submissions to Nevada Medicaid, **Molina** indicated that no modifications were made to the claims data. In addition, **Molina** noted that it added "Claim Filing Indicator" based on provider-reported TPL information for institutional and professional encounters.

Table 3-2 highlights the data checks **Molina** performs for all 837P and 837I encounters regarding the completeness and accuracy of a data element.

Table 3-2—Quality Checks for 837P and 837I Encounters Before Submission to Nevada Medicaid

Data Element Validated	Description of Validation Performed
Member	Validates the member detail that is extracted and reported on the encounter to ensure member data such as first name, last name, demographic data, and member ID is present on the encounter prior to submission.
Provider Data	Validates all provider data present on the encounter are extracted and reported. This validation applies to billing, paying to, rendering, attending, ordering, prescribing, and service facility.
Date of Service	Validates dates of service are present at header and line level for professional and institutional encounters. Ensures the claims do not have a future date and are within the claim dates of service range.
Revenue Code/CPT/HCPCS	Validates validity and presence of revenue codes/CPT/HCPCS codes at the line level for professional and institutional encounters against reference tables.
Modifiers	Validates validity and presence of modifiers at the line level for professional and institutional encounters against reference tables.
POS for 837P Encounter	Validates the validity of POS codes on the encounter against reference tables.
Duplicate Encounter	Validates if an encounter is a duplicate of another encounter previously submitted and accepted by Nevada Medicaid.
Diagnosis Codes	Validates diagnosis codes reported on the encounter are valid against reference tables.
Diagnosis Code Pointers	Validates if duplicate diagnosis code pointers are present on the encounter.

Data Element Validated	Description of Validation Performed
Adjudication Date	Validates if the adjudication date is null or a future date from the date of submission.
EDI Compliance (Threshold Edits)	Validates encounters against X12 EDI compliance rules.

Table 3-3 displays **Molina**'s field mapping procedures that are performed during data processing and validation prior to adjudicating claims for payment processing. **Molina** also performed field mapping procedures during data processing for submission to Nevada Medicaid, including codes and fields maintained by vendors/ subcontractors.

Table 3-3—Field Mapping

Field	Description of Mapping	Source of Reference Table	Frequency of Updating Reference Table	Processing Stage
Rendering NPI	National Plan and Provider Enumeration System (NPPES) Validity	NPPES	Daily	Prior to payment processing
Billing NPI	NPPES Validity	NPPES	Daily	Prior to payment processing
SNIP 1-6	National Uniform Claim Committee (NUCC)/HIPAA X12	NUCC	Quarterly	Prior to payment processing
Service Date for 837I Encounters	Statement dates and all relevant dates (line level date, date of birth [DOB], discharge date, admit date, etc.) within a single claim are cohesive.	Not applicable	Not applicable	Prior to payment processing
Service Date for 837P Encounters	Header Service Dates and Line Service Dates or other relevant dates (line level date, DOB, death date, admit date, etc.) within a single claim are cohesive.	Not applicable	Not applicable	Prior to payment processing
VSP – Member Rate Codes	North Region South Region	REF*23	Whenever change occurs	Prior to submission to Nevada Medicaid

Field	Description of Mapping	Source of Reference Table	Frequency of Updating Reference Table	Processing Stage
Member Fields (Subscriber/Patient loop and segments)	Member fields are mapped from **Molina**'s member data tables to the Subscriber/Patient loop and segments to report on the encounter file to Nevada Medicaid.	**Molina** member data tables	Whenever change occurs	Prior to submission to Nevada Medicaid
Provider Fields (All provider fields received on the claim.)	Provider fields are mapped from **Molina**'s provider data tables to the applicable provider data loops and segments to report on the encounter file to Nevada Medicaid.	**Molina** provider data tables	Whenever change occurs	Prior to submission to Nevada Medicaid
Claim Information	Claim information is mapped from **Molina**'s claims data tables to map to the applicable loops and segments to report on the encounter file to Nevada Medicaid.	**Molina** claims data tables.	Whenever change occurs	Prior to submission to Nevada Medicaid

Duplicate, Denied, and Adjusted Claims

Molina identified duplicated claims in the 837P and 837I files by using data elements Member ID, Claim Form Type, Rendering Provider ID, Date of Service (header level for inpatient and line level for outpatient/professional), CPT, Modifiers, historical claims status (PAY/PAID/WAITPAY), and historical line status (OKAY/WARN). Once an encounter was identified as a true duplicate against history, the encounter was denied during adjudication. Encounters that were rejected by Nevada Medicaid due to duplication were submitted for recovery due to overpayment. Encounters that were rejected due to timing between a reversal and a replacement were resubmitted to Nevada Medicaid. For duplicated pharmacy encounters identified by Nevada Medicaid, **Molina** reviewed them with its pharmacy benefit manager to determine if they were not fixable as they were true duplicates.

Molina did not submit fully denied claims or voided claims to Nevada Medicaid. However, **Molina** submitted denied lines to Nevada Medicaid with $0 paid at the line level and did not include claim adjustment reason codes that signify additional payments had been made.

If a claim was adjusted after the original payment was made, **Molina** submitted adjusted encounters to Nevada Medicaid based on the following:

- If a previous iteration was accepted, the newest iteration was resubmitted as a replacement.
- If no previous iteration was accepted, the adjustment was submitted as an original.

In addition, if **Molina** identified an overpayment and no adjustment was made in its claims processing systems, **Molina** would still adjust the encounter to remove the overpayment. The duration of

identification to re-submission for adjustments depended on the number of claims. If there were over 5,000 claims, the duration was 60 days. If there were less than 5,000 claims, the duration was 45 days. Lastly, if an original iteration was never accepted by Nevada Medicaid and the adjustment was void, the adjustment would not be submitted. In general, regardless of the original status, if the adjustment had a paid amount, **Molina** will submit the adjustment to Nevada Medicaid.

Collection, Use, and Submission of Provider Data

Provider data were collected and maintained by both **Molina** and its subcontractors, VSP and CVS (i.e., VSP and CVS collected and maintained provider data to support the vision and pharmacy benefits, respectively). **Molina** was responsible for the initial collection and credentialing of providers, as well as maintaining and updating provider records within 30 days of receipt of any change requests. **Molina** also used its Provider Match Logic (PML) to evaluate whether the provider information billed on the claims matched with values in its system for fields such as Pay-To-Name, Tax ID, Address, Rendering Provider Name, NPI. If no match was found, **Molina** would pend the claim and then process it manually.

Collection, Use, and Submission of Enrollment Data

Enrollment data were collected and maintained solely by **Molina**. Its subcontractors received monthly full files and daily change enrollment files from **Molina**. **Molina** used a similar process to PML to link enrollment data to claims called Member Match Logic, or MML, where submitted claims were matched to enrollment data based on a member's name, DOB, and member ID. If no match was found, **Molina** would pend the claim and then manually review and process it.

Data Exchange Policies and Procedures

This section discusses the findings based on responses related to data exchange policies and procedures in the questionnaire submitted by **Molina**.

Molina submitted encounters (including those collected by its subcontractors) weekly to Nevada Medicaid directly via the SFTP. These generated encounters followed an established workflow that began with the encounters being loaded into an outbound database. These data were then processed to ensure they passed **Molina**'s internal validation checks using its Outbound Rules Engine. Any encounters that triggered edits were kept within the EMS for review by specific staff members. Once resolved, the data were then resubmitted in the next scheduled batch process. After passing the internal validation checks, the encounters were included in the outbound files submitted to Nevada Medicaid. Any response files received from Nevada Medicaid were uploaded by **Molina**'s IT department. Then the Encounters Operations staff reviewed acceptance results and determined whether any immediate action was needed to resolve file-level impacts. They also reviewed any potential errors.

Encounters collected by **Molina**'s subcontractors followed a different workflow. Once subcontractors submitted data to **Molina** via SFTP, **Molina** submitted them to Nevada Medicaid. Upon receiving response files from Nevada Medicaid, **Molina** transferred them to its subcontractors for subcontractors to load into their systems. After the subcontractors processed the response files and reconciled the submission, **Molina**'s Encounters Operations Department received reports from subcontractors and routinely monitored submissions. To ensure timely resolutions, the Encounters Operations leads met with subcontractors on a frequent basis (monthly or more frequently as needed) to review errors and elevate issues.

Molina's encounter submission process included many policies and procedures such as submission policies and procedures (including a specific document for each subcontractor), error policies and procedures, encounter data alterations policies, and incurable encounters policies. To ensure policies and procedures are followed, **Molina** generated weekly and monthly reports. In addition, **Molina** hosted monthly workgroup calls with its subcontractors to discuss errors and submissions.

Payment Structures of Encounter Data

This section focuses primarily on **Molina**'s collection of payment-related claims and how claims were paid. Table 3-4 shows **Molina**'s pricing methodology for the respective encounters.

Table 3-4—Pricing Methodology by Claim Type and Payment Arrangement

Payment Type	Inpatient	Outpatient	Pharmacy	Long Term Care
Percent of Billed	1.0%	2.0%	0.0%	0.0%
Line-by-line	0.0%	98.0%	0.0%	0.0%
Per-diem	99.0%	0.0%	0.0%	100%
Ingredient Cost	0.0%	0.0%	100%*	0.0%
Total	**100%**	**100%**	**100%**	**100%**

* Pharmacy claims were adjudicated at point of sale as each claim was submitted by the pharmacy. Pharmacies were then reimbursed in accordance with the requirements set forth in their contractual agreements.

For inpatient, outpatient, and long-term care encounters, **Molina** noted the pricing methodology in the Contract Type Code field. For pharmacy encounters, **Molina** reported the payment arrangement on the 480-H9 field. In addition, **Molina** noted that it did not have bundled payment arrangements for any services.

Third-Party Liability (TPL) Data

Molina collected additional insurance data through a variety of sources including internal team identification, provider claim submissions, and subcontractors. **Molina** also verified the TPL data through payer portals or phone outreach to the payer and stored the TPL data within its claim processing system with the following actions:

- Deny a claim if there was no primary explanation of benefit (EOB) submitted for a claim whose date of service was within known TPL coverage spans.
- Pend a claim to load TPL information for a claim if a primary EOB was submitted for a claim when the date of service did not have TPL existing in **Molina**'s claim processing system.
- Pursue post-payment recovery if **Molina** paid a claim as the primary payer and the TPL was identified retrospectively.

When submitting encounter data to Nevada Medicaid, **Molina** obtained TPL payment information directly from its claim processing system or paper submission, which was used in calculating the secondary payment amount **Molina** was liable to pay.

Zero-Paid Claims

If **Molina** was not the primary payer for a member and the primary payer's payment exceeded **Molina**'s allowable amount, then **Molina**'s payment would be $0.00. **Molina** reported these zero-paid claims to Nevada Medicaid with a claim status in position 2 of loop 2300 CLM01.

There were no zero-paid claims from **Molina**'s capitated providers. **Molina** reported the pricing information for the capitated claims in loop 2300 REF segment with a "G1" qualifier and a contract type code of "04."

Encounter Data Quality Monitoring and Reporting

This section evaluates how **Molina** monitored its encounter data quality from the following three questions:

- How did **Molina** monitor encounter data quality?
- How did **Molina** address feedback from Nevada Medicaid?
- What are the challenges or requests from **Molina**?

Monitor Encounter Data Quality

Table 3-5 highlights that **Molina** stored pharmacy and vision data submitted by its subcontractors and reviewed the data after submission. **Molina** stated that it did not review or modify pharmacy and vision data prior to submission to Nevada Medicaid because it required its subcontractors to generate 5010 HIPAA-mandated files and conduct state-specific encounter validations prior to submitting the encounter data to **Molina**.

Table 3-5—Molina's Process for Encounters Collected by Subcontractors

Subcontractor and Subcontractor Name	Stored by Molina	Reviewed by Molina Before Submission	Not Modified by Molina Before Submission	Reviewed by Molina After Submission
Pharmacy: CVS	✓	×	✓	✓
Vision: VSP	✓	×	✓	✓

HSAG collected responses from **Molina** regarding the quality checks performed by itself and its subcontractors. To help categorize the responses from **Molina**, HSAG included some standard data quality checks for **Molina** to select in its questionnaire responses. Table 3-6 provides a brief description of the checks.

Table 3-6—Data Quality Check Descriptions

Data Quality Checks	Description
Claim Volume by Submission Month	Evaluates the number of unique claims based on the month when the claims were submitted to Molina.
Claim Volume PMPM	Evaluates the number of unique claims PMPM based on the month when the services occurred.
Field-Level Completeness	Evaluates whether there are any missing and/or extra values for a specific data element.
Field-Level Validity	Evaluates whether the values for a specific data element are valid.
Timeliness	Evaluates whether the source entity submits claims to Molina in a timely manner.
Reconciliation with Financial Reports	Evaluates whether the payment fields in the claims align with the financial reports.
EDI Compliance Edits	Evaluates whether 837 professional and 837 institutional files pass the EDI compliance edits.
Medical Record Review	Evaluates whether some of the data elements in the claims are complete and accurate when comparing to the medical records.

Table 3-7 presents the data quality checks conducted by **Molina** or its subcontractors.

Table 3-7—Molina's Data Quality Checks by Encounter Type

Encounter Type	Completeness and Accuracy*	Claim Volume by Submission Month	Reconciliation With Financial Reports	Timeliness
Professional and Institutional Encounters Collected by **Molina**	✓	✓	×	✓

Encounter Type	Completeness and Accuracy*	Claim Volume by Submission Month	Reconciliation With Financial Reports	Timeliness
Pharmacy Encounters Collected by CVS	✓	✓	×	✓
Vision Encounters Collected by VSP	✓	✓	×	✓

* The Completeness and Accuracy column included the quality checks of Field-Level Completeness, Field-Level Validity, and EDI Compliance Edits.

While **Molina** and/or its subcontractors evaluated claim volume by submission month, field-level completeness and accuracy, and submission timeliness, it did not note any reports regarding claim volume PMPM, reconciliation with financial reports (e.g., clerk disperse journal), or medical record review to ensure encounter data accuracy, completeness, and timeliness. In addition, the example report appeared to include vision encounters from VSP in the "Professional" category, which may mask the data issues from vision encounters since vision encounters only accounted for a small portion of the professional encounters.

Address Feedback from Nevada Medicaid

Upon receiving encounters from **Molina**, Nevada Medicaid generated a series of response files (e.g., 999) based on the EDI compliance edits and additional edits (e.g., duplicate edits) applied by Nevada Medicaid. **Molina** stored and loaded the response files into its SQL tables to track the status for each encounter. The percentage of 837P and 837I encounter records rejected by Nevada Medicaid's edits was between 2.0 percent and 2.5 percent, which was higher than the percentage of records rejected by the EDI translator (0.0 percent). After reviewing the response files, **Molina** analyzed the specific encounter causing the rejection and determined whether it was a provider error or submission error. If it was a provider error, **Molina** would recover the claim from the provider and then resubmit it. If the error was from **Molina** 's submission process, **Molina** would resubmit it using the correct original claim information. **Molina** may also reach out to Nevada Medicaid regarding a specific error code from Nevada Medicaid's edits to see whether the error was on Nevada Medicaid's side. Overall, based on the feedback from Nevada Medicaid, **Molina** tried to update its upfront logics to avoid additional encounter rejections moving forward.

Internal and External Challenges

When responding to the questionnaire, **Molina** did not anticipate any upcoming changes to its encounter data submission process, as it was not facing any internal or external issues when submitting its encounter data to Nevada Medicaid.

4. Comparative Analysis

Background

This section presents findings from the results of the comparative analysis of the professional, institutional, pharmacy, and dental encounter data maintained by Nevada Medicaid and the MCEs. The analysis examined the extent to which encounters submitted by the MCEs and maintained in Nevada Medicaid's data warehouse (and the data subsequently extracted and submitted by Nevada Medicaid to HSAG for the study) were accurate and complete when compared to data the MCEs submitted to HSAG.

To compare Nevada Medicaid's and the MCEs' submitted data, HSAG developed a comparable match key between the two data sources. Data fields used in developing the match keys varied by MCE and encounter type but generally included the *ICN* (internal control number) or *TCN* (transaction control number) and detail line number. These data elements were concatenated to create a unique match key, which became the unique identifier for each encounter detail line in Nevada Medicaid's and each MCE's data.

Record Completeness

As described in the "Methodology" section, two aspects of record completeness are used—record omission and record surplus.

Encounter record omission and surplus rates are summary metrics designed to evaluate discrepancies between two data sources—i.e., primary and secondary. The primary data source refers to data maintained by an organization (e.g., MCE) responsible for sending data to another organization (e.g., Nevada Medicaid). The data acquired by the receiving organization is referred to as the secondary data source. By comparing these two data sources (i.e., primary and secondary), the analysis yields the percentage of records contained in one source and not the other, and vice versa. As such, encounter record omission refers to the percentage of encounters reported in the primary data source but missing from the secondary data source. For this analysis, the omission rate identifies the percentage of encounters reported by an MCE that are missing from Nevada Medicaid's data. Similarly, the encounter record surplus rate refers to the percentage of encounters reported in the secondary data source (Nevada Medicaid) that are missing from the primary data source (the MCE).

Encounter Data Record Omission and Record Surplus

Table 4-1 displays the percentage of records present in the files submitted by the MCEs that were not found in Nevada Medicaid's files (record omission) and the percentage of records present in Nevada Medicaid's files but not present in the files submitted by the MCEs (record surplus). **Lower rates indicate better performance for both record omission and record surplus.**

Table 4-1—Record Omission and Surplus Rates, by MCE and Encounter Type

MCE	Professional Encounters		Institutional Encounters		Pharmacy Encounters		Dental Encounters	
	Omission	Surplus	Omission	Surplus	Omission	Surplus	Omission	Surplus
Anthem	1.6%	5.5%	1.7%	4.7%	0.1%	0.3%	—	—
Molina	6.4%	2.3%	7.3%	3.8%	0.3%	0.3%	—	—
SilverSummit	1.5%	2.2%	3.0%	4.1%	0.6%	0.3%	—	—
UHC HPN	1.4%	3.3%	1.6%	7.4%	<0.1%	8.6%	—	—
LIBERTY	—	—	—	—	—	—	0.2%	1.8%
MCO Statewide	**2.1%**	**3.7%**	**2.7%**	**5.4%**	**0.2%**	**2.6%**	—	—

Note: "—" in the gray shaded cells indicates that the encounter type was not applicable for the MCE.

Key Findings: Table 4-1

- The overall statewide record omission rate and record surplus rate among professional encounters were low at 2.1 percent and 3.7 percent, respectively. This suggests that 97.9 percent of professional encounters in the MCO-submitted files were also present in Nevada Medicaid-submitted files, and that 96.3 percent of professional encounters in Nevada Medicaid-submitted files were also present in the MCO-submitted files.
  - Notable MCO-specific findings revealed **Anthem** had a slightly elevated record surplus rate at 5.5 percent and **Molina** had an elevated record omission rate at 6.4 percent. Upon review, HSAG determined that 82.2 percent of the record surplus for **Anthem** were denied claims in Nevada Medicaid's professional data submission. **Anthem**'s investigation revealed that **Anthem** and Nevada Medicaid identified a different iteration of the claim as the final one. HSAG also investigated the elevated omission rate for **Molina** and observed that 69.6 percent of the distinct internal control numbers (ICNs) assigned by Nevada Medicaid appeared in both the medical and vision professional files submitted by **Molina**. In addition, **Molina** included encounters rejected by Nevada Medicaid in the data submission to HSAG, which caused the extra records in the data submitted to HSAG.
- The overall statewide record omission rate among institutional encounters was low at 2.7 percent; however, there was a slightly elevated record surplus rate at 5.4 percent. This suggests that 97.3 percent of institutional encounters in the MCO-submitted files were also present in Nevada Medicaid-submitted files, but only 94.6 percent of institutional encounters in Nevada Medicaid-submitted files were also present in the MCO-submitted files.
  - Notable MCO-specific findings revealed **Molina** had an elevated record omission rate at 7.3 percent, and **UHC HPN** had an elevated record surplus rate at 7.4 percent. Upon review, HSAG determined that majority of the extra records in the **Molina**-submitted data had a combination of *Recipient ID* and *Header Service to Date* that were not found in Nevada Medicaid-submitted data. **Molina** noted that the extra records in the data submitted to HSAG were encounters rejected by Nevada Medicaid. Additional investigation determined that 71.9 percent of the surplus records for **UHC HPN**-submitted data were denied claims in Nevada Medicaid's

institutional data submission. For the extra institutional records in Nevada Medicaid's data, **UHC HPN** noted that they were not the latest iteration of the encounters. This situation derived from where the original was a denied claim, and the latest iteration was a paid claim that was sent on a new day.

- The overall statewide record omission rate and record surplus rate among pharmacy encounters were low at 0.2 percent and 2.6 percent, respectively. This suggests that 99.8 percent of pharmacy encounters in the MCO-submitted files were also present in Nevada Medicaid-submitted files, and that 97.4 percent of pharmacy encounters in Nevada Medicaid-submitted files were also present in the MCO-submitted files.
  - Notable MCO-specific findings revealed that **UHC HPN** had an elevated record surplus rate at 8.6 percent. Upon review, HSAG determined that 95.3 percent of the surplus records for the **UHC HPN**-submitted data were denied claims in Nevada Medicaid's pharmacy data submission. Moreover, further investigation from **UHC HPN** noted that many of the pharmacy encounters in surplus records were "voided" encounters, which were not submitted to HSAG since they were not the final adjudicated records based on HSAG's data requirements document.
- **LIBERTY** was the only MCE to submit dental encounters, and its record omission rate and record surplus rate was low at 0.2 percent and 1.8 percent, respectively. This suggests that 99.8 percent of dental encounters in the **LIBERTY**-submitted files were also present in Nevada Medicaid-submitted files, and that 98.2 percent of dental encounters in Nevada Medicaid-submitted files were also present in the **LIBERTY**-submitted files.

Data Element Completeness and Accuracy

This section presents the data element omission results by key data element and evaluates completeness based on percentage of records with values present in the MCEs' data systems but not in Nevada Medicaid's data warehouse. Similarly, data element surplus results are presented by key data element and evaluate completeness based on the percentage of records with values present in Nevada Medicaid's data warehouse but not in the MCEs' data. Data element omission and surplus found in Nevada Medicaid's data warehouse illustrate discrepancies in the completeness of Nevada Medicaid's encounter data. The data elements are considered relatively complete when they exhibit low element omission and surplus rates.

This section also presents data accuracy results by key data element and evaluates accuracy based on the percentage of records with values present in both data sources and which contain the same values. Element-level accuracy is limited to those records present in both data sources and with values present in both data sources. Records with values missing from both data sources were not included in the denominator. The numerator is the number of records with the same non-missing values for a given data element. Higher data element accuracy rates indicate that the values populated for a data element in Nevada Medicaid's submitted encounter data are more accurate.

Finally, this section also presents the all-element accuracy results for records present in both data sources and with the same values (missing or non-missing) for **all** key data elements relevant to each claim type.

Table 4-2 through Table 4-8 present the results of encounter data element completeness and accuracy for each encounter type and describe the extent to which key data elements are comparable in Nevada Medicaid's and the MCEs' data systems. Table 4-9 presents the rates for all-element accuracy for each encounter type included in the study.

In total, there are four encounter types. Three of the encounter types including professional, institutional, and pharmacy encounters apply to the MCOs, not to the DBA. Therefore, the statewide rates for these three encounter types are for the four MCOs. The dental encounters are for the DBA only. Since there is only one DBA, there was no need for HSAG to calculate or display the statewide rates.

Professional Encounters

Table 4-2 displays the element omission, surplus, missing, and accuracy results for each key data element from professional encounters for all four MCOs. The "%" column lists the rates aggregated from all four MCOs, and the "N" column notes the number of MCOs with rates needing attention (e.g., an element omission or surplus rate above 5.0 percent, or an element accuracy rate lower than 95.0 percent). For more details regarding which MCOs had rates needing attention, please refer to Table 4-4, where a green check mark indicates no issues while "O," "S," and "A" indicate an MCO needs to investigate the element omission, element surplus, element missing, or element accuracy rates, respectively. In addition, the MCO-specific appendices contain the detailed rates for each study indicator. **For the element omission and surplus indicators, lower rates indicate better performance. For element accuracy, higher rates indicate better performance.**

Table 4-2—Data Element Completeness and Accuracy for All MCOs: Professional Encounters

Key Data Elements	Element Omission		Element Surplus		Element Missing+		Element Accuracy	
	%	N	%	N	%	N	%	N
Recipient ID	0.3%	0	<0.1%	0	0.0%	0	>99.9%	0
Header Service From Date	0.0%	0	0.0%	0	0.0%	0	>99.9%	0
Header Service To Date	0.0%	0	0.0%	0	0.0%	0	>99.9%	0
Detail Service From Date	0.0%	0	0.0%	0	0.0%	0	99.2%	1
Detail Service To Date	0.0%	0	0.0%	0	0.0%	0	99.2%	1
Billing Provider NPI	0.0%	0	<0.1%	0	0.0%	0	99.3%	0
Rendering Provider NPI	0.8%	0	<0.1%	0	<0.1%	0	98.2%	0
Referring Provider NPI^	0.2%	0	0.1%	0	49.5%	0	>99.9%	0
Primary Diagnosis Code	0.0%	0	0.0%	0	0.0%	0	98.1%	1
Secondary Diagnosis Codes[1,^]	<0.1%	0	2.8%	1	35.4%	0	96.4%	1
Procedure Code	<0.1%	0	<0.1%	0	<0.1%	0	99.9%	0

Key Data Elements	Element Omission		Element Surplus		Element Missing+		Element Accuracy	
	%	N	%	N	%	N	%	N
Procedure Code Modifier(s)[2,^]	<0.1%	0	<0.1%	0	72.4%	0	>99.9%	0
Units of Service	0.0%	0	0.0%	0	0.0%	0	92.9%	1
POS Code	0.0%	0	0.0%	0	0.0%	0	99.4%	0
NDC^	0.3%	0	<0.1%	0	96.1%	0	>99.9%	0
Drug Quantity	0.0%	0	0.0%	0	0.0%	0	99.7%	0
Header Paid Amount	0.0%	0	0.0%	0	0.0%	0	99.4%	0
Detail Paid Amount	0.0%	0	0.0%	0	0.0%	0	99.5%	0
Header TPL Paid Amount	0.0%	0	0.0%	0	0.0%	0	99.4%	0
Detail TPL Paid Amount	0.0%	0	0.0%	0	0.0%	0	98.6%	0
Paid Date	0.0%	0	0.0%	0	0.0%	0	67.2%	1

+ Indicates that the element was not populated in either data source.
^ Indicates that the data field is situational (i.e., not required for every encounter line).
[1] All submitted secondary diagnosis codes were ordered alphabetically and numerically, then concatenated as a single data element.
[2] All submitted procedure code modifiers were ordered alphabetically and numerically, then concatenated as a single data element.

Key Findings: Table 4-2

- The statewide professional data element omission and surplus rates for evaluated data elements were consistently low across all MCOs with omission rates at 0.8 percent or less and surplus rates at 2.8 percent or less.
  - **SilverSummit** was the only MCO to have an elevated data element surplus rate for the *Secondary Diagnosis Codes* data element (15.0 percent). This was primarily because the **SilverSummit**-submitted data had different *Primary Diagnosis Codes* across the lines of a claim, whereas Nevada Medicaid's data had the same *Diagnosis Codes* as illustrated by the example in Table 4-3. This was because **SilverSummit** pulled the diagnosis codes at the line level not the header level for the data submitted to HSAG.

Table 4-3—*Secondary Diagnosis Codes* Surplus Example for SilverSummit's Professional Encounters

Line	SilverSummit-Submitted Data		Nevada Medicaid-Submitted Data	
	Primary	Secondary	Primary	Secondary
1	R0781	Missing	R0781	S22080A
2	S22080A	Missing	R0781	S22080A

- The statewide professional data element missing rates were less than 0.1 percent for a majority (i.e., 17 out of 21) of all evaluated data elements.

  - All four MCOs had a data element missing rate above 5.0 percent for *Referring Provider NPI, Secondary Diagnosis Codes, Procedure Code Modifier(s),* and *NDC*. These findings are not surprising as the data elements listed are not expected to be 100 percent populated.

- The statewide professional data accuracy rates were consistently high across all MCOs for a majority (i.e., 19 out of 21) of the evaluated data elements. The *Units of Service* and *Paid Date* were the only data elements that were below 95.0 percent accuracy at the MCO statewide level. For each MCO, the bullets below and Table 4-4 show the accuracy rates needing MCOs' attention.
  - **Anthem** was the only MCO to have a data element accuracy below 95.0 percent for the *Units of Service* (79.8 percent) and *Paid Date* (4.0 percent) data elements. For both fields, the inaccuracies were because **Anthem** mapped them to the incorrect fields when preparing data for submission to HSAG.
  - **Molina** was the only MCO to have a data element accuracy below 95.0 percent for the *Detail Service From Date* (93.6 percent) and *Detail Service To Date* (93.4 percent) data elements. This was because **Molina** inadvertently overwrote the detail-level service dates with the header-level service dates for the data submitted to HSAG.
  - **SilverSummit** was the only MCO to have a data element accuracy below 95.0 percent for the *Primary Diagnosis Code* (89.8 percent) and Secondary *Diagnosis Codes* (75.8 percent) data elements.
    - For both fields, the primary root cause for the discrepancy was because **SilverSummit** pulled the diagnosis codes at the line level not the header level for the data submitted to HSAG (e.g., Line 2 for the example listed in Table 4-3 illustrates how this contributed to the inaccuracy for the *Primary Diagnosis Code* data element).
  - Of note, **UHC HPN** had no professional data elements that need improvement.

Table 4-4—MCO Variations for Data Element Completeness and Accuracy: Professional Encounters*

Key Data Elements	Anthem	Molina	SilverSummit	UHC HPN
Recipient ID	✓	✓	✓	✓
Header Service From Date	✓	✓	✓	✓
Header Service To Date	✓	✓	✓	✓
Detail Service From Date	✓	A	✓	✓
Detail Service To Date	✓	A	✓	✓
Billing Provider NPI	✓	✓	✓	✓
Rendering Provider NPI	✓	✓	✓	✓
Referring Provider NPI	✓	✓	✓	✓
Primary Diagnosis Code	✓	✓	A	✓
Secondary Diagnosis Codes	✓	✓	S, A	✓
Procedure Code	✓	✓	✓	✓
Procedure Code Modifier(s)	✓	✓	✓	✓
Units of Service	A	✓	✓	✓

Key Data Elements	Anthem	Molina	SilverSummit	UHC HPN
POS Code	✓	✓	✓	✓
NDC	✓	✓	✓	✓
Drug Quantity	✓	✓	✓	✓
Header Paid Amount	✓	✓	✓	✓
Detail Paid Amount	✓	✓	✓	✓
Header TPL Paid Amount	✓	✓	✓	✓
Detail TPL Paid Amount	✓	✓	✓	✓
Paid Date	A	✓	✓	✓

*O – Element Omission; S – Element Surplus; A – Element Accuracy; ✓– No issues

Institutional Encounters

Table 4-5 displays the element omission, surplus, missing, and accuracy results for each key data element from institutional encounters for all four MCOs. The "%" column lists the rates aggregated from all four MCOs, and the "N" column notes the number of MCOs with rates needing attention (e.g., an element omission or surplus rate above 5.0 percent, or an element accuracy rate lower than 95.0 percent). For more details regarding which MCOs had rates needing attention, please refer to Table 4-6, where a green check mark indicates no issues while "O," "S," and "A" indicate an MCO needs to investigate the element omission, element surplus, element missing, or element accuracy rates, respectively. In addition, the MCO-specific appendices contain the detailed rates for each study indicator. **For the element omission and surplus indicators, lower rates indicate better performance. For element accuracy, higher rates indicate better performance.**

Table 4-5—Data Element Completeness and Accuracy for All MCOs: Institutional Encounters

Key Data Elements	Element Omission		Element Surplus		Element Missing+		Element Accuracy	
	%	N	%	N	%	N	%	N
Recipient ID	0.0%	0	<0.1%	0	0.0%	0	>99.9%	0
Header Service From Date	0.0%	0	0.0%	0	0.0%	0	>99.9%	0
Header Service To Date	0.0%	0	0.0%	0	0.0%	0	99.5%	0
Detail Service From Date	0.0%	0	0.0%	0	0.0%	0	97.6%	1
Detail Service To Date	0.0%	0	0.0%	0	0.0%	0	97.3%	1
Admission Date^	11.2%	1	<0.1%	0	70.6%	0	100%	0
Discharge Status	0.0%	0	<0.1%	0	0.0%	0	>99.9%	0
Billing Provider NPI	0.0%	0	<0.1%	0	0.0%	0	>99.9%	0
Attending Provider NPI	2.4%	0	0.2%	0	<0.1%	0	>99.9%	0

Key Data Elements	Element Omission		Element Surplus		Element Missing+		Element Accuracy	
	%	N	%	N	%	N	%	N
Referring Provider NPI^	<0.1%	0	0.0%	0	98.5%	0	100%	0
Primary Diagnosis Code	0.0%	0	<0.1%	0	0.0%	0	97.7%	1
Secondary Diagnosis Code(s)[1,^]	3.4%	2	<0.1%	0	7.5%	0	57.5%	3
Procedure Code*	<0.1%	0	0.1%	0	29.3%	0	99.0%	0
Procedure Code Modifier(s)[2,^]	0.1%	0	0.1%	0	85.2%	0	99.8%	0
Units of Service	0.0%	0	0.0%	0	0.0%	0	81.7%	1
Revenue Code	0.0%	0	<0.1%	0	0.0%	0	99.5%	0
Surgical Procedure Code(s)[3,^]	<0.1%	0	0.0%	0	88.8%	0	57.1%	4
TOB Code	0.0%	0	0.0%	0	0.0%	0	93.1%	3
NDC^	1.6%	0	0.1%	0	80.7%	0	99.5%	0
Drug Quantity^	0.0%	0	0.0%	0	0.0%	0	99.3%	0
Header Paid Amount	0.0%	0	0.0%	0	0.0%	0	99.8%	0
Detail Paid Amount	0.0%	0	0.0%	0	0.0%	0	99.4%	0
Header TPL Paid Amount	0.0%	0	0.0%	0	0.0%	0	99.6%	0
Detail TPL Paid Amount	0.0%	0	0.0%	0	0.0%	0	99.5%	0
Paid Date	0.0%	0	0.0%	0	0.0%	0	66.1%	1

+ Indicates that the element was not populated in either data source.

^ Indicates that the data field is situational (i.e., not required for every encounter line).

[1] All submitted secondary diagnosis codes were ordered alphabetically and numerically, then concatenated as a single data element.

[2] All submitted procedure code modifiers were ordered alphabetically and numerically, then concatenated as a single data element.

[3] All submitted secondary surgical procedure codes were ordered alphabetically and numerically, then concatenated as a single data element.

Key Findings: Table 4-5

- The statewide institutional data element omission and surplus rates were consistently low across all MCOs. The data element omission rates were less than 5.0 percent for all data elements except for the *Admission Date.* The data element surplus rates were less than 5.0 percent for all data elements.
  - **Molina** was the only MCO to have a data element omission rate above 5.0 percent for the *Admission Date* data element (81.3 percent). **Molina** provided those extra dates to HSAG because providers submitted the *Admission Date* values that were the same as the *Header Service From Date* values.

  - **Anthem** and **Molina** had a data element omission rate above 5.0 percent for the *Secondary Diagnosis Code(s)* data element (5.9 percent and 10.6 percent, respectively).
    - **Anthem** noted that it interpreted the secondary diagnosis as the second code in a sequence, which caused the omissions.
    - **Molina** included secondary diagnosis codes with qualifiers other than "ABF" and "ABK" in the data to HSAG (e.g., qualifier "APR" for patient reason for visit codes)

- The statewide institutional data element missing rates were less than 0.1 percent for a majority (i.e., 18 out of 25) of all evaluated data elements. These findings are not surprising as the data elements with higher element missing rates are not expected to be 100 percent populated.
- The statewide institutional data accuracy rates were consistently high across all MCOs for a majority (i.e., 20 out of 25) of the evaluated data elements. The *Secondary Diagnosis Code(*s*)*, *Units of Service, Surgical Procedure Code(s)*, *TOB Code,* and *Paid Date* were the only data elements that were below 95.0 percent at the statewide level. For each MCO, the bullets below and Table 4-6 show the accuracy rates needing MCOs' attention.
  - **Anthem**, **Molina**, and **SilverSummit** had a data element accuracy below 95.0 percent for the *Secondary Diagnosis Code(s)* data element (47.2 percent, 0.4 percent, and 42.2 percent, respectively).
    - **Anthem** noted that the inaccuracies were from the data submitted to HSAG.
    - **Molina** included secondary diagnosis codes with qualifiers other than "ABF" and "ABK" in the data to HSAG (e.g., qualifier "APR" for patient reason for visit codes)
    - **SilverSummit** pulled the diagnosis codes at the line level not the header level for the data submitted to HSAG, which caused the inaccuracies.
  - **Anthem**, **Molina**, **SilverSummit**, and **UHC HPN** had a data element accuracy below 95.0 percent for the *Surgical Procedure Code(s)* data element (56.6 percent, 58.5 percent, 55.8 percent, and 57.7 percent, respectively).
    - The inaccuracies from **Anthem** and **SilverSummit** were because the MCOs removed duplicates (i.e., same surgical procedure code on different detail lines) when preparing data for submission to HSAG.
    - **Molina** and **UHC HPN** investigated a few examples and noted that the values submitted to HSAG matched with their claim systems; therefore, they need to conduct an additional investigation with Nevada Medicaid.
  - **Molina**, **SilverSummit,** and **UHC HPN** had a data element accuracy below 95.0 percent for the *TOB Code* data element (88.8 percent, 86.3 percent, and 91.7 percent, respectively). For all three MCOs, nearly all inaccurate codes were due to differences in the last digit of the *TOB Code* which denotes the sequence of bills within a specific episode of care.
    - **Molina** noted that the *TOB Code* submitted to HSAG reflected the value recorded in **Molina**'s claims system (e.g., TOB Code = "131"). If an encounter previously accepted by Nevada Medicaid was resubmitted, the frequency code must be updated to "7" to indicate a replacement (e.g., TOB Code = "137"), which caused the inaccuracies.

  - **UHC HPN** noted a scenario where the encounter was submitted to Nevada Medicaid only once (e.g., TOB Code = "131") but the same service had been denied before. Therefore, its claims system recognized it as a replacement with TOB Code = "137."
  - **SilverSummit** noted both scenarios as **Molina** and **UHC HPN** mentioned above.
- **Anthem** was the only MCO with a data element accuracy below 95.0 percent for the *Primary Diagnosis Code* (93.1 percent), *Units of Service* (48.2 percent)., and *Paid Date* (0.0 percent) data elements.
  - **Anthem** noted that it interpreted the primary diagnosis code as the admitting diagnosis code, which caused the inaccuracies.
  - For *Units of Service* and *Paid Date* data elements, the inaccuracies were because **Anthem** mapped them to the incorrect fields when preparing data for submission to HSAG.
- **Molina** was the only MCO with a data element accuracy below 95.0 percent for the *Detail Service From Date* (86.3 percent) and *Detail Service To Date* (83.2 percent) data elements. This was because **Molina** inadvertently overwrote the detail-level service dates with the header-level service dates for the data submitted to HSAG.

Table 4-6—MCO Variations for Data Element Completeness and Accuracy: Institutional Encounters*

Key Data Elements	Anthem	Molina	SilverSummit	UHC HPN
Recipient ID	✓	✓	✓	✓
Header Service From Date	✓	✓	✓	✓
Header Service To Date	✓	✓	✓	✓
Detail Service From Date	✓	A	✓	✓
Detail Service To Date	✓	A	✓	✓
Admission Date	✓	O	✓	✓
Discharge Status	✓	✓	✓	✓
Billing Provider NPI	✓	✓	✓	✓
Attending Provider NPI	✓	✓	✓	✓
Referring Provider NPI	✓	✓	✓	✓
Primary Diagnosis Code	A	✓	✓	✓
Secondary Diagnosis Code(s)[1]	O, A	O, A	A	✓
Procedure Code	✓	✓	✓	✓
Procedure Code Modifier(s)[2]	✓	✓	✓	✓
Units of Service	A	✓	✓	✓
Revenue Code	✓	✓	✓	✓
Surgical Procedure Code(s)[3]	A	A	A	A
TOB Code	✓	A	A	A
NDC	✓	✓	✓	✓

Key Data Elements	Anthem	Molina	SilverSummit	UHC HPN
Drug Quantity	✓	✓	✓	✓
Header Paid Amount	✓	✓	✓	✓
Detail Paid Amount	✓	✓	✓	✓
Header TPL Paid Amount	✓	✓	✓	✓
Detail TPL Paid Amount	✓	✓	✓	✓
Paid Date	A	✓	✓	✓

*O – Element Omission; S – Element Surplus; A – Element Accuracy; ✓ – No issues

Pharmacy Encounters

Table 4-7 displays the element omission, surplus, missing, and accuracy results for each key data element from pharmacy encounters for all four MCOs. The "%" column lists the rates aggregated from all four MCOs, and the "N" column notes the number of MCOs with rates needing attention (e.g., an element omission or surplus rate above 5.0 percent, or an element accuracy rate lower than 95.0 percent). In addition, the MCO-specific appendices contain the detailed rates for each study indicator. **For the element omission and surplus indicators, lower rates indicate better performance. For element accuracy, higher rates indicate better performance.**

Table 4-7—Data Element Completeness and Accuracy for All MCOs: Pharmacy Encounters

Key Data Elements	Element Omission		Element Surplus		Element Missing+		Element Accuracy	
	%	N	%	N	%	N	%	N
Recipient ID	0.1%	0	<0.1%	0	0.0%	0	>99.9%	0
Date of Service	0.0%	0	0.0%	0	0.0%	0	100%	0
Billing Provider NPI	0.0%	0	0.0%	0	0.0%	0	>99.9%	0
Prescribing Provider NPI	3.4%	0	0.0%	0	<0.1%	0	>99.9%	0
NDC	0.0%	0	0.0%	0	0.0%	0	>99.9%	0
Drug Quantity	0.0%	0	0.0%	0	0.0%	0	99.9%	0
Days of Supply	0.0%	0	<0.1%	0	0.0%	0	100%	0
Paid Amount	0.0%	0	0.0%	0	0.0%	0	100%	0
TPL Paid Amount	0.0%	0	0.0%	0	0.0%	0	99.7%	0
Paid Date	0.0%	0	0.0%	0	0.0%	0	100%	0

+ Indicates that the element was not populated in either data source.

Key Findings: Table 4-7

- The statewide pharmacy data element omission and surplus rates were consistently low across all MCOs for all the evaluated data elements. The statewide element omission rates were 3.4 percent or less and element surplus rates were less than 0.1 percent for all data elements.
- The statewide pharmacy data element missing rates were less than 0.1 percent for all the evaluated data elements.
- The statewide pharmacy data accuracy for were consistently high across all MCOs for all the evaluated data elements.
- At the MCO level, none of the element-level results need the MCOs' attention.

Dental Encounters

Table 4-8 displays the element omission, surplus, missing, and accuracy results for each key data element from dental encounters for the DBA. **For the element omission and surplus indicators, lower rates indicate better performance. For element accuracy, higher rates indicate better performance.**

Table 4-8—Data Element Completeness and Accuracy: Dental Encounters—LIBERTY

Key Data Elements	Element Omission	Element Surplus	Element Missing+	Element Accuracy
Recipient ID	0.2%	0.0%	0.0%	>99.9%
Header Service From Date	0.0%	0.0%	0.0%	>99.9%
Header Service To Date	0.0%	0.0%	0.0%	>99.9%
Detail Service From Date	0.0%	0.0%	0.0%	>99.9%
Detail Service To Date	0.0%	0.0%	0.0%	>99.9%
Billing Provider NPI	0.0%	0.0%	0.0%	95.2%
Rendering Provider NPI	0.3%	0.0%	0.0%	>99.9%
Referring Provider NPI^	0.0%	0.0%	100%	—
All Diagnosis Codes[1]	0.0%	2.7%	1.9%	98.9%
Procedure Code	<0.1%	0.0%	0.0%	>99.9%
Units of Service	0.0%	0.0%	0.0%	100%
POS Code	<0.1%	0.0%	0.0%	>99.9%
Tooth Number^	0.0%	0.0%	60.5%	>99.9%
Tooth Surface Codes[2,^]	<0.1%	0.0%	91.4%	>99.9%
Oral Cavity Codes[3,^]	<0.1%	0.0%	92.1%	99.8%
Header Paid Amount	0.0%	0.0%	0.0%	99.9%
Detail Paid Amount	0.0%	0.0%	0.0%	>99.9%

Key Data Elements	Element Omission	Element Surplus	Element Missing+	Element Accuracy
Paid Date	0.0%	0.0%	0.0%	>99.9%

+ Indicates that the element was not populated in either data source.
^ Indicates that the data field is situational (i.e., not required for every encounter line).
[1] All submitted diagnosis codes at the line level were aggregated to the header level, then ordered alphabetically and numerically, and then concatenated as a single data element.
[2] All submitted tooth surface codes were ordered alphabetically and numerically, then concatenated as a single data element.
[3] All submitted oral cavity codes were ordered alphabetically and numerically, then concatenated as a single data element.

Key Findings: Table 4-8

- **LIBERTY**'s dental data element omission and surplus rates were consistently low for all the evaluated data elements. For all data elements, the omission rates were 0.3 percent or less and surplus rates were 2.7 percent or less.
- **LIBERTY**'s dental data element missing rates were less than 2.0 percent for a majority (i.e., 14 out of 18) of all evaluated data elements.
  - The data element missing rate was 100 percent for the *Referring Provider NPI* since **LIBERTY** did not submit values for this data element to Nevada Medicaid. **LIBERTY** noted that its current management information system lacked the capability to capture the *Referring Provider NPI* values; however, **LIBERTY** had listed a comprehensive action plan in the data discrepancy report to submit the *Referring Provider NPI* values to Nevada Medicaid soon.
  - The *Tooth Number*, *Tooth Surface Codes,* and *Oral Cavity Codes* had high data element missing rates. These fields are not expected to be 100 percent populated since they are not required.
- **LIBERTY** dental data element accuracy rates were consistently high across all the evaluated data elements.

All-Element Accuracy

Table 4-9 displays the all-element accuracy results for the percentage of records present in both data sources with the same values (missing and non-missing) for all key data elements relevant to each encounter data type.

Table 4-9—All-Element Accuracy, by MCE and Encounter Type

MCE	Professional	Institutional	Pharmacy	Dental
Anthem	4.0%	0.0%	96.0%	—
Molina	83.8%	0.0%	95.3%	—
SilverSummit	65.2%	35.3%	95.5%	—
UHC HPN	91.0%	81.4%	97.5%	—
LIBERTY	—	—	—	91.0%
MCO Statewide	**56.3%**	**34.0%**	**96.2%**	—

Note: "—" in the gray shaded cells indicates that the encounter type was not applicable for the MCE.

Key Findings: Table 4-9

- Overall, the statewide all-element accuracy rates were 56.3 percent, 34.0 percent, and 96.2 percent for professional, institutional, and pharmacy encounters, respectively.
  - The MCO-specific all-element accuracy for professional data ranged from 4.0 percent (**Anthem**) to 91.0 percent (**UHC HPN**). For **Anthem**, its low data element accuracy rate for the *Paid Date* data element was the primary cause for its lower all-element accuracy rate.
  - The MCO-specific all-element accuracy for institutional data ranged from 0.0 percent (**Anthem** and **Molina**) to 81.4 percent (**UHC HPN**). For **Anthem**, its low data element accuracy rate for the *Paid Date* data element was the primary cause for its lower all-element accuracy rate. For **Molina**, its low data element accuracy rate for the *Secondary Diagnosis Code(s)* data element and high element omission rate for the *Admission Date* data element were the primary causes for its lower all-element accuracy rate.
  - The MCO-specific all-element accuracy for pharmacy data ranged from 95.3 percent (**Molina**) to 97.5 percent (**UHC HPN**).
- For each MCO, the institutional data usually had the lowest all-element accuracy rate among the three encounter types.
- The all-element accuracy rate for **LIBERTY** was 91.0 percent.
- The low all-element accuracy rates could be caused by element omission, element surplus, and element inaccuracy from any of the evaluated data elements.

5. Medical/Dental Record Review

Background

Medical/dental records are considered the "gold standard" for documenting Medicaid members' access to and quality of services. The IS review examined the MCEs' data-handling processes, with the goal of enabling HSAG to understand how various systems interact and potentially impact the MCEs' abilities to submit complete, reasonable, and accurate data to Nevada Medicaid. The comparative analysis component of the study seeks to determine the completeness and validity of Nevada Medicaid's encounter data as well as how comparable these data are to the MCEs' data from which these data are based. Medical/dental record review further assessed data quality by investigating the completeness and accuracy of Nevada Medicaid's encounters compared to the information documented in the corresponding medical/dental records for Medicaid members.

This section presents findings from HSAG's medical/dental record review to examine the extent to which services documented in medical/dental records were not present in the encounter data (i.e., encounter data omission), as well as the extent to which services documented in the encounter data were not present in the members' corresponding medical/dental records (i.e., medical/dental record omission).

This section also presents findings from HSAG's evaluation of accuracy of diagnosis codes, procedure codes, and procedure code modifiers submitted by the MCEs' contracted providers to the MCEs and consequently submitted to Nevada Medicaid based on documentation contained in members' medical/dental records.

Medical/Dental Record Procurement Status

As noted in the "Methodology" section of this report, the final sample in the evaluation consisted of 411 cases randomly selected for each MCE. Additionally, to evaluate whether any dates of service were omitted from Nevada Medicaid's electronic encounters, HSAG reviewed a second date of service rendered by the same rendering or billing provider during the review period. The providers were requested to submit all medical/dental record documentation pertaining to an additional date of service occurring closest to the sampled members' selected date of service, if available. If a sampled member did not have a second visit with the same provider during the review period, HSAG evaluated only one date of service for that member. As such, the final number of cases reviewed were between 411 and 822 cases total for each MCE.

Nevada Medicaid's encounters for which a corresponding medical/dental record was not submitted were included in the analysis to underscore the impact that these omissions had on key data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) associated with encounter data completeness. For example, when no medical/dental record was submitted for an encounter based on the date of service, the subsequent diagnosis code(s), procedure code(s), and procedure code modifier(s) associated with that date of service were treated as medical/dental record omissions.

Table 5-1 displays the medical/dental record procurement status for each MCE. HSAG considered that the MCE submitted a medical/dental record for a case when either the MCE marked "Received" on the tracking sheet or HSAG found documentation to support either the sample or second date of service.

Table 5-1—Medical Record Procurement Status

MCE	Number of Records Requested	Number of Records Submitted[1]	Percentage of Records Submitted
MCO Procurement Rate			
Anthem	411	303	73.7%
Molina	411	337	82.0%
SilverSummit	411	303	73.7%
UHC HPN	411	365	88.8%
MCO Statewide	**1,644**	**1,308**	**79.6%**
DBA Procurement Rate			
LIBERTY	411	405	98.5%

[1] The number of medical records submitted was based on the MCEs' responses within the submitted tracking sheets and/or submitted records.

Key Findings: Table 5-1

- HSAG requested the procurement of records for a total of 1,644 cases from all four MCOs and 411 cases from **LIBERTY**. While all MCOs and **LIBERTY** completed and submitted tracking sheets associated with the requested cases, they included no medical/dental record documentation associated with some of the requested cases. An overall submission rate of 79.6 percent for MCOs and 98.5 percent for **LIBERTY** had medical/dental record documentation submitted, with MCO rates ranging from 73.7 (**Anthem** and **SilverSummit**) percent to 88.8 percent (**UHC HPN)**.
- Cases without medical/dental records contributed to the medical/dental record omission results detailed in the "Encounter Data Completeness" section of this report. Specifically, if medical/dental records were not submitted for a sampled date of service, all applicable associated data elements (i.e., *Date of Service, Diagnosis Code, Procedure Code*, and *Procedure Code Modifier*) were reported as medical record omissions. MCEs with relatively lower medical record submission rates would be more likely to exhibit higher medical record omission rates.

When the MCE could not procure a medical/dental record, the MCE noted the reason why it could not obtain the record on the tracking sheet. Table 5-2 highlights the major reasons that medical/dental record documentation was not submitted by each MCE.

Table 5-2—Reasons Medical/Dental Records Not Submitted for Date of Service, by MCE

MCE	Medical/ Dental Records Not Submitted	Non-Responsive Provider or Provider Did Not Respond in a Timely Manner		Member Issue		Facility Issue		Other	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
MCO Non-Submission Rate and Reasons									
Anthem	108	72	66.7%	20	18.5%	12	11.1%	4	3.7%
Molina	74	74	100%	0	0%	0	0.0%	0	0.0%
SilverSummit	108	94	87.0%	3	2.8%	1	0.9%	10	9.3%
UHC HPN	46	43	93.5%	0	0%	1	2.2%	2	4.3%
MCO Statewide	**336**	**283**	**82.7%**	**23**	**6.8%**	**14**	**4.2%**	**16**	**4.8%**
DBA Non-Submission Rate and Reasons									
LIBERTY	6	0	0.0%	4	66.7%	2	33.3%	0	0.0%

Key Findings: Table 5-2

- Of the requested 1,644 sample medical cases, MCOs did not submit 336 medical records (20.4 percent) for various reasons. Overall, the most cited reason for non-submission from the MCOs was *Non-Responsive Provider or Provider Did Not Respond in a Timely Manner* (82.7 percent). Other reasons included *Member Issue* (6.8 percent) and *Facility Issue* (4.2 percent). The *Member Issue* included the non-submission reasons "member was not a patient of this practice" and "member was a patient of this practice; however, no documentation was available for date of service." The *Facility Issue* included the reasons "provider refused to release records" and "facility was permanently closed." Additionally, to encourage providers to comply with the medical/dental records request, Nevada Medicaid published Web Announcement 3649 that stated the following.[5]

  – The Division of Health Care Financing and Policy's (DHCFP's) External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), is conducting the Fiscal Year 2024-2025 Encounter Data Validation Study. As part of the study, Managed Care Entities (MCEs) are required to provide clinical records documentation for a specified sample of Medicaid recipients. This study is a required activity. The DHCFP asks that all providers comply with the requests received from the MCEs within the time frames specified. Providers are required to promptly furnish the requested records at no cost, as is required in the Provider Participation Agreement signed with DHCFP.

[5] Division of Health Care Financing and Policy. Web Announcement 3649. Available at: web_announcement_3649_20250612.pdf (nv.gov). Accessed on: Sep 12, 2025.

  - **Anthem** and **SilverSummit** had the highest non-submission rates at 26.3 percent. For both MCOs, the most common reason for non-submission was *Non-Responsive Provider or Provider Did Not Respond in a Timely Manner*. Additionally, **Anthem** had higher percentages of non-submissions due to *Member Issue* (18.5 percent) and *Facility Issue* (11.1 percent) compared to other MCOs.
- Of the requested 411 sampled dental cases, **LIBERTY** did not submit six dental records. The non-submitted dental records included four cases that were not submitted due to a *Member Issue* and two cases that were not submitted due to a *Facility Issue.*

For the cases with medical records submitted to HSAG, Table 5-3 displays the number and percentage of cases with one additional date of service selected and submitted for the study. HSAG counted a case when either the MCE marked "Received" on the tracking sheet for the second date of service or HSAG found documentation to support the second date of service.

Table 5-3—Medical/Dental Record Submission Status for Second Date of Service

MCE	Number of Records Submitted[1]	Number of Records With One Additional Date of Service	Percent
MCO Submission Status for Second Date of Service			
Anthem	303	111	36.6%
Molina	337	171	50.7%
SilverSummit	303	156	51.5%
UHC HPN	365	223	61.1%
MCO Statewide	**1,308**	**661**	**50.5%**
DBA Submission Status for Second Date of Service			
LIBERTY	405	70	17.3%

[1] The number of medical records submitted was based on the MCEs' responses within the submitted tracking sheets and/or submitted records.

Key Findings: Table 5-3

- Among the 1,308 medical records received with dates of service from the original sample cases, 661 records (50.5 percent) had a second date of service submitted to HSAG according to the tracking sheet or documentation submitted. Among the four MCOs, the second date of service submission rates ranged from 36.6 percent (**Anthem**) to 61.1 percent (**UHC HPN**).
- Among the 405 dental records received with dates of service from the original sample cases, 70 records (17.3 percent) had a second date of service submitted to HSAG according to the tracking sheet or documentation submitted.
- Please note that a 100 percent submission rate is not expected for the second date of service because members may not have had a second date of service with the same billing or rendering provider within the study period.

Of note, while Table 5-3 shows the number of cases with documentation submitted for the second date of service, HSAG included the second date of service in the analysis only if it met the study criteria listed in the methodology section (e.g., within the study period, had the same billing or rendering provider as the sampled date of service).

Encounter Data Completeness

HSAG evaluated encounter data completeness by identifying differences between key data elements identified in Nevada Medicaid-based professional/dental encounters and the corresponding members' medical/dental records submitted for the analysis. These data elements included *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*. Of note, review of the *Procedure Code Modifier* is not applicable to dental encounters. Medical/dental record omission and encounter data omission represent two aspects of encounter data completeness through their identification of vulnerabilities in the process of claims documentation and communication among providers, MCEs, and Nevada Medicaid.

A medical/dental record omission occurred when an encounter data element (i.e., *Date of Service*, *Diagnosis Code*, *Procedure Code*, or *Procedure Code Modifier*) was not supported by documentation in the medical/dental record or the medical/dental record could not be found. Medical record omissions suggest opportunities for improvement within the provider's internal processes, such as billing processes and record documentation.

An encounter data omission occurred when an encounter data element (i.e., *Date of Service*, *Diagnosis Code*, *Procedure Code*, or *Procedure Code Modifier*) was documented in a member's medical/dental record but not present in the associated electronic encounter data. Encounter omissions also suggest opportunities for improvement in the areas of submission of claims encounters and/or the transmission of medical/dental service data between the providers, MCEs, and Nevada Medicaid.

HSAG evaluated the medical record and the encounter data omission rates for each MCE using the dates of service selected by HSAG and an additional date of service selected by the provider, if one was available. If more than one additional date of service was available from the medical/dental record, the provider was instructed to select the one closest to HSAG's selected date of service. **For both rates, lower values indicate better performance.**

As noted in the methodology section, since an equal number of cases were selected from each MCO to ensure an adequate sample size when reporting rates at the MCO level, HSAG made adjustments to calculate the MCO statewide rates associated with the MCOs' data elements that were evaluated to account for population differences among the MCOs for medical record review. Of note, since **LIBERTY** is the only DBA in the study, **LIBERTY**'s rates represented the statewide rates for dental record review. HSAG weighted each MCO's raw rates based on the volume of professional visits among the eligible population for that MCO. This approach ensured that no MCO was over- or underrepresented in the MCO statewide rates.

Date of Service Completeness

Table 5-4 presents the percentage of dates of service identified in the encounter data that were not supported by the members' medical/dental records provided by each of the participating MCEs (i.e., medical/dental record omission) and the percentage of dates of service from the members' medical/dental records that were not found in the encounter data provided by each participating MCE (i.e., encounter data omission). HSAG conducted the analysis at the date-of-service level.

Table 5-4—Medical/Dental Record Omission and Encounter Data Omission for Date of Service

MCE	Medical/Dental Record Omission		Encounter Data Omission	
	Date of Service Identified in the Encounter Data	Percent Not Supported by Members' Medical/Dental Records*	Date of Service Identified in Members' Medical/Dental Records	Percent Not Found in the Encounter Data*
MCO Medical Record Omission and Encounter Data Omission				
Anthem	510	23.1%	397	1.3%
Molina	542	14.8%	479	3.5%
SilverSummit	536	21.5%	428	1.6%
UHC HPN	591	8.1%	556	2.3%
MCO Statewide	**2,179**	**16.6%**	**1,860**	**2.3%**
DBA Dental Record Omission and Encounter Data Omission				
LIBERTY	471	1.7%	473	2.1%

* Lower rates indicate better performance.

Key Findings: Table 5-4

- When aggregating statewide, 16.6 percent and 1.7 percent of the dates of service in encounter data were not supported by the members' medical records (i.e., medical record omission) or dental records (i.e., dental record omission), respectively.
- All MCOs had a medical record omission rate 8.1 percent or more and **Anthem** and **SilverSummit** had the highest medical record omission at 23.1 percent and 21.5 percent, respectively, compared to the other participating MCEs. This trend is consistent relative to the medical record submission rate, where **Anthem** and **SilverSummit** had a relatively lower medical record submission rates (73.7 percent) compared to the other MCOs.
- When aggregating Statewide, 2.3 percent and 2.1 percent of the dates of service in the medical records and dental records, respectively, were not found in Nevada Medicaid's encounter data (i.e., encounter data omission).
  - For the MCOs, the medical record omission rate was higher than the encounter data omission rate. This is partially because not all sample cases had a second date of service (refer to Table

5-3). The denominator for encounter data omission is the number of dates of service identified in the medical records, and the numerator is the number of dates of service with no evidence of submission in the encounter data. If no second date of service was available in the medical records, then no date of service would be contributed to the denominator of the encounter data omission rate.

- All MCOs had an encounter data omission rate 3.5 percent or less.

Diagnosis Code Completeness

Table 5-5 presents the percentage of diagnosis codes identified in the encounter data that had no supporting documents in the members' medical/dental records (i.e., medical/dental record omission) and the percentage of diagnosis codes from members' medical/dental records that were not found in the encounter data (i.e., encounter data omission).

Table 5-5—Medical/Dental Record Omission and Encounter Data Omission for Diagnosis Code

MCE	Medical/Dental Record Omission		Encounter Data Omission	
	Number of Diagnosis Codes Identified in Encounter Data	Percent Not Documented in the Members' Medical/Dental Records*	Number of Diagnosis Codes Identified in Members' Medical/Dental Records	Percent Not Found in the Encounter Data*
MCO Medical Record Omission and Encounter Data Omission				
Anthem	1,394	22.6%	1,093	1.3%
Molina	1,520	17.7%	1,277	2.0%
SilverSummit	1,478	22.3%	1,159	0.9%
UHC HPN	1,602	10.0%	1,461	1.3%
MCO Statewide	**5,994**	**17.9%**	**4,990**	**1.4%**
DBA Dental Record Omission and Encounter Data Omission				
LIBERTY	760	13.8%	665	1.5%

* Lower rates indicate better performance.

Key Findings: Table 5-5

- When aggregating statewide, 17.9 percent and 13.8 percent of the diagnosis codes in the encounter data had no supporting documentation in the members' medical records (i.e., medical record omission) and in the members' dental records (i.e., dental record omission), respectively.
  - MCO-specific medical record omission rates ranged from 10.0 percent (**UHC HPN**) to 22.6 percent (**Anthem**).
  - The medical record omission rate for diagnosis codes was partially influenced by both medical record non-submission and medical record omission for the *Date of Service* data element. In the

analysis, when no medical records were submitted for a sample date of service, all diagnosis codes associated with that date of service were treated as medical record omissions.
    - Approximately 71.4 percent of medical record omissions for diagnosis codes were due to either HSAG not receiving the medical records or the medical records not supporting the specified date of service. In general, lower medical record omission rates for diagnosis codes were observed for MCEs with higher rates of medical record submission. Additionally, MCEs with higher medical record omission for dates of service also tended to have higher medical record omission for diagnosis codes.
  - For cases with medical records to validate the date of service, diagnosis codes frequently included in the encounter data but not supported in the members' medical records included:
    - Z71.82: Exercise counseling (Frequency = 27)
    - Z71.3: Dietary counseling and surveillance (Frequency = 22)
    - Z68.52: Body mass index pediatric, 5th percentile to less than 85th percentile for age (Frequency = 13)
    - Z68.54: Body mass index pediatric, greater than or equal to 95th percentile for age (Frequency = 10)
    - Z02.5: Encounter for exam for participation in sport (Frequency = 8)
  - For cases with dental records to validate the date of service, diagnosis codes frequently included in the encounter data but not supported in the members' dental records included:
    - Z01.20: Encounter dental exam cleaning without abnormal finding (Frequency = 24)
    - K02.9: Dental caries unspecified (Frequency = 11)
    - K02.63: Dental caries on smooth surface penetrating into pulp (Frequency = 8)
    - K05.01: Acute gingivitis non-plaque induced (Frequency = 7)
    - K02.61: Dental caries on smooth surface limited to enamel (Frequency = 6)
- When aggregating statewide, 1.4 percent of the diagnosis codes identified in the medical records and 1.5 percent of the diagnosis codes identified in the dental records were not found in the encounter data (i.e., encounter data omission).
  - The percentage of diagnosis codes identified in the medical records that were not found in the encounter data were 2.0 percent or less for all MCEs.
  - The trends for the encounter data omission rates for the *Diagnosis Code* data element and the encounter data omission rates for the *Date of Service* data element for these MCEs were similar, indicating that the omission of dates of service from the encounter data was the primary factor contributing to the rate of diagnosis code encounter data omissions.

Procedure Code Completeness

Table 5-6 presents the percentage of procedure codes identified in the encounter data that had no supporting documents in the members' medical/dental records (i.e., medical/dental record omission) and

the percentage of procedure codes from members' medical/dental records that were not found in the encounter data (i.e., encounter data omission). HSAG conducted the analysis at the procedure-code level.

Table 5-6—Medical/Dental Record Omission and Encounter Data Omission for Procedure Code

MCE	Medical/Dental Record Omission		Encounter Data Omission	
	Number of Procedure Codes Identified in Encounter Data	Percent Not Documented in the Members' Medical/Dental Records*	Number of Procedure Codes Identified in Members' Medical/Dental Records	Percent Not Found in the Encounter Data*
MCO Medical Record Omission and Encounter Data Omission				
Anthem	1,073	27.5%	789	1.4%
Molina	1,367	24.7%	1,057	2.6%
SilverSummit	1,328	32.5%	905	1.0%
UHC HPN	1,358	17.9%	1,130	1.3%
MCO Statewide	**5,126**	**25.5%**	**3,881**	**1.6%**
DBA Dental Record Omission and Encounter Data Omission				
LIBERTY	2,502	5.2%	2,382	0.4%

* Lower rates indicate better performance.

Key Findings: Table 5-6

- When aggregating statewide, 25.5 percent and 5.2 percent of the procedure codes identified in the encounter data were not supported by the members' medical records (i.e., medical record omission) or dental records (i.e., dental record omission), respectively.
  - In the analysis, when no medical or dental records were submitted for the sampled date of service, all procedure codes associated with that date of service were treated as medical record or dental record omissions. Similarly, for cases identified as a medical or dental record omission for dates of service, all procedure codes associated with those cases were also treated as medical record omissions.
    - Approximately 54.6 percent and 23.1 percent of procedure codes were counted as medical record and dental record omissions, respectively, due to non-submission of medical or dental records or documents submitted not supporting the sample date of service.
  - Among the MCOs, the rates of medical record omission for procedure codes ranged from 17.9 percent (**UHC HPN**) to 32.5 percent (**SilverSummit**). **LIBERTY** had a dental record omission rate of 5.2 percent.
    - For cases with medical records to validate the date of service, procedure codes that were frequently omitted from the members' medical records included:
      - 90460: Immunization administration through 18 years via any route of administration, with counseling by physician (Frequency = 80)

  - 90472: Administration of each additional immunization (Frequency = 35)
  - G0447: Face-to-face behavioral counseling for obesity, 15 minutes (Frequency =27)
  - 90461: Additional immunization administration through 18 years via any route of administration, with counseling by physician (Frequency = 25)
  - 96110: Developmental screening with scoring and documentation (Frequency = 20)
- For cases with dental records to validate the date of service, procedure codes that were frequently omitted from the members' dental records included:
  - D0230: Intra-Periapical each additional radiographic image (Frequency = 25)
  - D1206: Topical application of fluoride varnish (Frequency = 9)

- When aggregating statewide, 1.6 percent and 0.4 percent of the procedure codes identified in the medical and dental records, respectively, were not found in the encounter data (i.e., encounter data omission).
  - The percentage of procedure codes identified in the medical records that were not found in the encounter data was 2.6 percent or less for all MCEs.

Procedure Code Modifier Completeness

Table 5-7 presents the percentage of procedure code modifiers identified in the encounter data that had no supporting documents in the members' medical records (i.e., medical record omission) and the percentage of procedure code modifiers from the members' medical records that were not found in the encounter data (i.e., encounter data omission).

Of note, review of this data element is not applicable to dental encounters.

Table 5-7—Medical Record Omission and Encounter Data Omission for Procedure Code Modifiers

MCE	Medical Record Omission		Encounter Data Omission	
	Number of Procedure Code Modifiers Identified in Encounter Data	Percent Not Documented in Members' Medical Records*	Number of Procedure Code Modifiers Identified in Members' Medical Records	Percent Not Found in Encounter Data*
MCO Medical Record Omission and Encounter Data Omission				
Anthem	409	38.4%	259	2.7%
Molina	490	29.2%	354	2.0%
SilverSummit	484	26.0%	360	0.6%
UHC HPN	523	26.6%	391	1.8%
MCO Statewide	**1,906**	**29.6%**	**1,364**	**1.7%**

* Lower rates indicate better performance.

Key Findings: Table 5-7

- When aggregating statewide, 29.6 percent of the procedure code modifiers identified in the encounter data were not supported by the members' medical records.
  - Medical record omission rates for the *Procedure Code Modifier* data element ranged from 26.0 percent (**SilverSummit**) to 38.4 percent (**Anthem**). **Anthem** had the highest *Date of Service* data element medical record omission, which contributed to its high medical record omission rate for the *Procedure Code Modifier* data element.
  - The statewide medical record omission rate for the procedure code modifiers could have been attributed to several factors, including medical record non-submission for which subsequent procedure codes and procedure code modifiers were treated as medical record omissions; omitted procedure codes for which associated procedure code modifiers were also omitted; and providers not documenting the evidence related to the modifiers in the medical records despite submitting the modifiers to the MCEs.
    - For cases with medical records to validate the date of service, procedure code modifiers that were frequently omitted from the members' medical records included "25" (significant, separately identifiable evaluation and management [E&M] service by the same provider on the same day of the procedure or other service) at 29.7 percent and "59" (distinct procedural service) at 27.4 percent.
- When aggregating statewide, 1.7 percent of the procedure code modifiers identified in the medical records were not found in Nevada Medicaid's encounter data.
  - The percentage of procedure code modifiers identified in the medical records that were not found in the encounter data was 2.7 percent or less for all MCOs.

Encounter Data Accuracy

Encounter data accuracy was evaluated for dates of service that existed in both Nevada Medicaid's encounter data and the submitted medical/dental records, with values present in both data sources for the evaluated data element. HSAG considered the encounter data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) accurate if documentation in the medical/dental record supported the values contained in the electronic encounter data. **Higher accuracy rates for each data element indicate better performance.**

Diagnosis Code Accuracy

Table 5-8 presents the percentage of diagnosis codes associated with validated dates of service from the encounter data that were correctly coded based on the members' medical records. In addition, errors found in the diagnosis coding were separated into two categories: inaccurate coding and specificity error. Inaccurate coding occurred when the diagnosis code submitted by the provider should have been selected from a different family of codes based on the documentation in the medical record (e.g., R51 [headache] versus the documentation supporting G43 [migraine]). A specificity error occurred when the documentation supported a more specific code than was listed in Nevada Medicaid's encounter data

(e.g., unspecified abdominal pain [R10.9] when the provider noted during the exam that the abdominal pain was in the right lower quadrant [R10.31]). Specificity errors may also include diagnosis codes that do not have the required fourth or fifth digit.

Inaccurate coding and specificity errors in medical records were collectively considered as the denominator for the error type rates in Table 5-8.

Table 5-8—Accuracy Results and Error Types for Diagnosis Code

MCE	Accuracy Results		Error Type Rate[1]	
	Number of Diagnoses Present in Both Sources	Accuracy Rate	Percent From Inaccurate Coding	Percent From Specificity Error
MCO Accuracy Results				
Anthem	1,079	99.7%	100%	0.0%
Molina	1,251	99.2%	90.0%	10.0%
SilverSummit	1,148	99.6%	100%	0.0%
UHC HPN	1,442	99.9%	100%	0.0%
MCO Statewide	**4,920**	**99.6%**	**95.0%**	**5.0%**
DBA Accuracy Results				
LIBERTY	655	71.6%	100%	0.0%

[1] Inaccurate coding and specificity errors in medical records were collectively considered as the denominator for the error type rates.

Key Findings: Table 5-8

- Overall, 99.6 and 71.6 percent of the diagnosis codes for MCO statewide and **LIBERTY**, respectively, were accurate when they were present in both the encounter data and the medical/dental records.
- All four MCOs had similarly high rates of accuracy for diagnosis codes, with a rate of at least 99.2 percent. **LIBERTY** had a lower rate of accuracy for diagnosis codes, with a rate of 71.6 percent. Further investigation found that a majority of the inaccuracies were from diagnosis code Z01.20 (encounter for dental examination and cleaning without abnormal findings) in the encounter data while the dental records supported Z01.21 (encounter dental examination and cleaning with abnormal findings).
- For diagnosis coding accuracy among MCOs and **LIBERTY**, the errors were predominantly due to inaccurate coding (95.0 percent and 100 percent, respectively) rather than discrepancies associated with specificity errors (5.0 percent and 0.0 percent, respectively).

Procedure Code Accuracy

Table 5-9 presents the percentage of procedure codes associated with validated dates of service from the encounter data that were correctly coded based on the members' medical records. In addition, errors found in the procedure coding associated with the medical record reviews were separated into three categories:

- Higher level of service in the medical record: E&M codes documented in the medical record reflected a higher level of service performed by the provider than the E&M codes submitted in the encounter. For example, a patient was seen by a physician for a follow-up appointment for a worsening earache. The physician noted all key elements in the patient's medical record. The physician also changed the patient's medication during this visit. The encounter submitted showed a procedure code of 99212 (established patient self-limited or minor problem). With all key elements documented and a worsening condition, this visit should have been coded with a higher level of service, for example 99213 (established patient low-to-moderate severity).
- Lower level of service in the medical record: E&M codes documented in the medical record reflected a lower level of service than the E&M codes submitted in the encounter data. For example, a provider's notes omitted critical documentation elements of the E&M service, or the problem treated did not warrant a high-level visit. This would apply to a patient follow-up visit for an earache that was improving, required no further treatment, and for which no further problems were noted. The encounter submitted showed a procedure code of 99213 (established patient low-to-moderate severity). However, with an improving condition, the medical record describes lower level of service, or 99212 (established patient self-limited or minor problem).
- Inaccurate coding: The documentation in the medical/dental records did not support the procedure codes billed, or an incorrect procedure code was used in the encounter for scenarios other than the two mentioned above.

Inaccurate coding, codes with higher level of services, and codes with lower level of services in medical records were collectively considered as the denominator for the error type rates in Table 5-9.

Of note, for dental record review, errors in coding were only related to codes that were inaccurately coded. As such, there is no other error category to present.

Table 5-9—Accuracy Results and Error Types for Procedure Code

	Accuracy Results		Error Type Rate[1]		
MCE	Number of Procedures Present in Both Sources	Accuracy Rate	Percent From Inaccurate Coding	Percent From Higher Level of Services in Medical Records	Percent From Lower Level of Services in Medical Records
MCO Accuracy Results					
Anthem	778	96.1%	100%	0.0%	0.0%
Molina	1,030	95.7%	97.7%	2.3%	0.0%
SilverSummit	896	94.1%	94.3%	3.8%	1.9%

MCE	Accuracy Results		Error Type Rate[1]		
	Number of Procedures Present in Both Sources	Accuracy Rate	Percent From Inaccurate Coding	Percent From Higher Level of Services in Medical Records	Percent From Lower Level of Services in Medical Records
UHC HPN	1,115	96.4%	97.5%	2.5%	0.0%
MCO Statewide	**3,819**	**95.6%**	**97.0%**	**2.4%**	**0.6%**
DBA Accuracy Results					
LIBERTY	2,472	94.1%	100%	NA	NA

[1] Inaccurate coding, codes with higher level of services, and codes with lower level of services in medical records were collectively considered as the denominator for the error type rates.

NA indicates error type is not applicable for dental record review.

Key Findings: Table 5-9

- Statewide, among the MCOs, 95.6 percent of the procedure codes were accurate when present in the encounter data and medical records. The MCOs' rates were relatively similar with a range from 94.1 percent to 96.4 percent accuracy. The dental procedure code had a slightly lower accuracy rate at 94.1 percent.
- For the MCOs' procedure coding accuracy, 97.0 percent of the identified errors were associated with inaccurate coding. Secondly, 2.4 percent of the identified errors resulted from the medical records supporting a higher level of service. Lastly, 0.6 percent of the identified errors resulted from the medical records supporting a lower level of service.
- For the dental procedure code accuracy, 100 percent of the identified errors were associated with inaccurate coding.

Procedure Code Modifier Accuracy

Table 5-10 presents the percentage of procedure code modifiers associated with validated dates of service from the encounter data that were correctly coded based on members' medical records. The errors for this data element could not be separated into subcategories and therefore are not presented in Table 5-10.

Of note, the review of this data element is not applicable for dental encounters.

Table 5-10—Accuracy Results for Procedure Code Modifier

MCE	Number of Procedure Code Modifiers Present in Both Sources	Accuracy Rate
MCO Accuracy Results		
Anthem	252	98.8%
Molina	347	98.8%

MCE	Number of Procedure Code Modifiers Present in Both Sources	Accuracy Rate
SilverSummit	358	100%
UHC HPN	384	99.2%
MCO Statewide	**1,341**	**99.3%**

Key Findings: Table 5-10

- When aggregating statewide, 99.3 percent of the procedure code modifiers were accurate when they were present in both the encounter data and the members' medical records.
- All MCEs had high levels of accuracy for the procedure code modifiers ranging from 98.8 percent (Anthem and Molina) to 100 percent (SilverSummit).

All-Element Accuracy

Table 5-11 presents the percentage of dates of service present in both Nevada Medicaid's encounter data and in the medical/dental records with the same values for all key data elements listed in Table 2-2. The denominator is the total number of dates of service that matched in both data sources. The numerator is the total number of dates of service with matching values for all key data elements. Higher all-element accuracy rates indicate greater overall completeness and accuracy of Nevada Medicaid's encounter data when compared to the medical/dental records.

Table 5-11—All-Element Accuracy

MCE	Number of Dates of Service Present in Both Sources	All Element Accuracy Rate[1]
MCO All-Element Accuracy		
Anthem	392	69.1%
Molina	462	71.2%
SilverSummit	421	71.7%
UHC HPN	543	75.5%
MCO Statewide	**1,818**	**72.2%**
DBA All-Element Accuracy		
LIBERTY	463	37.6%

[1] The denominator for the element accuracy rate for each data element was defined differently from the denominator for the all-element accuracy rate. Therefore, the all-element accuracy rate could not be derived from the accuracy rate from each data element.

Key Findings: Table 5-11

- When aggregating statewide, among the MCOs, 72.2 percent of the dates of service present in both data sources contained accurate values for all three key data elements (i.e., *Diagnosis Code,*

Procedure Code, and *Procedure Code Modifier*). The medical record omission, encounter data omission, and element inaccuracy from all three data elements contributed to the moderately low statewide all-element accuracy rate, with *Procedure Code* contributing the most and *Diagnosis Code* contributing the least.

- For **LIBERTY**, 37.6 percent of the dates of service present in both data sources contained accurate values for the *Diagnosis Code* and *Procedure Code* data elements. The dental record omission, encounter data omission, and element inaccuracy for the two data elements contributed to the low all-element accuracy rate, with *Diagnosis Code* contributing the most and *Procedure Code* contributing the least.

6. Discussion

Conclusions

This section provides conclusions from each of the three activities conducted for the EDV study.

Information Systems Review

The IS review component of the EDV study provided self-reported qualitative information from **Molina** regarding the encounter data processes related to collection, processing, and transmission of encounter data to Nevada Medicaid. Key findings are below:

- Based on the data submission requirements (e.g., companion guides) from Nevada Medicaid, **Molina** demonstrated its capability to collect, process, and transmit encounter data to Nevada Medicaid, as well as develop data review and correction processes that can respond to quality issues identified by Nevada Medicaid.
- While submitting denied lines to Nevada Medicaid with $0 paid at the line level, **Molina** did not submit fully denied claims (i.e., all lines were denied) to Nevada Medicaid.
- While **Molina** and/or its subcontractors evaluated claim volume by submission month, field-level completeness and accuracy, and submission timeliness, it did not note any reports regarding claim volume PMPM, reconciliation with financial reports (e.g., clerk disperse journal), or medical record review. In addition, the example report from **Molina** appeared to include vision encounters in the "Professional" category, which may mask the data issues from vision encounters.
- **Molina** did not anticipate any upcoming changes to its encounter data submission process, as it was not facing any internal or external issues.

Comparative Analysis

For the comparative analysis component of the EDV study, HSAG evaluated the professional, institutional, and pharmacy encounters of the four MCOs (**Anthem**, **Molina**, **SilverSummit**, and **UHC HPN**) and the dental encounters of the DBA (**LIBERTY**). HSAG evaluated encounter data from both Nevada Medicaid and the MCEs with dates of service from January 1, 2023, through December 31, 2023, to assess the accuracy and completeness of the encounter data.

Throughout the comparative analysis section, lower omission and surplus rates indicate better performance while higher accuracy rates indicate better performance.

Record completeness

HSAG evaluated the record-level data completeness of Nevada Medicaid's encounter data by investigating the record omission and record surplus rates in Nevada Medicaid's data compared to each MCE's data.

The overall MCO record omission rates for professional, institutional, and pharmacy encounters were 2.1 percent, 2.7 percent, and 0.2 percent, respectively. This indicates more than 97.0 percent of records present in the files for each encounter type submitted by the MCOs were corroborated in Nevada Medicaid's submitted data. Likewise, the overall MCO record surplus rates for professional, institutional, and pharmacy encounters were 3.7 percent, 5.4 percent, and 2.6 percent, respectively. This indicates more than 94.0 percent of records present in the files for each encounter type submitted by Nevada Medicaid were corroborated in MCOs' submitted data. **UHC HPN** had the highest record surplus rate for institutional encounters, which moved the overall statewide rate above 5.0 percent. These surplus records were due to Nevada Medicaid having adjudication history in its encounter data (i.e., for the situation where the original was a denied claim and the latest iteration was a paid claim, Nevada Medicaid's data had both versions while the **UHC HPN**-submitted data only had the latest iteration).

LIBERTY had exceptional record omission and surplus rates, at 0.2 percent and 1.8 percent, respectively. This indicates 99.8 percent of dental records present in the files submitted by **LIBERTY** were corroborated in Nevada Medicaid's submitted data. Likewise, 98.2 percent of records present in the files submitted by Nevada Medicaid were corroborated in **LIBERTY**-submitted data.

Data Element Completeness and Accuracy

HSAG evaluated the element-level completeness of Nevada Medicaid's encounter data by assessing the element omission and element surplus rates for the key data elements. The professional data element omission rates and surplus rates were very low across all MCOs. **SilverSummit** was the only MCO to have a data element surplus rate above 5.0 percent (i.e., 15.0 percent for the *Secondary Diagnosis Code(s)* data element). Moreover, the institutional data element omission rates and surplus rates were also low across all MCOs. **Anthem** and **Molina** were the only MCOs to have a data element omission rate above 5.0 percent (i.e., 5.9 percent and 10.6 percent for the *Secondary Diagnosis Code(s)* data element for **Anthem** and **Molina**, respectively, and **Molina**'s 81.3 percent for the *Admission Date* data element). Lastly, the pharmacy and dental data element omission rates and surplus rates were consistently below 5.0 percent across all MCEs. These values indicate that an overwhelming majority of pharmacy and dental records with values present in the MCE-submitted data files were also present in Nevada Medicaid-submitted data files for the applicable key data elements, and vice versa.

HSAG determined element-level accuracy by comparing key data element values between Nevada Medicaid's and the MCEs' records where data were present in both sources. Overall, among records that could be matched between Nevada Medicaid-submitted data and the MCE-submitted data, high rates of accuracy were noted. Within professional encounters, the statewide data element accuracy for each of the key data elements, except for the *Units of Service* and *Paid Date* data elements, were at least 95.0

percent. Conversely, within institutional encounters, the statewide data element accuracy for each of the key elements varied. While most were at least 95.0 percent, the *Secondary Diagnosis Code(s), Units of Service, Surgical Procedure Code(s), TOB Code*, and *Paid Date* were below 95.0 percent. Lastly, the pharmacy and dental statewide data element accuracy rates were at least 95.0 percent for all key data elements.

All-Element Accuracy

HSAG assessed all-element accuracy by identifying records present in both data sources that contained the same values (missing or non-missing) across all data elements. The overall MCE all-element accuracy rate varied across encounter types. These rates for professional, institutional, pharmacy, and dental encounters were 56.3 percent, 34.0 percent, 96.2 percent, and 91.0 percent**,** respectively. **Anthem** and **Molina** had a 0.0 percent all-element accuracy rate for institutional encounters. The inaccuracy in *Paid Date* was a significant contributor for **Anthem**, where the root of the issue was due to incorrect mapping (i.e., the *MCO Received Date* was incorrectly mapped to the *Paid Data* field for the data submitted to HSAG for the EDV study). The inaccuracy in the *Secondary Diagnosis Codes* data element was a significant contributor for **Molina**, where the root of the issue was due to including secondary diagnosis codes with an "APR" qualifier (indicating patient reason for visit). **Molina** acknowledged that if secondary diagnosis codes with only the "ABF" (indicating secondary diagnosis codes) and "ABK" (indicating primary diagnosis code) qualifiers were to be submitted to HSAG, this issue would not exist. The pharmacy and dental encounters had relatively higher all-element accuracy rates due to no elements having high element omission or surplus rates and having high element accuracy rates for individual data elements.

Medical/Dental Record Review

The medical/dental record review activity evaluated encounter data completeness and accuracy through a review of medical/dental records for physician/dentist services rendered from January 1, 2023, through December 31, 2023.

Encounter Data Completeness

Table 6-1 displays the medical/dental record omission and encounter data omission rates for each key data element from the medical/dental record review activity.

Table 6-1—Medical/Dental Record Review: Encounter Data Completeness Summary

Data Elements	MCO					DBA
	MCO Statewide	Anthem	Molina	SilverSummit	UHC HPN	LIBERTY
Medical/Dental Record Omission						
Date of Service	**16.6%**	23.1%	14.8%	21.5%	8.1%	1.7%
Diagnosis Code	**17.9%**	22.6%	17.7%	22.3%	10.0%	13.8%

Data Elements	MCO					DBA
	MCO Statewide	Anthem	Molina	SilverSummit	UHC HPN	LIBERTY
Procedure Code	**25.5%**	27.5%	24.7%	32.5%	17.9%	5.2%
Procedure Code Modifier	**29.6%**	38.4%	29.2%	26.0%	26.6%	NA
Encounter Data Omission						
Date of Service	**2.3%**	1.3%	3.5%	1.6%	2.3%	2.1%
Diagnosis Code	**1.4%**	1.3%	2.0%	0.9%	1.3%	1.5%
Procedure Code	**1.6%**	1.4%	2.6%	1.0%	1.3%	0.4%
Procedure Code Modifier	**1.7%**	2.7%	2.0%	0.6%	1.8%	NA

NA indicates that the data element was not applicable for dental record review.

The final sample cases included in the evaluation consisted of 411 cases randomly selected per MCE, along with any submitted second dates of service for each sampled member. Two indicators were evaluated for encounter data completeness:

- Medical/dental record omission occurred when an encounter data element was not documented in the medical/dental record.
- Encounter data omission occurred when an encounter data element was documented in the medical/dental record but not found in the associated encounters.

Overall, the medical record omission rates were higher than the encounter data omission rates for all of the key data elements (i.e., *Date of Service, Diagnosis Code, Procedure Code,* and *Procedure Code Modifier*) for the MCOs. The dental record omission rates were consistently lower than the MCO medical record omission rates due to the high dental record submission rate from **LIBERTY**. The *Date of Service* and *Procedure Code* data elements for the dental encounter data were generally supported by the members' dental records, as evidenced by the dental record *Date of Service* omission rate of 1.7 percent and *Procedure Code* omission rate of 5.2 percent. However, the *Diagnosis Code* (17.9 percent for medical and 13.8 percent for dental), *Procedure Code* (25.5 percent for medical), and *Procedure Code Modifier* (29.6 percent for medical) data elements within the encounter data were moderately supported by the medical/dental records. As determined during the review, some common reasons for medical/dental record omissions included:

- The medical/dental record was not submitted for the study.
- The provider did not document the services performed in the medical/dental record despite submitting claims or encounters.
- The provider did not provide the services(s) found in the encounter data.

Anthem had the highest medical record omission rate for *Date of Service, Diagnosis Code*, and *Procedure Code Modifier* data elements compared to the other MCEs. **SilverSummit** had the highest

medical record omission rate for the *Procedure Code* data element. **LIBERTY**'s dental record omission rates were generally low compared to the other MCEs for the *Date of Service, Diagnosis Code,* and *Procedure Code* data elements. The encounter data omission for all MCEs and data elements were relatively low (i.e., 3.5 percent or less).

Encounter Data Accuracy

Table 6-2 displays the element accuracy rates for each key data element and the all-element accuracy rates.

Table 6-2—Encounter Data Accuracy Summary

Data Elements	MCO						DBA
	MCO Statewide	Anthem	Molina	SilverSummit	UHC HPN	MCO Statewide Error Type	LIBERTY
Diagnosis Code	**99.6%**	99.7%	99.2%	99.6%	99.9%	Inaccurate Code: (95.0%) Specificity Error: (5.0%)	71.6%
Procedure Code	**95.6%**	96.1%	95.7%	94.1%	96.4%	Inaccurate Code: (97.0%) Higher Level of Service in Medical Record: (2.4%) Lower Level of Service in Medical Record: (0.6%)	94.1%
Procedure Code Modifier	**99.3%**	98.8%	98.8%	100%	99.2%	—	NA
All-Element Accuracy	**72.2%**	69.1%	71.2%	71.7%	75.5%	—	37.6%

NA indicates that the data element was not applicable for dental record review.
"—" denotes that the error type analysis was not applicable to a given data element.

Overall, when key data elements were present in both Nevada Medicaid professional data and the medical records and evaluated independently, the data element values were found to be accurate for the MCOs. Among the data elements evaluated, 99.6 percent of diagnosis codes, 95.6 of procedure codes, and 99.3 percent of procedure code modifiers present in both sources were accurate. In comparison to the MCOs, the DBA, **LIBERTY**, had lower accuracy rates for the key data elements *Diagnosis Code* (71.6 percent) and *Procedure Code* (94.1 percent) for dental encounters. The errors affecting the *Diagnosis Code* and *Procedure Code* data elements were mostly due to the use of inaccurate codes for both medical and dental records instead of other error types as shown in Table 5-8 and Table 5-9.

Statewide, among the MCOs, 72.2 percent of the dates of service present in both data sources contained accurate values for all three key data elements (i.e., *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*). The relatively low statewide all-element accuracy rates were caused by the medical record omissions, encounter data omissions, and element inaccuracies from all three key data elements, with *Procedure Code* contributing the most and *Diagnosis Code* contributing the least. For the DBA **LIBERTY**, 37.6 percent of the dates of service present in both data sources contained accurate values for the *Diagnosis Code* and *Procedure Code* data elements. The low all-element accuracy rate was

caused by dental record omission, encounter data omission, and element inaccuracy for the two data elements, with *Diagnosis Code* contributing the most and *Procedure Code* contributing the least.

Recommendations

To improve the quality of encounter data submissions from the MCEs, HSAG offers the following recommendations for each component of the EDV study to assist Nevada Medicaid and the MCEs in addressing opportunities for improvement:

Information Systems Review

- **Molina** should work with Nevada Medicaid to decide whether the fully denied claims should be submitted to Nevada Medicaid.
- **Molina** should explore the possibility of developing or enhancing monitoring reports to assess the accuracy, completeness, and/or timeliness of the encounters as noted below.
  - **Molina** should develop reports regarding claim volume PMPM or reconciliation with financial reports (e.g., clerk disperse journal).
  - **Molina** should monitor vision encounters separately from other professional encounters.

Comparative Analysis

- The results from the comparative analysis indicated that encounters submitted by the MCEs and maintained in Nevada Medicaid's data warehouse were relatively complete (i.e., low record omission and surplus rates) when compared to data the MCEs submitted to HSAG. However, there were a few record omission and surplus rates between 5.0 and 9.0 percent. HSAG recommends that Nevada Medicaid work with the MCEs to resolve these issues (i.e., refer to the MCE-specific data discrepancy reports or the MCE-specific appendix in the report). In addition, HSAG recommends that Nevada Medicaid continue its current monitoring efforts to maintain the quality of encounter data submissions and promptly address any identified data issues.
- While many key data elements showed high completeness and accuracy rates, some elements had high element omission/surplus rates or low accuracy rates. HSAG recommends that Nevada Medicaid work with the MCEs to resolve issues related to these data elements (i.e., refer to the MCE-specific data discrepancy reports or the MCE-specific appendices in the report). This involves clarifying the requirements for submitting, collecting, and reporting these data elements to improve the overall data quality.
- **Anthem**, **Molina**, and **SilverSummit** reported system query errors when extracting data for the EDV study. MCEs should review and implement standard quality controls to ensure accurate data extracts from their respective systems. Standardizing data extraction procedures and enhancing quality controls will help reduce errors associated with data extraction.

Medical/Dental Record Review

- The results from the medical/dental record review also indicated that the key data elements (i.e., *Date of Service, Diagnosis Code*, *Procedure Code,* and *Procedure Code Modifier*) in the encounters submitted by the MCEs and maintained in Nevada Medicaid's data warehouse were generally supported by members' medical and dental records, with few exceptions. As such, HSAG recommends Nevada Medicaid continue its current efforts in monitoring encounter data submissions and addressing any identified data issues with the MCE's encounter data submissions.
- Since the results of the medical/dental record review are dependent on the MCEs' submission of complete and accurate supporting documentation, HSAG recommends that Nevada Medicaid consider setting record submission standards to ensure the MCEs and providers are more responsive in procuring requested records. By having the MCEs submit complete and accurate documentation and records, results will be more representative of the actual documentation available.
- The medical record omission rates for *Date of Service, Diagnosis Code, Procedure Code*, and *Procedure Code Modifier* were relatively high across all MCOs. The dental record omission rate for *Diagnosis Code* was relatively high for **LIBERTY**. As such, MCEs should investigate the root causes of these medical record omissions and consider performing periodic medical/dental record reviews of submitted claims to verify appropriate coding and data completeness, where appropriate. Findings from these reviews should be used to provide targeted education and training for providers regarding encounter data submissions, medical/dental record documentation, and coding practices.
- **LIBERTY** should investigate the relatively low accuracy rate for data element *Diagnosis Code* and implement any changes needed.

Study Limitations

- Findings associated with the IS review were based on self-reported questionnaire responses submitted to HSAG by **Molina**. HSAG did not confirm the statements made in the questionnaire.
- The comparative analysis and medical/dental record review results presented in this study were dependent on the quality of encounter data submitted by Nevada Medicaid and the MCEs. Any substantial and systematic errors in the extraction of encounter data may bias the results and compromise the validity and reliability of study findings.
- The findings from the comparative analysis and medical/dental record review were associated with encounters with dates of service from January 1, 2023, through December 31, 2023. As such, results may not reflect the current quality of Nevada Medicaid's and the MCEs' encounter data or changes implemented since January 2024.
- Since the MCEs did not submit the *Discharge Date* field to Nevada Medicaid, and Nevada Medicaid derived its values based on the *Last Date of Service* and *Patient Discharge Status Code*, Nevada Medicaid decided to remove the *Discharge Date* field from the study since the values in the MCE-submitted and Nevada Medicaid-submitted data might not be comparable.
- Since the second date of service may be for a denied encounter, HSAG included denied encounters in the medical/dental review analysis for the second date of service. However, there were adjudication histories for the denied encounters, which caused the same procedure code to appear in

the data more than once while the service only occurred once. This contributed to the medical record omissions for the procedure code. Of note, this scenario occurred rarely; therefore, the impact to the study results was minimal.

Appendix A. Blank Questionnaire for Molina

This section contains images of the blank questionnaire sent to **Molina** for the IS review.

Encounter Data Validation Questionnaire for Molina

Overview

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, the Division of Health Care Financing and Policy (DHCFP), a Division of the State of Nevada, Department of Health and Human Services (DHHS), requires its contracted managed care organizations (MCOs) and its dental benefit administrator (DBA)/prepaid ambulatory health plan (PAHP), collectively referred to as managed care entities (MCEs), to submit high-quality encounter data. DHCFP relies on the quality of these encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

In fiscal year (FY) 2025, DHCFP contracted Health Services Advisory Group, Inc. (HSAG) to conduct an encounter data validation (EDV) study. In alignment with the *CMS EQR Protocol 5. Validation of Encounter Data by the Medicaid and CHIP [Children's Health Insurance Program] Managed Care Plan: An Optional EQR-Related Activity*, February 2023 (CMS EQR Protocol 5),[1] HSAG will conduct the EDV study based on three evaluation activities designed to evaluate the completeness and accuracy of DHCFP's encounter data. The three activities are as follows:

- Information systems (IS) review—assessment of MCEs' information systems and processes. The goal of this activity is to examine the extent to which the MCEs' infrastructures are likely to collect and process complete and accurate data. This activity corresponds to Activity 2: Review the MCP's Capability in the CMS EQR Protocol 5.
- Comparative analysis—analysis of DHCFP's electronic encounter data completeness and accuracy through a comparative analysis between DHCFP's electronic encounter data and the data extracted from the MCEs' data systems. The goal of this activity is to evaluate the extent to which encounter data in DHCFP's data warehouse are complete and accurate based on corresponding information stored in each MCE's data systems. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in the CMS EQR Protocol 5.
- Medical/dental records review—analysis of DHCFP's electronic encounter data completeness and accuracy through a review of a sample of DHCFP's electronic encounter data and the associated medical/dental records. The goal of this activity is to evaluate the extent to which DHCFP's encounter data are complete and accurate when compared to information contained within the member's medical/dental records. This activity corresponds to the Activity 4: Review Medical Records in the CMS EQR Protocol 5. Of note, conducting a medical/dental record review will be contingent upon whether the IS review and comparative analysis indicate that the completeness and accuracy of DHCFP's encounter data are sufficient.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5: Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: September 11, 2024.

—Final Copy—

Encounter Data Validation: IS Review Questionnaire for Molina
State of Nevada
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Since FY 2025 is the first year HSAG will be conducting the EDV study for Molina Healthcare of Nevada, Inc. (Molina), HSAG will include the IS review component of the EDV activity for Molina. The IS review will evaluate and determine whether Molina's systems can collect and report high quality encounter data. Concurrent with the IS review, HSAG will conduct the comparative analysis for Molina to ascertain whether data are complete and are of high quality in order to proceed with the medical record review component of the EDV activity.

The IS review will include an evaluation of Molina's processes for collecting, maintaining, and submitting encounter data to DHCFP and on the strengths and limitations of Molina's information systems in promoting and maintaining quality encounter data. In alignment with *Activity 2: Review the MCP's Capability* in the CMS EQR Protocol 5, HSAG has developed the following EDV focused questionnaire to gather information regarding Molina's information systems and data processing procedures. The IS review will enable HSAG to understand how various systems interact to determine whether such interactions have an impact on Molina's ability to submit complete and accurate data.

General Instructions

HSAG developed the following questionnaire customized in collaboration with DHCFP to gather both general information and specific procedures for data processing, personnel, and data acquisition capabilities. The questionnaire is divided into the following four domains:

Section A: *Encounter Data Sources and Systems*

Section B: *Data Exchange Policies and Procedures*

Section C: *Payment Structures of Encounter Data*

Section D: *Encounter Data Quality Monitoring and Reporting*

Molina must complete all sections of the following questionnaire, providing comprehensive answers to the questions and attaching supporting documentation (e.g., policies and procedures, data layouts, data flow diagrams, sample reports, sample data, etc.), where applicable. If different staff members within Molina are responsible for different aspects of the processes, please distribute multiple copies of the questionnaire and ensure that each group provides answers to the applicable questions in each section. **Responses need to be merged into a single final version; uploading multiple sections and documents is not acceptable.**

Upon evaluating answers to the questionnaire and additional documentation, HSAG's EDV team may conduct additional follow-up with Molina via email or conference calls.

Submission of Questionnaire and Documentation

- Molina should upload the completed questionnaire and supporting documentation electronically to HSAG's Secure Access File Exchange (SAFE) site, https://safe.hsag.com/ in your specific project subfolder labeled "*NV Molina_Encounter Data Validation*."
- Please contact Brittani Alley at BAlley@hsag.com for assistance with access to HSAG's SAFE site.
- HSAG requests that Molina upload the completed questionnaires, and any attachments, to HSAG's SAFE site no later than **Thursday, January 2, 2025**. Upon completion of upload, please notify Krithiga Gopi via email at KGopi@hsag.com.
- Please provide the descriptions for the acronyms used in your responses in the table below or spell them out when using the acronyms for the first time.

Acronym	Description

Encounter Data Validation—MCO Focused Questionnaire

Section A: Encounter Data Sources and Systems

Contact person for this section (Name and Title)	
Contact Information (Phone Number and Email)	

Please note that if your staff members use an electronic version of this questionnaire, the response boxes are expandable. Do not worry about pagination. If you use the same data system for multiple clients or lines of business, please limit your responses to specific procedures related to the processing of DHCFP's claims and encounters. If supplemental files or supporting documents are provided, please note the filename(s) in your response.

1. Using a list or data flow diagram, outline the path your encounter data follow from the time a member receives a service(s) until the encounter is processed by DHCFP. If the data path differs by or within a claim type, provide a separate list or data flow diagram for each claim type and scenario. Be sure to identify any subcontractors responsible for processing the data and the associated processes with the subcontractors. *Note: The first section of the table is provided as an example. The table can be expanded if additional rows are required.*

Data Source[1]	Description of Data Flow	Supporting Document(s)
837 Professional	*Web portal claims keyed via DDE (Direct Data Entry) are converted to 837 files for electronic processing. Once converted, web claims follow the same process as those submitted in electronic format.*	*<insert file name>*
837 Professional		
837 Institutional		
Paper		
Pharmacy		
Vision		
Non-Emergency Transportation		
<insert other data sources[2]>		

[1] These sources represent claims/encounter submissions from the rendering provider to Molina or subcontractor.

[2] Examples include hearing, chiropractic, laboratory, etc.

2. For each key source of data (i.e., all data you receive that are included in the encounter data submissions to DHCFP), provide a description of the files received, the frequency of receipt, and the approximate percentage of claims submitted by capitated versus fee-for-service (FFS) providers. *Note: The first section of the table is provided as an example. The table can be expanded if additional rows are required.*

Data Source[1]	Description of Data Received (Including Format)	Frequency[2]	Approximate Percentage of Claims from Capitated Providers
Pharmacy	*We receive point of service claims submitted by retail pharmacies from our vendor, Express Scripts. Files are submitted using the NCPDP D.0 format.*	*Weekly*	*65%*
Medical in 837 Professional Format			
Medical in 837 Institutional Format			
Pharmacy			
Vision			
Non-Emergency Transportation			
<insert other sources[3]>			

[1] These sources represent claims/encounter submissions from the rendering provider to Molina or subcontractor.
[2] Frequency = Daily, weekly, twice a month, monthly, every other month, etc.
[3] Examples include hearing, chiropractic, laboratory, etc.

3. For each key source of data, provide a description of the software used to receive data, validate data, and prepare outbound encounters for submission to DHCFP. *Note: The first section of the table is provided as an example. The table can be expanded if additional rows are required.*

Data Source[1]	Software Used to Receive Data	Software Used to Validate Data	Software Used to Generate Encounters for DHCFP
Paper claims	*Convert to 837 format through an optical character recognition (OCR) software by <insert name>*	*Facets*	*Encounter Data Manager*
Medical in 837 Professional Format			

Data Source[1]	Software Used to Receive Data	Software Used to Validate Data	Software Used to Generate Encounters for DHCFP
Paper claims	*Convert to 837 format through an optical character recognition (OCR) software by <insert name>*	*Facets*	*Encounter Data Manager*
Medical in 837 Institutional Format			
Pharmacy			
Vision			
Non-Emergency Transportation			
<insert other sources[2]>			

[1] These sources represent claims/encounter submissions from the rendering provider to Molina or subcontractor.
[2] Examples include hearing, chiropractic, laboratory, etc.

4. For encounters submitted to DHCFP through 837 professional and institutional formats, please describe the software used for the Electronic Data Interchange (EDI) compliance checks and the Workgroup for Electronic Data Interchange Strategic National Implementation Process (WEDI SNIP) levels that are used in the EDI compliance checks.

Data Source[1]	Software for EDI Compliance Check	WEDI SNIP Level
Vision claims	*SpecBuilder*	*Levels 1 to 5*
Medical in 837 Professional Format		
Medical in 837 Institutional Format		
Vision		
Non-Emergency Transportation		
<insert other sources[2]>		

[1] These sources represent claims/encounter submissions from the rendering provider to Molina or subcontractor.
[2] Examples include hearing, chiropractic, laboratory, etc.

5. Please specify the modifications, reformatting or changes made to the claims/encounter data to accommodate DHCFP's encounter data submission standards. Describe the modifications, deletions, or reformatting using specific data field names and examples. If a subcontractor prepares the encounter data submission for you, please specify the modifications made by the subcontractor and

additional modifications made by the MCO separately. *Note: The first row of the table is provided as an example. The table can be expanded if additional rows are required.*

Data Type	Field	Modification Details	Modification Made By
Vision Claims	*Provider ID*	*Zeros are added to the beginning of values in the Provider ID field to pad the results to a standard length of characters (e.g., 00003126).*	*MCO*

6. Please specify how you prepare/enrich data elements that are not on the claims from providers but required by DHCFP. Describe the source of the data and process to create these data elements. If a subcontractor prepares the encounter data submission for you, please specify the modifications made by the subcontractor and additional modifications made by Molina separately. *Note: The first row of the table is provided as an example. The table can be expanded if additional rows are required.*

Data Type	Field	Source Data and Creation Process	Modification Made By
Professional Claims	*Taxonomy Code*	*Obtain taxonomy codes from a reference file by linking with provider NPI and procedure code.*	*MCO*

7. Describe the data checks regarding the completeness and accuracy of a data element for each type of claims and the percentage of validated claims. *Note: The first row of the table is provided as an example. The table can be expanded if additional rows are required.*

Types of Claims/Data Elements Validated	Description of Validation Performed	Percentage of Claims Validated
Vision/Diagnosis codes	*Validate code is accurate against reference table.*	*99%*

Types of Claims/Data Elements Validated	Description of Validation Performed	Percentage of Claims Validated

8. Describe any code and/or field mapping performed during data processing and **validation** prior to adjudicating claims for payment processing, including those maintained by vendors/subcontractors, as appropriate. *Note: The first row of the table is provided as an example. The table can be expanded if additional rows are required.*

Field	Description of Mapping	Source of Reference Table	Frequency of Updating Reference Table
Rendering Provider NPI	*Map to reference table*	*Provider enrollment file*	*Quarterly*

9. Describe any code and/or field mapping performed during data processing for **submission** to DHCFP, including codes and/or fields maintained by vendors/ subcontractors, as appropriate. *Note: The first row of the table is provided as an example. The table can be expanded if additional rows are required.*

Field	Description of Mapping	Source of Reference Table	Frequency of Updating Reference Table
Subcontractor ID	*Map to correct value assigned by DHCFP for each program and sender*	*N/A*	*Whenever change occurs*

10. Describe the process to identify duplicate claims. Provide details on the fields used to identify duplicates, where in the process the duplicates are identified, and how they are handled for each category of service.

837 Professional
837 Institutional
NCPDP

11. Describe the types of claims/encounters that are not submitted to DHCFP (e.g., paid, denied, voided, adjusted claims).

12. What is the process to submit denied or partially denied claims/encounters to DHCFP.

13. Describe the process to submit adjustments/replacements/voids/corrections (collectively referred to as adjustments) to encounters that have previously been submitted to DHCFP.

13a. What is the process to identify encounters for which adjustments are required?	

13b. Describe the process to submit adjustments.	
13c. How long does it take from identification to re-submission for encounters needing adjustments?	
13d. If adjustments are not submitted, describe why these encounters were not submitted.	

14. The following questions address the collection, use, and submission of **provider data** and **enrollment data**.

Provider Data	
14a. Data collected and maintained by?	☐ By the MCO ☐ By a subcontractor ☐ By both
14b. List the name of the subcontractor and the type of data maintained (e.g., Subcontractor X for all vision services)	
14c. List Molina's and the subcontractor's responsibilities in collecting and maintaining the data.	
14d. Describe the flow of data from collection to maintenance including processes associated with the subcontractor	
14e. Describe the process for linking data to claims/encounters including any procedures for reconciling differences between data submitted on the claim/encounter and your provider data	

Enrollment data	
14f. Data collected and maintained by?	☐ By the MCO ☐ By a subcontractor ☐ By both
14g. List the name of the subcontractor and the type of data maintained (e.g., Subcontractor X for all vision services)	
14h. List Molina's and the subcontractor's responsibilities in collecting and maintaining the data	
14i. Describe the flow of data from collection to maintenance including processes associated with the subcontractor	
14j. Describe the process for linking data to claims/encounters including any procedures for reconciling differences between the data submitted on the claim/encounter and your enrollment data	

Section B: Data Exchange Policies and Procedures

Contact person for this section (Name and Title)	
Contact Information (Phone Number and Email)	

Please note that if your staff members use an electronic version of this questionnaire, the response boxes are expandable. Do not worry about pagination. If supplemental files or supporting documents are provided, please note the filename in your response.

1. Describe the encounter data submission process used by Molina. Include details outlining the organizational and operational policies and procedures related to your encounter data submissions and how you enforce the policies and procedures.

1a. What is the frequency of encounter submission to DHCFP?	
1b. Are encounters submitted directly or through a subcontractor?	
1c. Describe the encounter submission process.	
1d. Describe the policies and procedures related to the encounter submission process.	
1e. How are these measures described above enforced?	

2. List the point(s) of contact at Molina and their role in the encounter data submission processes to DHCFP.
Note: The table can be expanded if additional rows are required.

Point of Contact	Description of Data Submission Responsibility

Section C: Payment Structures of Encounter Data

Contact person for this section (Name and Title)	
Contact Information (Phone Number and Email)	

Please note that if your staff members use an electronic version of this questionnaire, the response boxes are expandable. Do not worry about pagination. If supplemental files or supporting documents are provided, please note the filename in your response.

1. How are claims paid (e.g., percent of billed, line-by-line, case rate, etc.)? If different methods exist, please add to the table below and then list them by percentage of claim dollars for each payment type.

Payment Type	Inpatient	Outpatient	Pharmacy	Long Term Care
Percent of Billed				
Line-by-line				
Per-diem				
Variable Per Diem				
Capitation				
DRG				
Negotiated (Flat) Rate				
Ingredient Cost (for Pharmacy)				
Other (Please describe)				
Other (Please describe)				
Total	**100%**	**100%**	**100%**	**100%**

2. How are each of the payment arrangements listed above reflected in the encounter data submissions? If outpatient visits are paid through sub-capitated arrangements, how does Molina determine the paid amount submitted to DHCFP?

Inpatient	
Outpatient	

Pharmacy	
Long Term Care	

3. Are any services submitted to the MCO under bundle-payment structures? If so, what services are submitted for bundled-payments? For example, if delivery services are considered bundle payments, please specify whether encounters on both delivery and all prenatal/postpartum services are collected by Molina.

4. What is the process for collecting coordination of benefits/third party liability (TPL) data? Additionally, what is the process for submitting encounters with TPL payments. Provide separate responses for different types of claims including pharmacy encounters.

4a. How are other insurance data collected? Are your subcontractors required to collect other insurance data?	
4b. How are claims processed with TPL? How is the process different if other insurance is submitted after the initial claim processing?	
4c. What source of data is used to verify the accuracy of the third-party claims information? Where do you store payment information and the source data? How is third party information populated into encounters submitted to DHCFP?	
4d. What are the measures taken to ensure the accuracy of the TPL payment amount?	

5. Describe the process to capture, monitor accuracy, and submit zero-pay claims to DHCFP.

5a. What scenarios create zero-pay amounts for Molina (e.g., full payment by TPL, exceeding Molina's allowed amount)?	
5b. How are zero-pay claims reflected in the encounter data, if at all? If not, please elaborate.	
5c. Are zero-pay claims for sub-capitated providers processed and submitted to DHCFP? If so, describe how the completeness and accuracy of the claims are assessed.	

6. What is the process for submitting pricing information to DHCFP on capitated claims?

Section D: Encounter Data Quality Monitoring and Reporting

Contact person for this section (Name and Title)	
Contact Information (Phone Number and Email)	

Please note that if your staff members use an electronic version of this questionnaire, the response boxes are expandable. Do not worry about pagination. If supplemental files or supporting documents are provided, please note the filename in your response.

This section focuses on the quality checks **performed by Molina or its subcontractor(s)** regarding the claims/encounter data in your data warehouse. This section focuses on the claims/encounter data before Molina prepares the data for submission to DHCFP. Specifically, the claims/encounter data referenced in this section are the source data used to prepare for encounter submissions to DHCFP.

The table below shows a brief description for these checks. If the checks from the drop-down list are not appropriate for Molina, please choose "Other" and then include the details in the "Description" column.

Data Quality Checks in Drop-Down List	Description
Claim Volume by Submission Month	Evaluates the number of unique claims based on the month when the claims were submitted to your entity. Please describe the specifications for the counts and any stratifications you may use.
Claim Volume PMPM	Evaluates the number of unique claims per member per month based on the month when the services occurred. Please describe the specifications for the counts and any stratifications you may use.
Field-Level Completeness	Evaluates whether there are any missing and/or extra values for a specific data element. Please provide a list of variables and specifications for the evaluation.
Field-Level Validity	Evaluates whether the values for a specific data element are valid. Please provide a list of variables and specifications for the evaluation.
Timeliness	Evaluates whether the source entity submits claims to your MCO in a timely manner.
Reconciliation with Financial Reports	Evaluates whether the payment fields in the claims align with the financial reports from your MCO.
EDI Compliance Edits	Evaluates whether 837 professional and 837 institutional files pass the EDI compliance edits. Please describe the WEDI SNIP levels that are used in the EDI compliance checks.
Medical Record Review	Evaluates whether some of the data elements in the claims are complete and accurate when comparing to the medical records.

1. Upon receiving claims/encounter files from your subcontractors, please use the table below to indicate the following for each subcontractor:

- Column 2: Does Molina store the claims/encounter files from subcontractors in its data warehouse?
- Column 3: Does Molina perform any quality checks on the claims/encounter files from subcontractors **before** submitting them to DHCFP? If not, please provide an explanation why the quality checks are not performed in the second box below.
- Column 4: Does Molina modify the claims/encounter files from subcontractors **before** submitting them to DHCFP?
- Column 5: Does Molina perform any quality checks on the claims/encounter data from subcontractors **after** submitting them to DHCFP?

Subcontractor	Stored by Molina	Reviewed by Molina Before Submission	Modified by Molina Before Submission	Reviewed by Molina After Submission
Pharmacy	*Yes*	*No*	*No*	*Yes*
Professional	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Institutional	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Pharmacy	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Vision	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Non-Emergency Transportation	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Other (*list and describe)*	Choose an item.	Choose an item.	Choose an item.	Choose an item.

Subcontractor	Explanation Why Claims/Encounter Data are Not Reviewed by Molina Before Submission to DHCFP
Pharmacy	*Molina is satisfied with the quality checks that the subcontractor has in place.*
Professional	
Institutional	
Pharmacy	
Vision	
Non-Emergency Transportation	
Other (*list and describe)*	

2. If Molina currently performs quality checks on the claims/encounter data from an **837 Institutional** subcontractor, please select the specific checks/validation, and include its description, frequency, and example reports. *Note: You can select from the drop-down list. The grey shaded row in the table is provided as an example. The table can be expanded if additional rows are required.*

Data Quality Checks	Description	Frequency	Supporting Documents
Claim Volume PMPM	*Calculate number of claims PMPM*	*Quarterly*	*Monitoring_2020Q1.pdf*
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>

3. If Molina currently performs quality checks on the claims/encounter data from an **837 Professional** subcontractor, please select the specific checks/validation, and include its description, frequency, and example reports. *Note: You can select from the drop-down list. The grey shaded row in the table is provided as an example. The table can be expanded if additional rows are required.*

Data Quality Checks	Description	Frequency	Supporting Documents
Claim Volume PMPM	*Calculate number of claims PMPM*	*Quarterly*	*Monitoring_2020Q1.pdf*
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>

4. If Molina currently performs quality checks on the claims/encounter data from a **Pharmacy** subcontractor, please select the specific checks/validation, and include its description, frequency, and example reports. *Note: You can select from the drop-down list. The grey shaded row in the table is provided as an example. The table can be expanded if additional rows are required.*

Data Quality Checks	Description	Frequency	Supporting Documents
Claim Volume PMPM	*Calculate number of claims PMPM*	*Quarterly*	*Monitoring_2020Q1.pdf*

Data Quality Checks	Description	Frequency	Supporting Documents
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>

5. If Molina currently performs quality checks on the claims/encounter data from a **Vision** subcontractor, please select the specific checks/validation, and include its description, frequency, and example reports. *Note: You can select from the drop-down list. The grey shaded row in the table is provided as an example. The table can be expanded if additional rows are required.*

Data Quality Checks	Description	Frequency	Supporting Documents
Claim Volume PMPM	*Calculate number of claims PMPM*	*Quarterly*	*Monitoring_2020Q1.pdf*
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>

6. If Molina currently performs quality checks on the claims/encounter data from a **NEMT** subcontractor, please select the specific checks/validation, and include its description, frequency, and example reports. *Note: You can select from the drop-down list. The grey shaded row in the table is provided as an example. The table can be expanded if additional rows are required.*

Data Quality Checks	Description	Frequency	Supporting Documents
Claim Volume PMPM	*Calculate number of claims PMPM*	*Quarterly*	*Monitoring_2020Q1.pdf*
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>

7. If Molina currently performs quality checks on the claims/encounter data from **Another** subcontractor, please select the specific checks/validation, and include its description, frequency, and example reports. *Note: You can select from the drop-down list. The grey shaded row in the table is provided as an example. The table can be expanded if additional rows are required.*

Data Quality Checks	Description	Frequency	Supporting Documents
Claim Volume PMPM	*Calculate number of claims PMPM*	*Quarterly*	*Monitoring_2020Q1.pdf*
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>

8. Does Molina conduct quality checks on the encounter data submitted to DHCFP that are not listed in items 2 through 7 in this section?
   - ☐ Yes (Proceed to the table below.)
   - ☐ No (If No, please provide an explanation why the quality checks were not performed in the box below.)
   - ☐ Don't know (If you don't know, please provide an explanation in the box below.)

Click or tap here to enter text.

If Yes, please select the specific checks/validation, and include its description, frequency, and example reports. *Note: You can select from the drop-down list. The grey shaded row in the table is provided as an example. The table can be expanded if additional rows are required.*

Data Quality Checks	Description	Frequency	Supporting Documents
Claim Volume PMPM	*Calculate number of claims PMPM*	*Quarterly*	*Monitoring_2020Q1.pdf*
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>
Choose an item.	Click or tap here to enter text.	Choose an item.	<insert file name>

9. Using the table below, please identify which transaction response files are used to support your encounter data submission activities and how the responses are tracked in your data system.

   - If the transaction responses are used to support encounter data submission activities, please explain the reason why in the last column and whether the transaction responses are stored in Molina's data system. *Note: The table can be expanded if additional rows are required.*

   - If the transaction responses are **not** used to support encounter data submission activities, please explain the reason why in the last column and whether the transaction responses are stored in Molina's s data system. *Note: The table can be expanded if additional rows are required.*

Transaction Response Files	Used to Support Encounter Data Submission?	Explanation of Transaction Response Use and Storage in the MCO's Data System
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

10. List the average rejection/pend percentage during calendar year 2023, for the different types of claims/encounters. If the rejection percentage is not available for each claim type, please populate "N/A" in the first row and the average overall percentage in the last row.

Claim/Encounter	Percentage of encounters submitted to DHCFP that are rejected by DHCFP's EDI translator	Percentage of encounters submitted to DHCFP that pass EDI translator but fail the DHCFP's encounter edit
Institutional		
Professional		
Pharmacy		
<Insert - Subcontractor>		

Claim/Encounter	Percentage of encounters submitted to DHCFP that are rejected by DHCFP's EDI translator	Percentage of encounters submitted to DHCFP that pass EDI translator but fail the DHCFP's encounter edit
Overall Rate		

11. What are Molina's processes for reconciling files rejected by DHCFP's EDI translator including key policies and procedures for:
    - Identification
    - Correction,
    - Resubmission of encounters to DHCFP

12. What are Molina's processes for reconciling transactions that fail DHCFP's encounter edits including key policies procedures for:
    - Identification
    - Correction
    - Subsequent resubmission of these encounters to DHCFP

13. How are the data in Molina's encounter data system/data warehouse used (e.g., rate-setting, HEDIS reporting, etc.)?

14. What internal challenges do you face in submitting encounter data to DHCFP? For example, are data dictionaries difficult to maintain/keep up to date? Are staff sufficiently trained for updates to the data warehouse?

15. What external challenges do you face in submitting encounter data to DHCFP? For example, are there challenges with DHCFP's EDI translator or DHCFP's encounter edits.

16. What changes in processes, resources, and/or support from DHCFP would help overcome internal and external challenges with encounter data submission to DHCFP?

17. Do you anticipate any changes to your encounter submission process that may impact your answers to the previous questions? When are they likely to become effective?

Attestation Statement

I hereby certify that I have reviewed the information entered on this questionnaire and that, to the best of my knowledge, the information is complete and accurate as of the date below.

_____ _____

Signature of CEO or responsible individual Date

_____

Print name and title

Appendix B. Statewide Comparative Analysis and Medical/Dental Record Review Results

For professional, institutional, and pharmacy encounters, this appendix contains detailed MCO statewide comparative analysis and medical record review results for the four MCOs. For the dental encounters, this appendix shows the results for **LIBERTY** since it is the only DBA.

Comparative Analysis

Table B-1—Statewide Record Omission and Surplus by Encounter Type

	Record Omission			Record Surplus		
Encounter Data Source	Denominator	Numerator	Rate*	Denominator	Numerator	Rate*
Professional	323,127	15,251,132	2.1%	578,986	15,506,991	3.7%
Institutional	148,659	5,465,900	2.7%	303,020	5,620,261	5.4%
Pharmacy	14,946	8,261,210	0.2%	219,741	8,466,005	2.6%
Dental	4,618	2,357,938	0.2%	43,751	2,397,071	1.8%

* Lower rates indicate better performance.

Table B-2—Statewide Element Omission, Surplus, and Missing, by Key Data Element—Professional Encounters

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCEs' Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Number of Matched Records: 14,928,005						
Recipient ID	40,848	0.3%	276	<0.1%	0	0.0%
Header Service From Date	0	0.0%	0	0.0%	0	0.0%
Header Service To Date	0	0.0%	0	0.0%	0	0.0%
Detail Service From Date	0	0.0%	0	0.0%	0	0.0%
Detail Service To Date	0	0.0%	0	0.0%	0	0.0%
Billing Provider NPI	0	0.0%	1,415	<0.1%	0	0.0%
Rendering Provider NPI	118,460	0.8%	72	<0.1%	16	<0.1%
Referring Provider NPI^	22,507	0.2%	19,236	0.1%	7,387,631	49.5%
Primary Diagnosis Code	0	0.0%	0	0.0%	0	0.0%

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCEs' Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Secondary Diagnosis Codes[1,^]	24	<0.1%	411,939	2.8%	5,277,784	35.4%
Procedure Code	288	<0.1%	3	<0.1%	2	<0.1%
Procedure Code Modifier(s)[2,^]	769	<0.1%	4,004	<0.1%	10,809,933	72.4%
Units of Service	0	0.0%	0	0.0%	0	0.0%
POS Code	0	0.0%	0	0.0%	0	0.0%
NDC^	40,541	0.3%	642	<0.1%	14,340,671	96.1%
Drug Quantity	0	0.0%	0	0.0%	0	0.0%
Header Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail Paid Amount	0	0.0%	0	0.0%	0	0.0%
Header TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Paid Date	0	0.0%	0	0.0%	0	0.0%

* Lower rates indicate better performance.
+ Indicates that the element was not populated in either data source.
^ Indicates that the data field is situational (i.e., not required for every encounter line).
[1] All submitted secondary diagnosis codes were ordered alphabetically and numerically, then concatenated as a single data element.
[2] All submitted procedure code modifiers were ordered alphabetically and numerically, then concatenated as a single data element.

Table B-3—Statewide Element Omission, Surplus, and Missing, by Key Data Element—Institutional Encounters

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCEs' Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Number of Matched Records: 5,317,241						
Recipient ID	0	0.0%	149	<0.1%	0	0.0%
Header Service From Date	0	0.0%	0	0.0%	0	0.0%
Header Service To Date	0	0.0%	0	0.0%	0	0.0%

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCEs' Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Detail Service From Date	0	0.0%	0	0.0%	0	0.0%
Detail Service To Date	0	0.0%	0	0.0%	0	0.0%
Admission Date^	596,168	11.2%	451	<0.1%	3,751,426	70.6%
Discharge Status	0	0.0%	1,291	<0.1%	0	0.0%
Billing Provider NPI	0	0.0%	9	<0.1%	0	0.0%
Attending Provider NPI	129,538	2.4%	11,149	0.2%	797	<0.1%
Referring Provider NPI^	191	<0.1%	0	0.0%	5,237,742	98.5%
Primary Diagnosis Code	0	0.0%	29	<0.1%	0	0.0%
Secondary Diagnosis Code(s)[1,^]	182,519	3.4%	5	<0.1%	397,420	7.5%
Procedure Code^	1,302	<0.1%	5,465	0.1%	1,557,169	29.3%
Procedure Code Modifier(s)[2,^]	4,114	0.1%	6,681	0.1%	4,531,221	85.2%
Units of Service	0	0.0%	0	0.0%	0	0.0%
Revenue Code	0	0.0%	296	<0.1%	0	0.0%
Surgical Procedure Code(s)[3,^]	1,617	<0.1%	0	0.0%	4,720,008	88.8%
TOB Code	0	0.0%	0	0.0%	0	0.0%
NDC^	82,728	1.6%	6,348	0.1%	4,293,334	80.7%
Drug Quantity^	0	0.0%	0	0.0%	0	0.0%
Header Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail Paid Amount	0	0.0%	0	0.0%	0	0.0%
Header TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Paid Date	0	0.0%	0	0.0%	0	0.0%

* Lower rates indicate better performance.
+ Indicates that the element was not populated in either data source.
^ Indicates that the data field is situational (i.e., not required for every encounter line).
[1] All submitted secondary diagnosis codes were ordered alphabetically and numerically, then concatenated as a single data element.
[2] All submitted procedure code modifiers were ordered alphabetically and numerically, then concatenated as a single data element.
[3] All submitted surgical procedure codes were ordered alphabetically and numerically, then concatenated as a single data element.

Table B-4—Statewide Element Omission, Surplus, and Missing, by Key Data Element—Pharmacy Encounters

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCOs' Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Number of Matched Records: 8,246,264						
Recipient ID	10,877	0.1%	11	<0.1%	0	0.0%
Date of Service	0	0.0%	0	0.0%	0	0.0%
Billing Provider NPI	0	0.0%	0	0.0%	0	0.0%
Prescribing Provider NPI	276,529	3.4%	0	0.0%	185	<0.1%
NDC	0	0.0%	0	0.0%	0	0.0%
Drug Quantity	0	0.0%	0	0.0%	0	0.0%
Days of Supply	0	0.0%	3	<0.1%	0	0.0%
Paid Amount	0	0.0%	0	0.0%	0	0.0%
TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Paid Date	0	0.0%	0	0.0%	0	0.0%

* Lower rates indicate better performance.
+ Indicates that the element was not populated in either data source.

Table B-5—LIBERTY Element Omission, Surplus, and Missing, by Key Data Element—Dental Encounters

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in LIBERTY's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Number of Matched Records: 2,353,320						
Recipient ID	5,580	0.2%	0	0.0%	0	0.0%
Header Service From Date	0	0.0%	0	0.0%	0	0.0%
Header Service To Date	0	0.0%	0	0.0%	0	0.0%
Detail Service From Date	0	0.0%	0	0.0%	0	0.0%
Detail Service To Date	0	0.0%	0	0.0%	0	0.0%
Billing Provider NPI	0	0.0%	0	0.0%	0	0.0%

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in LIBERTY's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Rendering Provider NPI	6,124	0.3%	0	0.0%	0	0.0%
Referring Provider NPI^	0	0.0%	0	0.0%	2,353,320	100%
All Diagnosis Codes[1]	0	0.0%	64,117	2.7%	45,404	1.9%
Procedure Code	2	<0.1%	0	0.0%	0	0.0%
Units of Service	0	0.0%	0	0.0%	0	0.0%
POS Code	1	<0.1%	0	0.0%	0	0.0%
Tooth Number^	0	0.0%	0	0.0%	1,424,929	60.5%
Tooth Surface Codes[2,^]	92	<0.1%	0	0.0%	2,151,994	91.4%
Oral Cavity Codes[3,^]	35	<0.1%	0	0.0%	2,166,729	92.1%
Header Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail Paid Amount	0	0.0%	0	0.0%	0	0.0%
Paid Date	0	0.0%	0	0.0%	0	0.0%

* Lower rates indicate better performance.
+ Indicates that the element was not populated in either data source.
^ Indicates that the data field is situational (i.e., not required for every encounter line).
[1] All submitted diagnosis codes at the line level were aggregated to the header level, then ordered alphabetically and numerically, and then concatenated as a single data element.
[2] All submitted tooth surface codes were ordered alphabetically and numerically, then concatenated as a single data element.
[3] All submitted oral cavity codes were ordered alphabetically and numerically, then concatenated as a single data element.

Table B-6—Statewide Element Accuracy—Professional Encounters

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Recipient ID	14,886,881	14,885,605	>99.9%
Header Service From Date	14,928,005	14,927,306	>99.9%
Header Service To Date	14,928,005	14,927,872	>99.9%
Detail Service From Date	14,928,005	14,805,980	99.2%
Detail Service To Date	14,928,005	14,803,795	99.2%
Billing Provider NPI	14,926,590	14,816,464	99.3%
Rendering Provider NPI	14,809,457	14,545,682	98.2%
Referring Provider NPI	7,498,631	7,498,625	>99.9%

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Primary Diagnosis Code	14,928,005	14,651,195	98.1%
Secondary Diagnosis Codes[1]	9,238,258	8,907,899	96.4%
Procedure Code	14,927,712	14,909,571	99.9%
Procedure Code Modifier(s)[2]	4,113,299	4,112,543	>99.9%
Units of Service	14,928,005	13,869,975	92.9%
POS Code	14,928,005	14,843,999	99.4%
NDC	546,151	545,907	>99.9%
Drug Quantity	14,928,005	14,884,892	99.7%
Header Paid Amount	14,928,005	14,840,962	99.4%
Detail Paid Amount	14,928,005	14,849,517	99.5%
Header TPL Paid Amount	14,928,005	14,838,809	99.4%
Detail TPL Paid Amount	14,928,005	14,723,902	98.6%
Paid Date	14,928,005	10,029,103	67.2%

[1] All submitted secondary diagnosis codes were ordered alphabetically and numerically, then concatenated as a single data element.
[2] All submitted procedure code modifiers were ordered alphabetically and numerically, then concatenated as a single data element.

Table B-7—Statewide Element Accuracy—Institutional Encounters

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Recipient ID	5,317,092	5,316,755	>99.9%
Header Service From Date	5,317,241	5,314,906	>99.9%
Header Service To Date	5,317,241	5,288,062	99.5%
Detail Service From Date	5,317,241	5,187,033	97.6%
Detail Service To Date	5,317,241	5,173,039	97.3%
Admission Date	969,196	969,196	100%
Discharge Status	5,315,950	5,314,272	>99.9%
Billing Provider NPI	5,317,232	5,316,962	>99.9%
Attending Provider NPI	5,175,757	5,174,754	>99.9%
Referring Provider NPI	79,308	79,308	100%
Primary Diagnosis Code	5,317,212	5,193,706	97.7%
Secondary Diagnosis Code(s)[1]	4,737,297	2,723,784	57.5%

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Procedure Code	3,753,305	3,715,594	99.0%
Procedure Code Modifier(s)[2]	775,225	773,917	99.8%
Units of Service	5,317,241	4,346,336	81.7%
Revenue Code	5,316,945	5,290,661	99.5%
Surgical Procedure Code(s)[3]	595,616	340,158	57.1%
TOB Code	5,317,241	4,947,962	93.1%
NDC	934,831	930,199	99.5%
Drug Quantity	5,317,241	5,279,927	99.3%
Header Paid Amount	5,317,241	5,307,656	99.8%
Detail Paid Amount	5,317,241	5,286,758	99.4%
Header TPL Paid Amount	5,317,241	5,297,561	99.6%
Detail TPL Paid Amount	5,317,241	5,290,028	99.5%
Paid Date	5,317,241	3,512,120	66.1%

[1] All submitted secondary diagnosis codes were ordered alphabetically and numerically, then concatenated as a single data element.
[2] All submitted procedure code modifiers were ordered alphabetically and numerically, then concatenated as a single data element.
[3] All submitted secondary surgical procedure codes were ordered alphabetically and numerically, then concatenated as a single data element.

Table B-8—Statewide Element Accuracy—Pharmacy Encounters

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Recipient ID	8,235,376	8,235,198	>99.9%
Date of Service	8,246,264	8,246,264	100%
Billing Provider NPI	8,246,264	8,246,172	>99.9%
Prescribing Provider NPI	7,969,550	7,969,149	>99.9%
NDC	8,246,264	8,243,603	>99.9%
Drug Quantity	8,246,264	8,241,713	99.9%
Days of Supply	8,246,261	8,246,261	100%
Paid Amount	8,246,264	8,246,264	100%
TPL Paid Amount	8,246,264	8,220,292	99.7%
Paid Date	8,246,264	8,246,264	100%

Table B-9—LIBERTY Element Accuracy—Dental Encounters

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Recipient ID	2,347,740	2,347,532	>99.9%
Header Service From Date	2,353,320	2,353,314	>99.9%
Header Service To Date	2,353,320	2,353,314	>99.9%
Detail Service From Date	2,353,320	2,353,314	>99.9%
Detail Service To Date	2,353,320	2,353,143	>99.9%
Billing Provider NPI	2,353,320	2,239,404	95.2%
Rendering Provider NPI	2,347,196	2,346,032	>99.9%
Referring Provider NPI	0	0	—
All Diagnosis Codes[1]	2,243,799	2,219,435	98.9%
Procedure Code	2,353,318	2,353,253	>99.9%
Units of Service	2,353,320	2,353,320	100%
POS Code	2,353,319	2,352,740	>99.9%
Tooth Number	928,391	928,372	>99.9%
Tooth Surface Codes[2]	201,234	201,224	>99.9%
Oral Cavity Codes[3]	186,556	186,266	99.8%
Header Paid Amount	2,353,320	2,351,444	99.9%
Detail Paid Amount	2,353,320	2,352,811	>99.9%
Paid Date	2,353,320	2,353,095	>99.9%

[1] All submitted diagnosis codes at the line level were aggregated to the header level, then ordered alphabetically and numerically, and then concatenated as a single data element.
[2] All submitted tooth surface codes were ordered alphabetically and numerically, then concatenated as a single data element.
[3] All submitted oral cavity codes were ordered alphabetically and numerically, then concatenated as a single data element.

Table B-10—Statewide All-Element Accuracy by Encounter Type

Encounter Type	Number of Records in Both Files	Number of Records With Same Values in Both Files	Rate
Professional	14,928,005	8,398,648	56.3%
Institutional	5,317,241	1,809,266	34.0%
Pharmacy	8,246,264	7,930,338	96.2%
Dental	2,353,320	2,141,214	91.0%

Medical Record Review Results

Table B-11—Medical Record Review: Encounter Data Completeness for All MCOs

	Medical Record Omission		Encounter Data Omission	
Data Element	Denominator	Percent*	Denominator	Percent*
Date of Service	2,179	16.6%	1,860	2.3%
Diagnosis Code	5,994	17.9%	4,990	1.4%
Procedure Code	5,126	25.5%	3,881	1.6%
Procedure Code Modifier	1,906	29.6%	1,364	1.7%

* Lower rates indicate better performance.

Table B-12—Medical Record Review: Encounter Data Completeness for LIBERTY

	Medical Record Omission		Encounter Data Omission	
Data Element	Denominator	Percent*	Denominator	Percent*
Date of Service	471	1.7%	473	2.1%
Diagnosis Code	760	13.8%	665	1.5%
Procedure Code	2,502	5.2%	2,382	0.4%

* Lower rates indicate better performance.

Table B-13—Medical Record Review: Encounter Data Accuracy for All MCOs

Data Element	Denominator	Percent	Main Error Type
Diagnosis Code[1]	4,920	99.6%	Incorrect Code: (95.0%) Specificity Error: (5.0%)
Procedure Code[2]	3,819	95.6%	Incorrect Code: (97.0%) Higher Level of Service in Medical Record: (2.4%) Lower Level of Service in Medical Record: (0.6%)
Procedure Code Modifier	1,341	99.3%	—
All-Element Accuracy[3]	1,818	72.2%	—

"—" denotes that the error type analysis was not applicable to a given data element.

[1] Inaccurate coding and specificity errors in service records were collectively considered as the denominator for the error type rates.

[2] Inaccurate coding, codes with higher level of services, and codes with lower level of services in service records were collectively considered as the denominator for the error type rates.

[3] The denominator for the element accuracy rate for each data element was defined differently from the denominator for the all-element accuracy rate. Therefore, the all-element accuracy rate could not be derived from the accuracy rate from each data element.

Table B-14—Medical Record Review: Encounter Data Accuracy for LIBERTY

Data Element	Denominator	Percent	Main Error Type
Diagnosis Code[1]	655	71.6%	Incorrect Code: (100%) Specificity Error: (0.0%)
Procedure Code[2]	2,472	94.1%	Incorrect Code: (100%) Higher Level of Service in Medical Record: (0.0%) Lower Level of Service in Medical Record: (0.0%)
All-Element Accuracy[3]	463	37.6%	—

"—" denotes the error type analysis was not applicable to the data element.
[1] Inaccurate coding and specificity errors in service records were collectively considered as the denominator for the error type rates.
[2] Inaccurate coding, codes with higher level of services, and codes with lower level of services in service records were collectively considered as the denominator for the error type rates.
[3] The denominator for the element accuracy rate for each data element was defined differently from the denominator for the all-element accuracy rate. Therefore, the all-element accuracy rate could not be derived from the accuracy rate from each data element.

Appendix C. Comparative Analysis and Medical Record Review Results for Anthem Blue Cross and Blue Shield Healthcare Solutions

This appendix contains detailed comparative analysis and medical record review results for **Anthem**.

Comparative Analysis Results

Table C-1—Record Omission and Surplus by Encounter Type

	Record Omission			Record Surplus		
Encounter Data Source	Denominator	Numerator	Rate*	Denominator	Numerator	Rate*
Professional	80,187	5,084,655	1.6%	290,284	5,294,752	5.5%
Institutional	31,131	1,819,585	1.7%	89,118	1,877,572	4.7%
Pharmacy	2,132	3,451,190	0.1%	9,154	3,458,212	0.3%

* Lower rates indicate better performance.

Table C-2—Element Omission, Surplus, and Missing, by Key Data Element—Professional Encounters

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCO's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Number of Matched Records: 5,004,468						
Recipient ID	17,982	0.4%	0	0.0%	0	0.0%
Header Service From Date	0	0.0%	0	0.0%	0	0.0%
Header Service To Date	0	0.0%	0	0.0%	0	0.0%
Detail Service From Date	0	0.0%	0	0.0%	0	0.0%
Detail Service To Date	0	0.0%	0	0.0%	0	0.0%
Billing Provider NPI	0	0.0%	0	0.0%	0	0.0%
Rendering Provider NPI	47,199	0.9%	0	0.0%	0	0.0%
Referring Provider NPI^	0	0.0%	0	0.0%	2,549,496	50.9%
Primary Diagnosis Code	0	0.0%	0	0.0%	0	0.0%
Secondary Diagnosis Codes[1,^]	0	0.0%	0	0.0%	1,800,989	36.0%
Procedure Code	17	<0.1%	0	0.0%	0	0.0%

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCO's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Procedure Code Modifier(s)[2,^]	0	0.0%	0	0.0%	3,649,922	72.9%
Units of Service	0	0.0%	0	0.0%	0	0.0%
POS Code	0	0.0%	0	0.0%	0	0.0%
NDC^	12,928	0.3%	0	0.0%	4,809,339	96.1%
Drug Quantity	0	0.0%	0	0.0%	0	0.0%
Header Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail Paid Amount	0	0.0%	0	0.0%	0	0.0%
Header TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Paid Date	0	0.0%	0	0.0%	0	0.0%

* Lower rates indicate better performance.
+ Indicates that the element was not populated in either data source.
^ Indicates that the data field is situational (i.e., not required for every encounter line).
[1] All submitted secondary diagnosis codes were ordered alphabetically and numerically, then concatenated as a single data element.
[2] All submitted procedure code modifiers were ordered alphabetically and numerically, then concatenated as a single data element.

Table C-3—Element Omission, Surplus, and Missing, by Key Data Element—Institutional Encounters

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCO's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Number of Matched Records: 1,788,454						
Recipient ID	0	0.0%	0	0.0%	0	0.0%
Header Service From Date	0	0.0%	0	0.0%	0	0.0%
Header Service To Date	0	0.0%	0	0.0%	0	0.0%
Detail Service From Date	0	0.0%	0	0.0%	0	0.0%
Detail Service To Date	0	0.0%	0	0.0%	0	0.0%

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCO's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Admission Date^	0	0.0%	0	0.0%	1,474,390	82.4%
Discharge Status	0	0.0%	0	0.0%	0	0.0%
Billing Provider NPI	0	0.0%	0	0.0%	0	0.0%
Attending Provider NPI	58,099	3.2%	0	0.0%	315	<0.1%
Referring Provider NPI^	0	0.0%	0	0.0%	1,762,781	98.6%
Primary Diagnosis Code	0	0.0%	0	0.0%	0	0.0%
Secondary Diagnosis Code(s) [1,^]	104,969	5.9%	0	0.0%	102,552	5.7%
Procedure Code^	132	<0.1%	0	0.0%	510,755	28.6%
Procedure Code Modifier(s)[2,^]	0	0.0%	0	0.0%	1,497,313	83.7%
Units of Service	0	0.0%	0	0.0%	0	0.0%
Revenue Code	0	0.0%	0	0.0%	0	0.0%
Surgical Procedure Code(s)[3,^]	0	0.0%	0	0.0%	1,593,854	89.1%
TOB Code	0	0.0%	0	0.0%	0	0.0%
NDC^	23,678	1.3%	0	0.0%	1,461,966	81.7%
Drug Quantity^	0	0.0%	0	0.0%	0	0.0%
Header Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail Paid Amount	0	0.0%	0	0.0%	0	0.0%
Header TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Paid Date	0	0.0%	0	0.0%	0	0.0%

* Lower rates indicate better performance.
+ Indicates that the element was not populated in either data source.
^ Indicates that the data field is situational (i.e., not required for every encounter line).
[1] All submitted secondary diagnosis codes were ordered alphabetically and numerically, then concatenated as a single data element.
[2] All submitted procedure code modifiers were ordered alphabetically and numerically, then concatenated as a single data element.
[3] All submitted surgical procedure codes were ordered alphabetically and numerically, then concatenated as a single data element.

Table C-4—Element Omission, Surplus, and Missing, by Key Data Element—Pharmacy Encounters

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCO's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Number of Matched Records: 3,449,058						
Recipient ID	5,494	0.2%	11	<0.1%	0	0.0%
Date of Service	0	0.0%	0	0.0%	0	0.0%
Billing Provider NPI	0	0.0%	0	0.0%	0	0.0%
Prescribing Provider NPI	121,792	3.5%	0	0.0%	44	<0.1%
NDC	0	0.0%	0	0.0%	0	0.0%
Drug Quantity	0	0.0%	0	0.0%	0	0.0%
Days of Supply	0	0.0%	3	<0.1%	0	0.0%
Paid Amount	0	0.0%	0	0.0%	0	0.0%
TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Paid Date	0	0.0%	0	0.0%	0	0.0%

* Lower rates indicate better performance.
+ Indicates that the element was not populated in either data source.

Table C-5—Element Accuracy—Professional Encounters

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Recipient ID	4,986,486	4,986,447	>99.9%
Header Service From Date	5,004,468	5,004,468	100%
Header Service To Date	5,004,468	5,004,468	100%
Detail Service From Date	5,004,468	5,004,468	100%
Detail Service To Date	5,004,468	5,004,468	100%
Billing Provider NPI	5,004,468	5,004,468	100%
Rendering Provider NPI	4,957,269	4,914,188	99.1%
Referring Provider NPI	2,454,972	2,454,972	100%
Primary Diagnosis Code	5,004,468	5,004,468	100%
Secondary Diagnosis Codes[1]	3,203,479	3,203,479	100%
Procedure Code	5,004,451	5,004,451	100%

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Procedure Code Modifier(s)[2]	1,354,546	1,354,546	100%
Units of Service	5,004,468	3,995,235	79.8%
POS Code	5,004,468	4,940,351	98.7%
NDC	182,201	182,201	100%
Drug Quantity	5,004,468	5,004,291	>99.9%
Header Paid Amount	5,004,468	5,004,468	100%
Detail Paid Amount	5,004,468	5,004,468	100%
Header TPL Paid Amount	5,004,468	5,003,520	>99.9%
Detail TPL Paid Amount	5,004,468	4,999,126	99.9%
Paid Date	5,004,468	200,423	4.0%

[1] All submitted secondary diagnosis codes were ordered alphabetically and numerically, then concatenated as a single data element.
[2] All submitted procedure code modifiers were ordered alphabetically and numerically, then concatenated as a single data element.

Table C-6—Element Accuracy—Institutional Encounters

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Recipient ID	1,788,454	1,788,422	>99.9%
Header Service From Date	1,788,454	1,788,454	100%
Header Service To Date	1,788,454	1,788,454	100%
Detail Service From Date	1,788,454	1,773,629	99.2%
Detail Service To Date	1,788,454	1,782,405	99.7%
Admission Date	314,064	314,064	100%
Discharge Status	1,788,454	1,788,454	100%
Billing Provider NPI	1,788,454	1,788,454	100%
Attending Provider NPI	1,730,040	1,729,989	>99.9%
Referring Provider NPI	25,673	25,673	100%
Primary Diagnosis Code	1,788,454	1,665,173	93.1%
Secondary Diagnosis Code(s)[1]	1,580,933	745,835	47.2%
Procedure Code	1,277,567	1,277,567	100%
Procedure Code Modifier(s)[2]	291,141	291,141	100%
Units of Service	1,788,454	862,768	48.2%

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Revenue Code	1,788,454	1,788,315	>99.9%
Surgical Procedure Code(s)[3]	194,600	110,227	56.6%
TOB Code	1,788,454	1,788,454	100%
NDC	302,810	302,810	100%
Drug Quantity	1,788,454	1,787,552	99.9%
Header Paid Amount	1,788,454	1,788,454	100%
Detail Paid Amount	1,788,454	1,788,454	100%
Header TPL Paid Amount	1,788,454	1,787,830	>99.9%
Detail TPL Paid Amount	1,788,454	1,788,184	>99.9%
Paid Date	1,788,454	0	0.0%

[1] All submitted secondary diagnosis codes were ordered alphabetically and numerically, then concatenated as a single data element.
[2] All submitted procedure code modifiers were ordered alphabetically and numerically, then concatenated as a single data element.
[3] All submitted secondary surgical procedure codes were ordered alphabetically and numerically, then concatenated as a single data element.

Table C-7—Element Accuracy—Pharmacy Encounters

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Recipient ID	3,443,553	3,443,532	>99.9%
Date of Service	3,449,058	3,449,058	100%
Billing Provider NPI	3,449,058	3,449,058	100%
Prescribing Provider NPI	3,327,222	3,327,184	>99.9%
NDC	3,449,058	3,448,016	>99.9%
Drug Quantity	3,449,058	3,448,098	>99.9%
Days of Supply	3,449,055	3,449,055	100%
Paid Amount	3,449,058	3,449,058	100%
TPL Paid Amount	3,449,058	3,436,588	99.6%
Paid Date	3,449,058	3,449,058	100%

Table C-8—All-Element Accuracy by Encounter Type

Encounter Type	Number of Records in Both Files	Number of Records With Same Values in Both Files	Rate
Professional	5,004,468	199,078	4.0%
Institutional	1,788,454	0	0.0%
Pharmacy	3,449,058	3,309,847	96.0%

Data Discrepancy Report

The last column in the image below displays the written responses from **Anthem** in the data discrepancy report noting **Anthem**'s investigative efforts, explanations of root causes, and action plans.

Table	Discrepancy Item	Anthem's Investigation Efforts, Explanations of Root Cause(s), and Action Plan(s)
Table 1	Professional Encounters—Record Surplus: 5.5 percent	Our analysis revealed that Anthem sent the latest iteration of the record, as per the audit file requirement to only "include encounters that have reached their final status". It appears that DHCFP may have sent a different iteration, leading to the discrepancy.
Table 2	Professional Encounters—*Units of Service* Accuracy: 79.8 percent	Anthem submitted the paid units, where the units of service were recorded as 0, while DHCFP submitted billed units, which were non-zero. This difference is likely due to Anthem focusing on finalized claims data, reflecting what was actually paid, whereas the state's records appear to represent the originally billed units.
Table 2	Professional Encounters—*Paid Date* Accuracy: 4.0 percent	Our research revealed that the audit file paid date was mapped from the 2330B/DTP*573 of the 837P, which represents the 'MCO received date', causing the discrepancy. To improve accuracy and align with future audit expectations, we will ensure that the audit extract dates corresponds to the line level paid date, which reflects the actual MCO paid dates. This adjustment should resolve the discrepancies.
Table 3	Institutional Encounters—*Secondary Diagnosis Codes* Omission: 5.9 percent	Anthem initially interpreted the secondary diagnosis as the second code in a sequence. For instance, in TCN 240785439500ANVMD, which contains two diagnosis codes in the 837 – HI*ABK:J020 and HI*APR:J029 - the second diagnosis was reported from HI*APR:J029. To prevent similar issues in future audits, Anthem will seek loop and segment clarification for this data element.

Table	Discrepancy Item	Anthem's Investigation Efforts, Explanations of Root Cause(s), and Action Plan(s)
Table 3	Institutional Encounters—*Primary Diagnosis Codes* Accuracy: 93.1 percent	Anthem initially interpreted the Primary diagnosis as the Admitting diagnosis (HI*ABJ). To prevent similar issues in future audits, Anthem will seek loop and segment clarification for this data element.
Table 3	Institutional Encounters—*Secondary Diagnosis Codes* Accuracy: 47.2 percent	Our analysis of the audit observation revealed that the Anthem submitted data included more Secondary Diagnosis Codes than the DHCFP-submitted data due to the manner in which we extracted the audit file. Our process involved sending the full string of diagnosis codes (HI*APR and HI*ABF), resulting in the discrepancy. With future audits, Anthem will work to ensure alignment in how diagnosis codes are sent in the audit file.
Table 3	Institutional Encounters—*Units of Service* Accuracy: 48.2 percent	Anthem submitted the paid units, where the units of service were recorded as 0, while DHCFP submitted billed units, which were non-zero. This difference is likely due to Anthem focusing on finalized claims data, reflecting what was actually paid, whereas the state's records appear to represent the originally billed units.
Table 3	Institutional Encounters—*Surgical Procedure Code* Accuracy: 56.6 percent	Our research indicated that the difference in the number of Surgical Procedure Codes between DHCFP and Anthem submissions is due to duplication - Anthem removed duplicate procedure codes from the audit file. To prevent similar issues with future audits, Anthem will seek requirement clarification when a duplicate code is found.

Table	Discrepancy Item	Anthem's Investigation Efforts, Explanations of Root Cause(s), and Action Plan(s)
Table 3	Institutional Encounters—*Paid Date* Accuracy: 0.0 percent	Our research revealed that the audit file paid date was mapped from the header DTP*573 of the 837I, which represents the 'MCO received date', causing the discrepancy. To improve accuracy and align with future audit expectations, we will ensure that the audit extract paid date corresponds to the line level paid date, which reflects the actual MCO paid dates. This adjustment should resolve the discrepancies.

Medical Record Review Results

Table C-9—Medical Record Procurement Status: Requested Date of Service

Number of Medical Records Requested	Number of Medical Records Submitted[1]	Percentage of Medical Records Submitted
411	303	73.7%

[1] The number of medical records submitted was based on the MCO's responses within the submitted tracking sheets and/or submitted records.

Table C-10—Medical Record Non-Submission Reasons: Requested Date of Service

Non-Submission Reason	Number	Percent
Record was not located at this facility.	6	5.6%
Member was not a patient of this practice.	15	13.9%
Member was a patient of this practice; however, no documentation was available for date of service.	5	4.6%
Non-responsive provider or provider did not respond in a timely manner.	72	66.7%
Provider refused to release records.	0	0.0%
Facility was permanently closed.	6	5.6%
Other.	4	3.7%
Total*	**108**	**100%**

* The sum of rates from all non-submission reasons may not equal 100 percent due to rounding.

Table C-11—Medical Record Submission Status: Second Date of Service

Number of Medical Records Submitted[1]	Number of Medical Records Submitted With a Second Date of Service	Percentage of Medical Records With a Second Date of Service
303	111	36.6%

[1] The number of medical records submitted was based on the MCO's responses within the submitted tracking sheets and/or submitted records.

Table C-12—Medical Record Review: Encounter Data Completeness

	Medical Record Omission		Encounter Data Omission	
Data Element	Denominator	Percent*	Denominator	Percent*
Date of Service	510	23.1%	397	1.3%
Diagnosis Code	1,394	22.6%	1,093	1.3%
Procedure Code	1,073	27.5%	789	1.4%
Procedure Code Modifier	409	38.4%	259	2.7%

* Lower rates indicate better performance.

Table C-13—Medical Record Review: Encounter Data Accuracy

Data Element	Denominator	Percent	Main Error Type
Diagnosis Code[1]	1,079	99.7%	Incorrect Code: (100%) Specificity Error: (0.0%)
Procedure Code[2]	778	96.1%	Incorrect Code: (100%) Higher Level of Service in Medical Record: (0.0%) Lower Level of Service in Medical Record: (0.0%)
Procedure Code Modifier	252	98.8%	—
All-Element Accuracy[3]	392	69.1%	—

"—" denotes that the error type analysis was not applicable to a given data element.

[1] Inaccurate coding and specificity errors in service records were collectively considered as the denominator for the error type rates.

[2] Inaccurate coding, codes with higher level of services, and codes with lower level of services in service records were collectively considered as the denominator for the error type rates.

[3] The denominator for the element accuracy rate for each data element was defined differently from the denominator for the all-element accuracy rate. Therefore, the all-element accuracy rate could not be derived from the accuracy rate from each data element.

Strengths, Weaknesses, and Recommendations

Based on the results from the comparative analysis and medical record review, HSAG identified the following areas of strength and opportunities for improvement. Along with each opportunity for improvement, HSAG has also provided a recommendation to help target improvement efforts.

Strengths

Comparative Analysis

Strength #1: Anthem's data exhibited a high record-level data completeness, with minimal record omission and surplus rates for institutional and pharmacy encounters.

Strength #2: Anthem's data exhibited strong professional and pharmacy data element completeness with all element omission and surplus rates less than 5.0 percent.

Strength #3: Anthem's data exhibited strong pharmacy data element accuracy, where all 10 of the evaluated data elements had data accuracy rates greater than 95.0 percent.

Medical Record Review

Strength #4: The *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 1.3 percent, 1.3 percent, 1.4 percent, and 2.7 percent, respectively.

Strength #5: When the three key data elements (*Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 96.1 percent each.

Weaknesses and Recommendations

Comparative Analysis

Weakness #1: Anthem's professional data had a marginally elevated record surplus rate of 5.5 percent.

Why the weakness exists: Anthem noted in its data discrepancy report, "*Our analysis revealed that **Anthem** sent the latest iteration of the record, as per the audit file requirement to only 'include encounters that have reached their final status.' It appears that DHCFP may have sent a different iteration, leading to discrepancy.*"

Recommendation: Anthem should work with Nevada Medicaid to decide whether **Anthem** and/or Nevada Medicaid have the correct logic to identify final adjudicated records.

Weakness #2: Although the element omission and element surplus rates were low for most data elements between the **Anthem**-submitted and Nevada Medicaid-submitted data, the following data element had a rate higher than 5.0 percent:

- Institutional encounters: Element omission for *Secondary Diagnosis Code(s)*

Why the weakness exists: Anthem initially interpreted the secondary diagnosis as the second code in a sequence.

Recommendation: Anthem should follow the action plan noted in the data discrepancy report to ensure the data element noted above is submitted to Nevada Medicaid and HSAG completely. In addition, **Anthem** should review and implement standard quality controls to ensure accurate data extracts from its respective systems.

Weakness #3: Although matched records largely contained similar values between the **Anthem**-submitted data and Nevada Medicaid-submitted data, the following data elements had an accuracy rate lower than 95.0 percent:

- Professional encounters: *Units of Service* and *Paid Date*.
- Institutional encounters: *Primary Diagnosis Code, Secondary Diagnosis Code(*s*)*, *Units of Service, Surgical Procedure Code(s)*, and *Paid Date*.

Why the weakness exists: Anthem prepared/mapped the data fields incorrectly for the data submitted to HSAG.

Recommendation: Anthem should follow the action plan noted in the data discrepancy report to ensure the data elements noted above have accurate values submitted to Nevada Medicaid and HSAG. In addition, **Anthem** should review and implement standard quality controls to ensure accurate data extracts from its respective systems.

Medical Record Review

Weakness #4: Anthem was unable to procure all of the requested medical records from its contracted providers, resulting in a low medical record procurement rate (73.7 percent). The low medical record procurement rate consequently affected the results of the medical record reviews of key data elements that were evaluated.

Why the weakness exists: The most cited reason for non-submission was *Non-Responsive Provider or Provider Did Not Respond in a Timely Manner* (66.7 percent).

Recommendation: To ensure **Anthem**'s contracted provider accountability in addressing submission of medical records for auditing, inspection, and examination related to its members, **Anthem** should consider strengthening and/or enforcing its contract requirements with providers in providing the requested documentation.

Weakness #5: More than 22.0 percent of values for each of the data elements (*Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) identified in the encounter data were not supported by the members' medical records.

Why the weakness exists: While non-submission of the medical records was the primary cause, the findings where encounter data were not supported by the medical records can stem from several other potential reasons, which might involve provider documentation practices (e.g., incomplete or inaccurate documentation, coding errors, lack of detail), data submission (e.g., incorrect coding during data submission or data entry errors), or processing issues (e.g., data mapping or translation issues, errors in data transmission).

Recommendation: Anthem should investigate the root cause(s) of these omissions, with a focus on both provider documentation practices and data handling processes. Periodic medical record reviews of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers. Topics should include encounter data submissions, medical record documentation requirements, and coding practices to reduce future omissions and improve data accuracy.

Appendix D. IS Review, Comparative Analysis, and Medical Record Review Results for Molina Healthcare of Nevada, Inc.

This appendix contains detailed IS Review, comparative analysis, and medical record review results for **Molina**.

Comparative Analysis Results

Table D-1—Record Omission and Surplus by Encounter Type

Encounter Data Source	Record Omission			Record Surplus		
	Denominator	Numerator	Rate*	Denominator	Numerator	Rate*
Professional	128,680	2,007,966	6.4%	43,292	1,922,578	2.3%
Institutional	57,913	790,660	7.3%	28,647	761,394	3.8%
Pharmacy	3,259	1,117,525	0.3%	3,537	1,117,803	0.3%

* Lower rates indicate better performance.

Table D-2—Element Omission, Surplus, and Missing, by Key Data Element—Professional Encounters

Key Data Element	Element Omission		Element Surplus		Element Missing+	
	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCO's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Number of Matched Records: 1,879,286						
Recipient ID	5,217	0.3%	0	0.0%	0	0.0%
Header Service From Date	0	0.0%	0	0.0%	0	0.0%
Header Service To Date	0	0.0%	0	0.0%	0	0.0%
Detail Service From Date	0	0.0%	0	0.0%	0	0.0%
Detail Service To Date	0	0.0%	0	0.0%	0	0.0%
Billing Provider NPI	0	0.0%	1,401	0.1%	0	0.0%
Rendering Provider NPI	1,125	0.1%	0	0.0%	0	0.0%
Referring Provider NPI^	33	<0.1%	19,236	1.0%	976,883	52.0%
Primary Diagnosis Code	0	0.0%	0	0.0%	0	0.0%
Secondary Diagnosis Codes[1,^]	8	<0.1%	4,842	0.3%	653,308	34.8%

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCO's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Procedure Code	39	<0.1%	0	0.0%	0	0.0%
Procedure Code Modifier(s)[2,^]	19	<0.1%	3,484	0.2%	1,382,874	73.6%
Units of Service	0	0.0%	0	0.0%	0	0.0%
POS Code	0	0.0%	0	0.0%	0	0.0%
NDC^	5,352	0.3%	220	<0.1%	1,799,812	95.8%
Drug Quantity	0	0.0%	0	0.0%	0	0.0%
Header Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail Paid Amount	0	0.0%	0	0.0%	0	0.0%
Header TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Paid Date	0	0.0%	0	0.0%	0	0.0%

* Lower rates indicate better performance.
+ Indicates that the element was not populated in either data source.
^ Indicates that the data field is situational (i.e., not required for every encounter line).
[1] All submitted secondary diagnosis codes were ordered alphabetically and numerically, then concatenated as a single data element.
[2] All submitted procedure code modifiers were ordered alphabetically and numerically, then concatenated as a single data element.

Table D-3—Element Omission, Surplus, and Missing, by Key Data Element—Institutional Encounters

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCO's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Number of Matched Records: 732,747						
Recipient ID	0	0.0%	0	0.0%	0	0.0%
Header Service From Date	0	0.0%	0	0.0%	0	0.0%
Header Service To Date	0	0.0%	0	0.0%	0	0.0%
Detail Service From Date	0	0.0%	0	0.0%	0	0.0%

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCO's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Detail Service To Date	0	0.0%	0	0.0%	0	0.0%
Admission Date^	595,765	81.3%	0	0.0%	15	<0.1%
Discharge Status	0	0.0%	0	0.0%	0	0.0%
Billing Provider NPI	0	0.0%	0	0.0%	0	0.0%
Attending Provider NPI	8,224	1.1%	11,119	1.5%	15	<0.1%
Referring Provider NPI^	41	<0.1%	0	0.0%	723,069	98.7%
Primary Diagnosis Code	0	0.0%	0	0.0%	0	0.0%
Secondary Diagnosis Code(s) [1,^]	77,425	10.6%	0	0.0%	1,098	0.1%
Procedure Code^	82	<0.1%	0	0.0%	219,556	30.0%
Procedure Code Modifier(s) [2,^]	19	<0.1%	0	0.0%	631,334	86.2%
Units of Service	0	0.0%	0	0.0%	0	0.0%
Revenue Code	0	0.0%	0	0.0%	0	0.0%
Surgical Procedure Code(s) [3,^]	45	<0.1%	0	0.0%	646,754	88.3%
TOB Code	0	0.0%	0	0.0%	0	0.0%
NDC^	13,669	1.9%	2,315	0.3%	593,130	80.9%
Drug Quantity^	0	0.0%	0	0.0%	0	0.0%
Header Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail Paid Amount	0	0.0%	0	0.0%	0	0.0%
Header TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Paid Date	0	0.0%	0	0.0%	0	0.0%

* Lower rates indicate better performance.
+ Indicates that the element was not populated in either data source.
^ Indicates that the data field is situational (i.e., not required for every encounter line).
[1] All submitted secondary diagnosis codes were ordered alphabetically and numerically, then concatenated as a single data element.
[2] All submitted procedure code modifiers were ordered alphabetically and numerically, then concatenated as a single data element.
[3] All submitted surgical procedure codes were ordered alphabetically and numerically, then concatenated as a single data element.

Table D-4—Element Omission, Surplus, and Missing, by Key Data Element—Pharmacy Encounters

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCO's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Number of Matched Records: 1,114,266						
Recipient ID	2,248	0.2%	0	0.0%	0	0.0%
Date of Service	0	0.0%	0	0.0%	0	0.0%
Billing Provider NPI	0	0.0%	0	0.0%	0	0.0%
Prescribing Provider NPI	45,352	4.1%	0	0.0%	18	<0.1%
NDC	0	0.0%	0	0.0%	0	0.0%
Drug Quantity	0	0.0%	0	0.0%	0	0.0%
Days of Supply	0	0.0%	0	0.0%	0	0.0%
Paid Amount	0	0.0%	0	0.0%	0	0.0%
TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Paid Date	0	0.0%	0	0.0%	0	0.0%

* Lower rates indicate better performance.
+ Indicates that the element was not populated in either data source.

Table D-5—Element Accuracy—Professional Encounters

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Recipient ID	1,874,069	1,874,064	>99.9%
Header Service From Date	1,879,286	1,878,762	>99.9%
Header Service To Date	1,879,286	1,879,280	>99.9%
Detail Service From Date	1,879,286	1,758,112	93.6%
Detail Service To Date	1,879,286	1,755,938	93.4%
Billing Provider NPI	1,877,885	1,877,034	>99.9%
Rendering Provider NPI	1,878,161	1,873,721	99.8%
Referring Provider NPI	883,134	883,128	>99.9%
Primary Diagnosis Code	1,879,286	1,879,131	>99.9%
Secondary Diagnosis Codes[1]	1,221,128	1,220,975	>99.9%
Procedure Code	1,879,247	1,874,664	99.8%

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Procedure Code Modifier(s)[2]	492,909	492,901	>99.9%
Units of Service	1,879,286	1,866,881	99.3%
POS Code	1,879,286	1,879,286	100%
NDC	73,902	73,902	100%
Drug Quantity	1,879,286	1,879,059	>99.9%
Header Paid Amount	1,879,286	1,799,681	95.8%
Detail Paid Amount	1,879,286	1,809,438	96.3%
Header TPL Paid Amount	1,879,286	1,808,554	96.2%
Detail TPL Paid Amount	1,879,286	1,870,419	99.5%
Paid Date	1,879,286	1,805,438	96.1%

[1] All submitted secondary diagnosis codes were ordered alphabetically and numerically, then concatenated as a single data element.
[2] All submitted procedure code modifiers were ordered alphabetically and numerically, then concatenated as a single data element.

Table D-6—Element Accuracy—Institutional Encounters

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Recipient ID	732,747	732,747	100%
Header Service From Date	732,747	732,747	100%
Header Service To Date	732,747	732,747	100%
Detail Service From Date	732,747	632,091	86.3%
Detail Service To Date	732,747	609,375	83.2%
Admission Date	136,967	136,967	100%
Discharge Status	732,747	731,082	99.8%
Billing Provider NPI	732,747	732,728	>99.9%
Attending Provider NPI	713,389	713,383	>99.9%
Referring Provider NPI	9,637	9,637	100%
Primary Diagnosis Code	732,747	732,747	100%
Secondary Diagnosis Code(s)[1]	654,224	2,707	0.4%
Procedure Code	513,109	513,109	100%
Procedure Code Modifier(s)[2]	101,394	101,394	100%
Units of Service	732,747	732,579	>99.9%

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Revenue Code	732,747	732,737	>99.9%
Surgical Procedure Code(s)[3]	85,948	50,259	58.5%
TOB Code	732,747	650,449	88.8%
NDC	123,633	123,633	100%
Drug Quantity	732,747	729,979	99.6%
Header Paid Amount	732,747	732,747	100%
Detail Paid Amount	732,747	732,747	100%
Header TPL Paid Amount	732,747	731,179	99.8%
Detail TPL Paid Amount	732,747	731,748	99.9%
Paid Date	732,747	727,641	99.3%

[1] All submitted secondary diagnosis codes were ordered alphabetically and numerically, then concatenated as a single data element.
[2] All submitted procedure code modifiers were ordered alphabetically and numerically, then concatenated as a single data element.
[3] All submitted secondary surgical procedure codes were ordered alphabetically and numerically, then concatenated as a single data element.

Table D-7—Element Accuracy—Pharmacy Encounters

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Recipient ID	1,112,018	1,112,018	100%
Date of Service	1,114,266	1,114,266	100%
Billing Provider NPI	1,114,266	1,114,266	100%
Prescribing Provider NPI	1,068,896	1,068,883	>99.9%
NDC	1,114,266	1,113,699	99.9%
Drug Quantity	1,114,266	1,113,709	>99.9%
Days of Supply	1,114,266	1,114,266	100%
Paid Amount	1,114,266	1,114,266	100%
TPL Paid Amount	1,114,266	1,109,258	99.6%
Paid Date	1,114,266	1,114,266	100%

Table D-8—All-Element Accuracy by Encounter Type

Encounter Type	Number of Records in Both Files	Number of Records With Same Values in Both Files	Rate
Professional	1,879,286	1,574,350	83.8%
Institutional	732,747	0	0.0%
Pharmacy	1,114,266	1,061,529	95.3%

Data Discrepancy Report

The last column in the image below displays the written responses from **Molina** in the data discrepancy report noting **Molina**'s investigative efforts, explanations of root causes, and action plans.

Table	Discrepancy Item	Molina's Investigation Efforts, Explanations of Root Cause(s), and Action Plan(s)
Table 1	Professional Encounters—Record Omission: 6.4 percent	Molina's review of the sample data found that the three records included in Molina's claims extracts, but not in DHCFP's and no ICN is a result of including Encounters that were rejected by DHCFP on submission for failing Encounter edits validation (i.e. duplicates). Guidance was provided to include both Accepted and Rejected Encounters in our claims extracts which added to the omission and surplus when compared against DHCFP's data. There were examples from our review that also did not include the latest claim in the chain during the claims extract process. Corrections to the logic that was used to retrieve the latest claims in the chain is in flight and to be corrected by October 2025.
Table 1	Institutional Encounters—Record Omission: 7.3 percent	Molina's review of the sample data found that the three records included in Molina's claims extracts, but not in DHCFP's and no ICN is a result of including Encounters that were rejected by DHCFP on submission for failing Encounter edits validation (i.e. duplicates). Guidance was provided to include both Accepted and Rejected Encounters in our claims extracts which added to the omission and surplus when compared against DHCFP's data. Other examples included scenarios where Molina's submission of the Encounter was within the review period and in DHCFP's system before the 06/30/24 cutoff (ex.7023079210548, 7023107022058). There were examples from our review that also did not include the latest claim in the chain during the claims extract process. Corrections to the logic that was used to retrieve the latest claims in the chain is in flight and to be corrected by October 2025.
Table 2	Professional Encounters—*Detail Service From Date* Accuracy: 93.6 percent	Molina's review found that the extracted data mapped to the claims extract overrode the line level dates of service with the header level from and through dates of service. Corrections have been made to our claims extract logic to prevent this issue from occurring again.

Table	Discrepancy Item	Molina's Investigation Efforts, Explanations of Root Cause(s), and Action Plan(s)
Table 2	Professional Encounters—*Detail Service To* Date Accuracy: 93.4 percent	Molina's review found that the extracted data mapped to the claims extract overrode the line level dates of service with the header level from and through dates of service. Corrections have been made to our claims extract logic to prevent this issue from occurring again.
Table 3	Institutional Encounters—*Admission Date* Omission:81.3 percent	Molina's Encounters submissions process aligns with 837I ASC X12N (Version 005010X223) for outpatient claims submissions. The field is situational and required for inpatient claims but not outpatient claims. Further validation found that the admission date to Header Service From Date were the same as the provider billed Molina with those dates.
Table 3	Institutional Encounters—*Secondary Diagnosis Codes* Omission:10.6 percent	Molina's review found that the Secondary Diagnosis codes submitted with a qualifier of PRV were submitted to HSAG as received by the provider. Screenshots to support the review where the data was submitted to DHCFP as received from the provider are attached. We also found Encounters where DHCFP advised that a secondary Diagnosis Code was not reported Molina included in the Encounters extracts with an APR qualifier. Molina acknowledges as per our review that HSAG only requested for secondary diagnosis codes with ABF and ABK qualifiers to be included in the claims extracts.
Table 3	Institutional Encounters—*Detail Service From Date* Accuracy: 86.3 percent	Molina's review found that the extracted data mapped to the claims extract overrode the line level dates of service with the header level from and through dates of service. Corrections have been made to our claims extract logic to prevent this issue from occurring again.
Table 3	Institutional Encounters—*Detail Service To* Date Accuracy: 83.2 percent	Molina's review found that the extracted data mapped to the claims extract overrode the line level dates of service with the header level from and through dates of service. Corrections have been made to our claims extract logic to prevent this issue from occurring again.
Table 3	Institutional Encounters—*Secondary Diagnosis Codes* Accuracy: 0.4 percent	Molina's review found that the Secondary Diagnosis codes submitted with a qualifier of PRV were submitted to HSAG as received by the provider. Screenshots to support the review where the data was submitted to DHCFP as received from the provider are attached. We also found Encounters where DHCFP advised that a secondary Diagnosis Code was not reported Molina included in the Encounters extracts with an APR qualifier. Molina acknowledges as per our review that HSAG only requested for secondary diagnosis codes with ABF and ABK qualifiers to be included in the claims' extracts.

Table	Discrepancy Item	Molina's Investigation Efforts, Explanations of Root Cause(s), and Action Plan(s)
Table 3	Institutional Encounters—*Surgical Procedure Codes* Accuracy: 58.5percent	Molina's Encounters submissions process aligns with 837I ASC X12N (Version 005010X223) for outpatient claims submissions. The field is situational and required for inpatient claims but not outpatient claims. Further validation found that the data was included in our Claims Extracts as we store the data in our data repositories.
Table 3	Institutional Encounters—*TOB Code* Accuracy: 88.8 percent	The Type of Bill (TOB) submitted in the extract reflects the value recorded in Molina's claims system. If an encounter previously accepted by DHCFP is being resubmitted, the frequency code must be updated to '7' to indicate a replacement. This updated frequency code would no longer match the original value in DHCFP's records. Additionally, DHCFP's 837I Companion Guide specifies frequency codes '1', '7', and '8' as acceptable. Molina's encounter extract logic ensures that TOB values are reported in accordance with DHCFP's encounter submission guidance.

Medical Record Review Results

Table D-9—Medical Record Procurement Status: Requested Date of Service

Number of Medical Records Requested	Number of Medical Records Submitted[1]	Percentage of Medical Records Submitted
411	337	82.0%

[1] The number of medical records submitted was based on the MCO's responses within the submitted tracking sheets and/or submitted records.

Table D-10—Medical Record Non-Submission Reasons: Requested Date of Service

Non-Submission Reason	Number	Percent
Record was not located at this facility.	0	0.0%
Member was not a patient of this practice.	0	0.0%
Member was a patient of this practice; however, no documentation was available for date of service.	0	0.0%
Non-responsive provider or provider did not respond in a timely manner.	74	100%
Provider refused to release records.	0	0.0%
Facility was permanently closed.	0	0.0%
Other.	0	0.0%
Total	**74**	**100%**

Table D-11—Medical Record Submission Status: Second Date of Service

Number of Medical Records Submitted[1]	Number of Medical Records Submitted With a Second Date of Service	Percentage of Medical Records With a Second Date of Service
337	171	50.7%

[1] The number of medical records submitted was based on the MCO's responses within the submitted tracking sheets and/or submitted records.

Table D-12—Medical Record Review: Encounter Data Completeness

	Medical Record Omission		Encounter Data Omission	
Data Element	Denominator	Percent*	Denominator	Percent*
Date of Service	542	14.8%	479	3.5%
Diagnosis Code	1,520	17.7%	1,277	2.0%
Procedure Code	1,367	24.7%	1,057	2.6%
Procedure Code Modifier	490	29.2%	354	2.0%

* Lower rates indicate better performance.

Table D-13—Medical Record Review: Encounter Data Accuracy

Data Element	Denominator	Percent	Main Error Type
Diagnosis Code[1]	1,251	99.2%	Incorrect Code: (90.0%) Specificity Error: (10.0%)
Procedure Code[2]	1,030	95.7%	Incorrect Code: (97.7%) Higher Level of Service in Medical Record: (2.3%) Lower Level of Service in Medical Record: (0.0%)
Procedure Code Modifier	347	98.8%	—
All-Element Accuracy[3]	462	71.2%	—

"—" denotes that the error type analysis was not applicable to a given data element.
[1] Inaccurate coding and specificity errors in service records were collectively considered as the denominator for the error type rates.
[2] Inaccurate coding, codes with higher level of services, and codes with lower level of services in service records were collectively considered as the denominator for the error type rates.
[3] The denominator for the element accuracy rate for each data element was defined differently from the denominator for the all-element accuracy rate. Therefore, the all-element accuracy rate could not be derived from the accuracy rate from each data element.

Strengths, Weaknesses, and Recommendations

Based on the results from the IS Review, comparative analysis, and medical record review, HSAG identified the following areas of strength and opportunities for improvement. Along with each

opportunity for improvement, HSAG has also provided a recommendation to help target improvement efforts.

Strengths

IS Review

Strength #1: Molina demonstrated its capability to collect, process, and transmit encounter data to Nevada Medicaid, as well as develop data review and correction processes that can respond to quality issues identified by Nevada Medicaid.

Comparative Analysis

Strength #2: Molina's pharmacy data exhibited high record-level data completeness, with minimal record omission (0.3 percent) and surplus (0.3 percent) rates.

Strength #3: Molina's data exhibited strong professional and pharmacy data element completeness with all element omission and surplus rates less than 5.0.

Strength #4: Molina's data exhibited strong pharmacy data element accuracy, where all 10 of the evaluated data elements had data accuracy rates greater than 95.0 percent.

Medical Record Review

Strength #5: The *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 3.5 percent, 2.0 percent, 2.6 percent, and 2.0 percent, respectively.

Strength #6: When the three key data elements (*Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 95.7 percent each.

Weaknesses and Recommendations

IS Review

Weakness #1: While submitting denied lines to Nevada Medicaid with $0 paid at the line level, **Molina** did not submit fully denied claims (i.e., all lines were denied) to Nevada Medicaid.

Why the weakness exists: If fully denied claims (i.e., all lines were denied) represent services provided to the Medicaid members, Nevada Medicaid might be interested in collecting them.

Recommendation: Molina should work with Nevada Medicaid to decide whether the fully denied claims should be submitted to Nevada Medicaid.

Weakness #2: While **Molina** and/or its subcontractors evaluated claim volume by submission month, field-level completeness and accuracy, and submission timeliness, it did not note any reports regarding claim volume per member per month (PMPM), reconciliation with financial reports (e.g., clerk disperse journal), or medical record review. In addition, the example report from **Molina** appeared to include vision encounters in the "Professional" category, which may mask the data issues from vision encounters.

Why the weakness exists: The implementation of comprehensive claims/encounter quality checks is required to ensure data accuracy, completeness, and timeliness.

Recommendation: Molina should explore the possibility of developing or enhancing monitoring reports to assess the accuracy, completeness, and/or timeliness of the encounters as noted below.

- **Molina** should develop reports regarding claim volume PMPM or reconciliation with financial reports (e.g., clerk disperse journal).
- **Molina** should monitor vision encounters separately from other professional encounters.

Comparative Analysis

Weakness #3: Molina's professional data had elevated record omission (6.4 percent). Additionally, Molina's institutional data also had elevated record omission (7.3 percent).

Why the weakness exists: Molina included professional and institutional encounters rejected by Nevada Medicaid in the data submission to HSAG. In addition, **Molina** submitted some of the vision encounters in both the vision file and professional file to HSAG.

Recommendation: Molina should work with Nevada Medicaid to make sure that professional and institutional encounters denied by Nevada Medicaid are corrected and resubmitted to Nevada Medicaid. In addition, **Molina** should review and implement standard quality controls to ensure accurate data extracts from its respective systems.

Weakness #4: Although the element omission and element surplus rates were low for most data elements between the **Molina**-submitted data and Nevada Medicaid-submitted data, the following data elements had a rate higher than 5.0 percent:

- Institutional encounters: Element omission for *Admission Date* and *Secondary Diagnosis Code(s)*

Why the weakness exists: Because providers submitted the *Admission Date* values the same as the *Header Service From Date* values, **Molina** provided those dates to HSAG. For the *Secondary Diagnosis Code(s)* fields, **Molina** included secondary diagnosis codes with qualifiers other than "ABF" and "ABK" in the data to HSAG (e.g., qualifier "APR" for patient reason for visit codes).

Recommendation: Molina should follow the action plan noted in the data discrepancy report to ensure the data elements noted above are submitted to Nevada Medicaid and HSAG completely. In addition, **Molina** should review and implement standard quality controls to ensure accurate data extracts from its respective systems.

Weakness #5: Although matched records largely contained similar values between the **Molina**-submitted data and Nevada Medicaid-submitted data, the following data elements had an accuracy rate lower than 95.0 percent:

- Professional encounters: *Detail Service From Date* and *Detail Service To Date*.
- Institutional encounters: *Detail Service From Date, Detail Service To Date*, *Secondary Diagnosis Code(s)*, *Surgical Procedure Code(s)*, and *TOB Code*.

Why the weakness exists: While additional analysis is needed to determine what caused the inaccuracies for the *Surgical Procedure Code(s)* and *TOB Code* data elements, **Molina** prepared the remaining data fields incorrectly for the data submitted to HSAG.

Recommendation: Molina should follow the action plan noted in the data discrepancy report to ensure the data elements noted above have accurate values submitted to Nevada Medicaid and HSAG. Secondly, **Molina** should work with Nevada Medicaid to further investigate the root causes for the *Surgical Procedure Code(s)* and *TOB Code* inaccuracies. Lastly, **Molina** should review and implement standard quality controls to ensure accurate data extracts from its respective systems.

Medical Record Review

Weakness #6: Molina was unable to procure all of the requested medical records from its contracted providers, resulting in a low medical record procurement rate (82.0 percent). The low medical record procurement rate consequently affected the results of the medical record reviews of key data elements that were evaluated.

Why the weakness exists: The reason for non-submission was *Non-Responsive Provider or Provider Did Not Respond in a Timely Manner* (100 percent).

Recommendation: To ensure **Molina**'s contracted provider accountability in addressing submission of medical records for auditing, inspection, and examination related to its members, **Molina** should consider strengthening and/or enforcing its contract requirements with providers in providing the requested documentation.

Weakness #7: More than 14.0 percent of values for each of the data elements (*Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) identified in the encounter data were not supported by the members' medical records.

Why the weakness exists: While non-submission of the medical records was the primary cause, the findings where encounter data were not supported by the medical records can stem from several other potential reasons, which might involve provider documentation practices (e.g., incomplete or inaccurate documentation, coding errors, lack of detail), data submission (e.g., incorrect coding during data submission or data entry errors), or processing issues (e.g., data mapping or translation issues, errors in data transmission).

Recommendation: Molina should investigate the root cause(s) of these omissions, with a focus on both provider documentation practices and data handling processes. Periodic medical record reviews of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing

education and training for providers. Topics should include encounter data submissions, medical record documentation requirements, and coding practices to reduce future omissions and improve data accuracy.

Appendix E. Comparative Analysis and Medical Record Review Results for SilverSummit Healthplan, Inc.

This appendix contains detailed comparative analysis and medical record review results for **SilverSummit**.

Comparative Analysis Results

Table E-1—Record Omission and Surplus by Encounter Type

Encounter Data Source	Record Omission			Record Surplus		
	Denominator	Numerator	Rate*	Denominator	Numerator	Rate*
Professional	40,326	2,745,298	1.5%	62,065	2,767,037	2.2%
Institutional	31,224	1,045,221	3.0%	42,915	1,056,912	4.1%
Pharmacy	9,517	1,558,983	0.6%	5,180	1,554,646	0.3%

* Lower rates indicate better performance.

Table E-2—Element Omission, Surplus, and Missing, by Key Data Element—Professional Encounters

Key Data Element	Element Omission		Element Surplus		Element Missing+	
	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCO's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Number of Matched Records: 2,704,972						
Recipient ID	5,728	0.2%	0	0.0%	0	0.0%
Header Service From Date	0	0.0%	0	0.0%	0	0.0%
Header Service To Date	0	0.0%	0	0.0%	0	0.0%
Detail Service From Date	0	0.0%	0	0.0%	0	0.0%
Detail Service To Date	0	0.0%	0	0.0%	0	0.0%
Billing Provider NPI	0	0.0%	0	0.0%	0	0.0%
Rendering Provider NPI	24,026	0.9%	0	0.0%	0	0.0%
Referring Provider NPI^	21,555	0.8%	0	0.0%	1,358,850	50.2%
Primary Diagnosis Code	0	0.0%	0	0.0%	0	0.0%
Secondary Diagnosis Codes[1,^]	7	<0.1%	407,097	15.0%	932,253	34.5%

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCO's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Procedure Code	9	<0.1%	1	<0.1%	2	<0.1%
Procedure Code Modifier(s)[2,^]	722	<0.1%	403	<0.1%	1,967,758	72.7%
Units of Service	0	0.0%	0	0.0%	0	0.0%
POS Code	0	0.0%	0	0.0%	0	0.0%
NDC^	6,734	0.2%	420	<0.1%	2,606,597	96.4%
Drug Quantity	0	0.0%	0	0.0%	0	0.0%
Header Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail Paid Amount	0	0.0%	0	0.0%	0	0.0%
Header TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Paid Date	0	0.0%	0	0.0%	0	0.0%

* Lower rates indicate better performance.
+ Indicates that the element was not populated in either data source.
^ Indicates that the data field is situational (i.e., not required for every encounter line).
[1] All submitted secondary diagnosis codes were ordered alphabetically and numerically, then concatenated as a single data element.
[2] All submitted procedure code modifiers were ordered alphabetically and numerically, then concatenated as a single data element.

Table E-3—Element Omission, Surplus, and Missing, by Key Data Element—Institutional Encounters

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCO's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Number of Matched Records: 1,013,997						
Recipient ID	0	0.0%	0	0.0%	0	0.0%
Header Service From Date	0	0.0%	0	0.0%	0	0.0%
Header Service To Date	0	0.0%	0	0.0%	0	0.0%
Detail Service From Date	0	0.0%	0	0.0%	0	0.0%

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCO's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Detail Service To Date	0	0.0%	0	0.0%	0	0.0%
Admission Date^	0	0.0%	0	0.0%	823,513	81.2%
Discharge Status	0	0.0%	1,291	0.1%	0	0.0%
Billing Provider NPI	0	0.0%	0	0.0%	0	0.0%
Attending Provider NPI	23,851	2.4%	0	0.0%	10	<0.1%
Referring Provider NPI^	52	<0.1%	0	0.0%	997,875	98.4%
Primary Diagnosis Code	0	0.0%	0	0.0%	0	0.0%
Secondary Diagnosis Code(s)[1,^]	122	<0.1%	5	<0.1%	102,729	10.1%
Procedure Code^	974	0.1%	5,394	0.5%	297,521	29.3%
Procedure Code Modifier(s)[2,^]	3,715	0.4%	6,421	0.6%	860,680	84.9%
Units of Service	0	0.0%	0	0.0%	0	0.0%
Revenue Code	0	0.0%	296	<0.1%	0	0.0%
Surgical Procedure Code(s)[3,^]	34	<0.1%	0	0.0%	897,574	88.5%
TOB Code	0	0.0%	0	0.0%	0	0.0%
NDC^	16,110	1.6%	3,792	0.4%	819,745	80.8%
Drug Quantity^	0	0.0%	0	0.0%	0	0.0%
Header Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail Paid Amount	0	0.0%	0	0.0%	0	0.0%
Header TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Paid Date	0	0.0%	0	0.0%	0	0.0%

* Lower rates indicate better performance.
+ Indicates that the element was not populated in either data source.
^ Indicates that the data field is situational (i.e., not required for every encounter line).
[1] All submitted secondary diagnosis codes were ordered alphabetically and numerically, then concatenated as a single data element.
[2] All submitted procedure code modifiers were ordered alphabetically and numerically, then concatenated as a single data element.
[3] All submitted surgical procedure codes were ordered alphabetically and numerically, then concatenated as a single data element.

Table E-4—Element Omission, Surplus, and Missing, by Key Data Element—Pharmacy Encounters

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCO's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Number of Matched Records: 1,549,466						
Recipient ID	1,308	0.1%	0	0.0%	0	0.0%
Date of Service	0	0.0%	0	0.0%	0	0.0%
Billing Provider NPI	0	0.0%	0	0.0%	0	0.0%
Prescribing Provider NPI	59,409	3.8%	0	0.0%	123	<0.1%
NDC	0	0.0%	0	0.0%	0	0.0%
Drug Quantity	0	0.0%	0	0.0%	0	0.0%
Days of Supply	0	0.0%	0	0.0%	0	0.0%
Paid Amount	0	0.0%	0	0.0%	0	0.0%
TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Paid Date	0	0.0%	0	0.0%	0	0.0%

* Lower rates indicate better performance.
+ Indicates that the element was not populated in either data source.

Table E-5—Element Accuracy—Professional Encounters

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Recipient ID	2,699,244	2,698,452	>99.9%
Header Service From Date	2,704,972	2,704,797	>99.9%
Header Service To Date	2,704,972	2,704,845	>99.9%
Detail Service From Date	2,704,972	2,704,122	>99.9%
Detail Service To Date	2,704,972	2,704,111	>99.9%
Billing Provider NPI	2,704,972	2,604,564	96.3%
Rendering Provider NPI	2,680,946	2,666,749	99.5%
Referring Provider NPI	1,324,567	1,324,567	100%
Primary Diagnosis Code	2,704,972	2,428,317	89.8%
Secondary Diagnosis Codes[1]	1,365,615	1,035,455	75.8%
Procedure Code	2,704,960	2,699,347	99.8%

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Procedure Code Modifier(s)[2]	736,089	735,776	>99.9%
Units of Service	2,704,972	2,668,717	98.7%
POS Code	2,704,972	2,695,906	99.7%
NDC	91,221	90,979	99.7%
Drug Quantity	2,704,972	2,662,457	98.4%
Header Paid Amount	2,704,972	2,702,368	99.9%
Detail Paid Amount	2,704,972	2,698,024	99.7%
Header TPL Paid Amount	2,704,972	2,688,924	99.4%
Detail TPL Paid Amount	2,704,972	2,693,980	99.6%
Paid Date	2,704,972	2,683,963	99.2%

[1] All submitted secondary diagnosis codes were ordered alphabetically and numerically, then concatenated as a single data element.
[2] All submitted procedure code modifiers were ordered alphabetically and numerically, then concatenated as a single data element.

Table E-6—Element Accuracy—Institutional Encounters

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Recipient ID	1,013,997	1,013,853	>99.9%
Header Service From Date	1,013,997	1,013,997	100%
Header Service To Date	1,013,997	1,013,997	100%
Detail Service From Date	1,013,997	1,002,800	98.9%
Detail Service To Date	1,013,997	1,002,799	98.9%
Admission Date	190,484	190,484	100%
Discharge Status	1,012,706	1,012,706	100%
Billing Provider NPI	1,013,997	1,013,997	100%
Attending Provider NPI	990,136	990,095	>99.9%
Referring Provider NPI	16,070	16,070	100%
Primary Diagnosis Code	1,013,997	1,013,772	>99.9%
Secondary Diagnosis Code(s)[1]	911,141	384,501	42.2%
Procedure Code	710,108	675,538	95.1%
Procedure Code Modifier(s)[2]	143,181	142,070	99.2%
Units of Service	1,013,997	970,448	95.7%

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Revenue Code	1,013,701	989,589	97.6%
Surgical Procedure Code(s)[3]	116,389	64,939	55.8%
TOB Code	1,013,997	875,061	86.3%
NDC	174,350	170,229	97.6%
Drug Quantity	1,013,997	982,462	96.9%
Header Paid Amount	1,013,997	1,010,968	99.7%
Detail Paid Amount	1,013,997	985,326	97.2%
Header TPL Paid Amount	1,013,997	997,634	98.4%
Detail TPL Paid Amount	1,013,997	1,006,301	99.2%
Paid Date	1,013,997	1,002,436	98.9%

[1] All submitted secondary diagnosis codes were ordered alphabetically and numerically, then concatenated as a single data element.
[2] All submitted procedure code modifiers were ordered alphabetically and numerically, then concatenated as a single data element.
[3] All submitted secondary surgical procedure codes were ordered alphabetically and numerically, then concatenated as a single data element.

Table E-7—Element Accuracy—Pharmacy Encounters

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Recipient ID	1,548,158	1,548,001	>99.9%
Date of Service	1,549,466	1,549,466	100%
Billing Provider NPI	1,549,466	1,549,466	100%
Prescribing Provider NPI	1,489,934	1,489,913	>99.9%
NDC	1,549,466	1,548,414	99.9%
Drug Quantity	1,549,466	1,548,481	99.9%
Days of Supply	1,549,466	1,549,466	100%
Paid Amount	1,549,466	1,549,466	100%
TPL Paid Amount	1,549,466	1,540,972	99.5%
Paid Date	1,549,466	1,549,466	100%

Table E-8—All-Element Accuracy by Encounter Type

Encounter Type	Number of Records in Both Files	Number of Records With Same Values in Both Files	Rate
Professional	2,704,972	1,764,684	65.2%
Institutional	1,013,997	358,374	35.3%
Pharmacy	1,549,466	1,479,612	95.5%

Data Discrepancy Report

The last column in the image below displays the written responses from **SilverSummit** in the data discrepancy report noting **SilverSummit**'s investigative efforts, explanations of root causes, and action plans.

Table	Discrepancy Item	SilverSummit's Investigation Efforts, Explanations of Root Cause(s), and Action Plan(s)
Table 2	Professional Encounters—*Secondary Diagnosis Codes* Surplus: 15.0 percent	Research by Silver Summit Data Analytics team – The code for the data pull was pulling diagnosis codes at the line level and not the header, which caused some to be omitted if not all codes were being applied to the individual lines. We can re-run and pull at the header, if needed.
Table 2	Professional Encounters—*Primary Diagnosis Codes* Accuracy: 89.8 percent	Research by Silver Summit Data Analytics team – The code for the data pull was pulling diagnosis codes at the line level and not the header, which caused some to be omitted if not all codes were being applied to the individual lines. We can re-run and pull at the header, if needed.
Table 2	Professional Encounters—*Secondary Diagnosis Codes* Accuracy: 75.8 percent	Research by Silver Summit Data Analytics team – The code for the data pull was pulling diagnosis codes at the line level and not the header, which caused some to be omitted if not all codes were being applied to the individual lines. We can re-run and pull at the header, if needed.
Table 4	Institutional Encounters—*Secondary Diagnosis Codes* Accuracy: 42.2 percent	Research by Silver Summit Data Analytics team – The code for the data pull was pulling diagnosis codes at the line level and not the header, which caused some to be omitted if not all codes were being applied to the individual lines. We can re-run and pull at the header, if needed.
Table 4	Institutional Encounters—*Surgical Procedure Code* Accuracy: 55.8 percent	Research by Silver Summit Data Analytics team – If a claim had multiple procedure codes of the same value on separate lines, our code was only pulling in the procedure code one time. We can update the code to pull all procedure codes and show a code multiple times if it was billed on multiple lines, if needed.
Table 4	Institutional Encounters—*TOB* Accuracy: 86.3 percent	Research by Silver Summit Data Analytics team – We are showing the discrepancies stem from adjusted claims either submitted as replacement claims in which our system did not appropriately update the bill type, or new original encounters where the services were billed previously under a different TCN, which showed in DHCFPs system as an original, but in our system/extract as a replacement. If needed, we can research further and attempt to correct and improve our accuracy for TOB.

Medical Record Review Results

Table E-9—Medical Record Procurement Status: Requested Date of Service

Number of Medical Records Requested	Number of Medical Records Submitted[1]	Percentage of Medical Records Submitted
411	303	73.7%

[1] The number of medical records submitted was based on the MCO's responses within the submitted tracking sheets and/or submitted records.

Table E-10—Medical Record Non-Submission Reasons: Requested Date of Service

Non-Submission Reason	Number	Percent
Record was not located at this facility.	1	0.9%
Member was not a patient of this practice.	2	1.9%
Member was a patient of this practice; however, no documentation was available for date of service.	1	0.9%
Non-responsive provider or provider did not respond in a timely manner.	94	87.0%
Provider refused to release records.	0	0.0%
Facility was permanently closed.	0	0.0%
Other.	10	9.3%
Total	**108**	**100%**

Table E-11—Medical Record Submission Status: Second Date of Service

Number of Medical Records Submitted[1]	Number of Medical Records Submitted With a Second Date of Service	Percentage of Medical Records With a Second Date of Service
303	156	51.5%

[1] The number of medical records submitted was based on the MCO's responses within the submitted tracking sheets and/or submitted records.

Table E-12—Medical Record Review: Encounter Data Completeness

	Medical Record Omission		Encounter Data Omission	
Data Element	Denominator	Percent*	Denominator	Percent*
Date of Service	536	21.5%	428	1.6%
Diagnosis Code	1,478	22.3%	1,159	0.9%

	Medical Record Omission		Encounter Data Omission	
Data Element	Denominator	Percent*	Denominator	Percent*
Procedure Code	1,328	32.5%	905	1.0%
Procedure Code Modifier	484	26.0%	360	0.6%

* Lower rates indicate better performance.

Table E-13—Medical Record Review: Encounter Data Accuracy

Data Element	Denominator	Percent	Main Error Type
Diagnosis Code[1]	1,148	99.6%	Incorrect Code: (100%) Specificity Error: (0.0%)
Procedure Code[2]	896	94.1%	Incorrect Code: (94.3%) Higher Level of Service in Medical Record: (3.8%) Lower Level of Service in Medical Record: (1.9%)
Procedure Code Modifier	358	100%	—
All-Element Accuracy[3]	421	71.7%	—

"—" denotes that the error type analysis was not applicable to a given data element.

[1] Inaccurate coding and specificity errors in service records were collectively considered as the denominator for the error type rates.

[2] Inaccurate coding, codes with higher level of services, and codes with lower level of services in service records were collectively considered as the denominator for the error type rates.

[3] The denominator for the element accuracy rate for each data element was defined differently from the denominator for the all-element accuracy rate. Therefore, the all-element accuracy rate could not be derived from the accuracy rate from each data element.

Strengths, Weaknesses, and Recommendations

Based on the results from the comparative analysis and medical record review, HSAG identified the following areas of strength and opportunities for improvement. Along with each opportunity for improvement, HSAG has also provided a recommendation to help target improvement efforts.

Strengths

Comparative Analysis

Strength #1: SilverSummit's data exhibited high record-level data completeness, with minimal record omission and surplus rates for all three encounter types.

Strength #2: SilverSummit's data exhibited strong institutional and pharmacy data element completeness with all element omission and surplus rates less than 5.0 percent.

Strength #3: SilverSummit's data exhibited strong pharmacy data element accuracy, where all 10 of the evaluated data elements had data accuracy rates greater than 95.0 percent.

Medical Record Review

Strength #4: The *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 1.6 percent, 0.9 percent, 1.0 percent, and 0.6 percent, respectively.

Strength #5: When the three key data elements (*Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 94.1 percent each.

Weaknesses and Recommendations

Comparative Analysis

Weakness #1: Although the element omission and element surplus rates were low for most data elements between the **SilverSummit**-submitted data and Nevada Medicaid-submitted data, the following data element had a rate higher than 5.0 percent:

- Professional encounters: Element surplus for *Secondary Diagnosis Code(s)*

Why the weakness exists: SilverSummit pulled the diagnosis codes at the line level, not the header level for the data submitted to HSAG.

Recommendation: SilverSummit should follow the action plan noted in the data discrepancy report to ensure the data element noted above is submitted to Nevada Medicaid and HSAG completely. In addition, **SilverSummit** should review and implement standard quality controls to ensure accurate data extracts from its respective systems.

Weakness #2: Although matched records largely contained similar values between the **SilverSummit**-submitted data and Nevada Medicaid-submitted data, the following data elements had an accuracy rate lower than 95.0 percent:

- Professional encounters: *Primary Diagnosis Code* and *Secondary Diagnosis Code(*s).
- Institutional encounters: *Secondary Diagnosis Code(*s), *Surgical Procedure Code(s)*, and *TOB Code*.

Why the weakness exists: While additional analysis is needed to determine what caused the inaccuracies for the *TOB Code* data element, **SilverSummit** prepared the remaining data fields incorrectly for the data submitted to HSAG.

Recommendation: SilverSummit should follow the action plan noted in the data discrepancy report to ensure the data elements noted above have accurate values submitted to Nevada Medicaid and HSAG. Secondly, **SilverSummit** should work with Nevada Medicaid to further investigate the root causes for the *TOB Code* inaccuracies. Lastly, **SilverSummit** should review and implement standard quality controls to ensure accurate data extracts from its respective systems.

Medical Record Review

Weakness #3: SilverSummit was unable to procure all of the requested medical records from its contracted providers, resulting in a low medical record procurement rate (73.7 percent). The low medical record procurement rate consequently affected the results of the medical record reviews of key data elements that were evaluated.

Why the weakness exists: The most cited reason for non-submission was *Non-Responsive Provider or Provider Did Not Respond in a Timely Manner* (87.0 percent).

Recommendation: To ensure **SilverSummit**'s contracted provider accountability in addressing submission of medical records for auditing, inspection, and examination related to its members, **SilverSummit** should consider strengthening and/or enforcing its contract requirements with providers in providing the requested documentation.

Weakness #4: More than 21.0 percent of values for each of the data elements (*Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) identified in the encounter data were not supported by the members' medical records.

Why the weakness exists: While non-submission of the medical records was the primary cause, the findings where encounter data were not supported by the medical records can stem from several other potential reasons, which can involve provider documentation practices (e.g., incomplete or inaccurate documentation, coding errors, lack of detail), data submission (e.g., incorrect coding during data submission or data entry errors), or processing issues (e.g., data mapping or translation issues, errors in data transmission).

Recommendation: SilverSummit should investigate the root cause(s) of these omissions, with a focus on both provider documentation practices and data handling processes. Periodic medical record reviews of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers. Topics should include encounter data submissions, medical record documentation requirements, and coding practices to reduce future omissions and improve data accuracy.

Appendix F. Comparative Analysis and Medical Record Review Results for UnitedHealthcare Health Plan of Nevada Medicaid

This appendix contains detailed comparative analysis and medical record review results for **UHC HPN**.

Comparative Analysis Results

Table F-1—Record Omission and Surplus by Encounter Type

	Record Omission			Record Surplus		
Encounter Data Source	Denominator	Numerator	Rate*	Denominator	Numerator	Rate*
Professional	73,934	5,413,213	1.4%	183,345	5,522,624	3.3%
Institutional	28,391	1,810,434	1.6%	142,340	1,924,383	7.4%
Pharmacy	38	2,133,512	<0.1%	201,870	2,335,344	8.6%

* Lower rates indicate better performance.

Table F-2—Element Omission, Surplus, and Missing, by Key Data Element—Professional Encounters

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCO's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Number of Matched Records: 5,339,279						
Recipient ID	11,921	0.2%	276	<0.1%	0	0.0%
Header Service From Date	0	0.0%	0	0.0%	0	0.0%
Header Service To Date	0	0.0%	0	0.0%	0	0.0%
Detail Service From Date	0	0.0%	0	0.0%	0	0.0%
Detail Service To Date	0	0.0%	0	0.0%	0	0.0%
Billing Provider NPI	0	0.0%	14	<0.1%	0	0.0%
Rendering Provider NPI	46,110	0.9%	72	<0.1%	16	<0.1%
Referring Provider NPI^	919	<0.1%	0	0.0%	2,502,402	46.9%
Primary Diagnosis Code	0	0.0%	0	0.0%	0	0.0%
Secondary Diagnosis Codes[1,^]	9	<0.1%	0	0.0%	1,891,234	35.4%
Procedure Code	223	<0.1%	2	<0.1%	0	0.0%

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCO's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Procedure Code Modifier(s)[2,^]	28	<0.1%	117	<0.1%	3,809,379	71.3%
Units of Service	0	0.0%	0	0.0%	0	0.0%
POS Code	0	0.0%	0	0.0%	0	0.0%
NDC^	15,527	0.3%	2	<0.1%	5,124,923	96.0%
Drug Quantity	0	0.0%	0	0.0%	0	0.0%
Header Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail Paid Amount	0	0.0%	0	0.0%	0	0.0%
Header TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Paid Date	0	0.0%	0	0.0%	0	0.0%

* Lower rates indicate better performance.
+ Indicates that the element was not populated in either data source.
^ Indicates that the data field is situational (i.e., not required for every encounter line).
[1] All submitted secondary diagnosis codes were ordered alphabetically and numerically, then concatenated as a single data element.
[2] All submitted procedure code modifiers were ordered alphabetically and numerically, then concatenated as a single data element.

Table F-3—Element Omission, Surplus, and Missing, by Key Data Element—Institutional Encounters

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCO's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Number of Matched Records: 1,782,043						
Recipient ID	0	0.0%	149	<0.1%	0	0.0%
Header Service From Date	0	0.0%	0	0.0%	0	0.0%
Header Service To Date	0	0.0%	0	0.0%	0	0.0%
Detail Service From Date	0	0.0%	0	0.0%	0	0.0%
Detail Service To Date	0	0.0%	0	0.0%	0	0.0%

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCO's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Admission Date^	403	<0.1%	451	<0.1%	1,453,508	81.6%
Discharge Status	0	0.0%	0	0.0%	0	0.0%
Billing Provider NPI	0	0.0%	9	<0.1%	0	0.0%
Attending Provider NPI	39,364	2.2%	30	<0.1%	457	<0.1%
Referring Provider NPI^	98	<0.1%	0	0.0%	1,754,017	98.4%
Primary Diagnosis Code	0	0.0%	29	<0.1%	0	0.0%
Secondary Diagnosis Code(s)[1,^]	3	<0.1%	0	0.0%	191,041	10.7%
Procedure Code^	114	<0.1%	71	<0.1%	529,337	29.7%
Procedure Code Modifier(s)[2,^]	380	<0.1%	260	<0.1%	1,541,894	86.5%
Units of Service	0	0.0%	0	0.0%	0	0.0%
Revenue Code	0	0.0%	0	0.0%	0	0.0%
Surgical Procedure Code(s)[3,^]	1,538	0.1%	0	0.0%	1,581,826	88.8%
TOB Code	0	0.0%	0	0.0%	0	0.0%
NDC^	29,271	1.6%	241	<0.1%	1,418,493	79.6%
Drug Quantity^	0	0.0%	0	0.0%	0	0.0%
Header Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail Paid Amount	0	0.0%	0	0.0%	0	0.0%
Header TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Paid Date	0	0.0%	0	0.0%	0	0.0%

* Lower rates indicate better performance.
+ Indicates that the element was not populated in either data source.
^ Indicates that the data field is situational (i.e., not required for every encounter line).
[1] All submitted secondary diagnosis codes were ordered alphabetically and numerically, then concatenated as a single data element.
[2] All submitted procedure code modifiers were ordered alphabetically and numerically, then concatenated as a single data element.
[3] All submitted surgical procedure codes were ordered alphabetically and numerically, then concatenated as a single data element.

Table F-4—Element Omission, Surplus, and Missing, by Key Data Element—Pharmacy Encounters

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in MCO's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Number of Matched Records: 2,133,474						
Recipient ID	1,827	0.1%	0	0.0%	0	0.0%
Date of Service	0	0.0%	0	0.0%	0	0.0%
Billing Provider NPI	0	0.0%	0	0.0%	0	0.0%
Prescribing Provider NPI	49,976	2.3%	0	0.0%	0	0.0%
NDC	0	0.0%	0	0.0%	0	0.0%
Drug Quantity	0	0.0%	0	0.0%	0	0.0%
Days of Supply	0	0.0%	0	0.0%	0	0.0%
Paid Amount	0	0.0%	0	0.0%	0	0.0%
TPL Paid Amount	0	0.0%	0	0.0%	0	0.0%
Paid Date	0	0.0%	0	0.0%	0	0.0%

* Lower rates indicate better performance.
+ Indicates that the element was not populated in either data source.

Table F-5—Element Accuracy—Professional Encounters

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Recipient ID	5,327,082	5,326,642	>99.9%
Header Service From Date	5,339,279	5,339,279	100%
Header Service To Date	5,339,279	5,339,279	100%
Detail Service From Date	5,339,279	5,339,278	>99.9%
Detail Service To Date	5,339,279	5,339,278	>99.9%
Billing Provider NPI	5,339,265	5,330,398	99.8%
Rendering Provider NPI	5,293,081	5,091,024	96.2%
Referring Provider NPI	2,835,958	2,835,958	100%
Primary Diagnosis Code	5,339,279	5,339,279	100%
Secondary Diagnosis Codes[1]	3,448,036	3,447,990	>99.9%
Procedure Code	5,339,054	5,331,109	99.9%

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Procedure Code Modifier(s)[2]	1,529,755	1,529,320	>99.9%
Units of Service	5,339,279	5,339,142	>99.9%
POS Code	5,339,279	5,328,456	99.8%
NDC	198,827	198,825	>99.9%
Drug Quantity	5,339,279	5,339,085	>99.9%
Header Paid Amount	5,339,279	5,334,445	99.9%
Detail Paid Amount	5,339,279	5,337,587	>99.9%
Header TPL Paid Amount	5,339,279	5,337,811	>99.9%
Detail TPL Paid Amount	5,339,279	5,160,377	96.6%
Paid Date	5,339,279	5,339,279	100%

[1] All submitted secondary diagnosis codes were ordered alphabetically and numerically, then concatenated as a single data element.
[2] All submitted procedure code modifiers were ordered alphabetically and numerically, then concatenated as a single data element.

Table F-6—Element Accuracy—Institutional Encounters

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Recipient ID	1,781,894	1,781,733	>99.9%
Header Service From Date	1,782,043	1,779,708	99.9%
Header Service To Date	1,782,043	1,752,864	98.4%
Detail Service From Date	1,782,043	1,778,513	99.8%
Detail Service To Date	1,782,043	1,778,460	99.8%
Admission Date	327,681	327,681	100%
Discharge Status	1,782,043	1,782,030	>99.9%
Billing Provider NPI	1,782,034	1,781,783	>99.9%
Attending Provider NPI	1,742,192	1,741,287	99.9%
Referring Provider NPI	27,928	27,928	100%
Primary Diagnosis Code	1,782,014	1,782,014	100%
Secondary Diagnosis Code(s)[1]	1,590,999	1,590,741	>99.9%
Procedure Code	1,252,521	1,249,380	99.7%
Procedure Code Modifier(s)[2]	239,509	239,312	99.9%
Units of Service	1,782,043	1,780,541	99.9%

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Revenue Code	1,782,043	1,780,020	99.9%
Surgical Procedure Code(s)[3]	198,679	114,733	57.7%
TOB Code	1,782,043	1,633,998	91.7%
NDC	334,038	333,527	99.8%
Drug Quantity	1,782,043	1,779,934	99.9%
Header Paid Amount	1,782,043	1,775,487	99.6%
Detail Paid Amount	1,782,043	1,780,231	99.9%
Header TPL Paid Amount	1,782,043	1,780,918	99.9%
Detail TPL Paid Amount	1,782,043	1,763,795	99.0%
Paid Date	1,782,043	1,782,043	100%

[1] All submitted secondary diagnosis codes were ordered alphabetically and numerically, then concatenated as a single data element.
[2] All submitted procedure code modifiers were ordered alphabetically and numerically, then concatenated as a single data element.
[3] All submitted secondary surgical procedure codes were ordered alphabetically and numerically, then concatenated as a single data element.

Table F-7—Element Accuracy—Pharmacy Encounters

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Recipient ID	2,131,647	2,131,647	100%
Date of Service	2,133,474	2,133,474	100%
Billing Provider NPI	2,133,474	2,133,382	>99.9%
Prescribing Provider NPI	2,083,498	2,083,169	>99.9%
NDC	2,133,474	2,133,474	100%
Drug Quantity	2,133,474	2,131,425	99.9%
Days of Supply	2,133,474	2,133,474	100%
Paid Amount	2,133,474	2,133,474	100%
TPL Paid Amount	2,133,474	2,133,474	100%
Paid Date	2,133,474	2,133,474	100%

Table F-8—All-Element Accuracy by Encounter Type

Encounter Type	Number of Records in Both Files	Number of Records With Same Values in Both Files	Rate
Professional	5,339,279	4,860,536	91.0%
Institutional	1,782,043	1,450,892	81.4%
Pharmacy	2,133,474	2,079,350	97.5%

Data Discrepancy Report

The last column in the image below displays the written responses from **UHC HPN** in the data discrepancy report noting **UHC HPN**'s investigative efforts, explanations of root causes, and action plans.

Table	Discrepancy Item	UHC HPN's Investigation Efforts, Explanations of Root Cause(s), and Action Plan(s)
Table 1	Institutional Encounters—Record Surplus: 7.4 percent	Per appendix B (example 3) in the MCO Data Submission Requirements document, it's noted that only the latest iteration of the claim/encounter should be included in the claim file. For all 30 of the INST examples provided the ICNs that were provided were not the latest iteration of the encounter. Only the latest iteration was submitted in our audit file. This situation seems to derive from where the original was a denied claim, and the latest iteration was a paid claim that we also sent as New Day.
Table 1	Pharmacy Encounters—Record Surplus: 8.6 percent	Per appendix B (example 2) in the MCO Data Submission Requirements document, it's noted to not send voided encounters. Of the 30 RX ICN examples, 28 of them were void submissions. One (1) was not the latest iteration of the encounter (7523233007446), which is similar to the institutional response above, and one (1) was incorrectly left out of the HPN claim pull (7023355070248). Please see the document labeled HPN_Encounters Appendix B on tab "Pharmacy Encounters".
Table 3	Institutional Encounters—*Surgical Procedure Code(s)* Accuracy: 57.7 percent	HPN verified what is in the MCE value matches what we have in our encounter system and is also what was submitted in the 837I submission file. Please see the document labeled HPN_Encounters Appendix A for examples.
Table 3	Institutional Encounters—*TOB Code* Accuracy: 91.7 percent	For encounter reporting we may not always be able to use the frequency code (third digit of bill type) as received from the provider. The provider could send HPN a corrected claim using the frequency code of '7'. If the original encounter (frequency code = '1') HPN submitted was rejected, HPN can't send the corrected claim with a frequency code of '7' because we can't replace a rejected encounter. HPN would need to send the corrected claim as an original where the frequency code will be '1'. Please see the document labeled HPN_Encounters Appendix B on tab "INST TOB Encounter Examples".

Medical Record Review Results

Table F-9—Medical Record Procurement Status: Requested Date of Service

Number of Medical Records Requested	Number of Medical Records Submitted[1]	Percentage of Medical Records Submitted
411	365	88.8%

[1] The number of medical records submitted was based on the MCO's responses within the submitted tracking sheets and/or submitted records.

Table F-10—Medical Record Non-Submission Reasons: Requested Date of Service

Non-Submission Reason	Number	Percent
Record was not located at this facility.	0	0.0%
Member was not a patient of this practice.	0	0.0%
Member was a patient of this practice; however, no documentation was available for date of service.	0	0.0%
Non-responsive provider or provider did not respond in a timely manner.	43	93.5%
Provider refused to release records.	0	0.0%
Facility was permanently closed.	1	2.2%
Other.	2	4.3%
Total	**46**	**100%**

Table F-11—Medical Record Submission Status: Second Date of Service

Number of Medical Records Submitted[1]	Number of Medical Records Submitted With a Second Date of Service	Percentage of Medical Records With a Second Date of Service
365	223	61.1%

[1] The number of medical records submitted was based on the MCO's responses within the submitted tracking sheets and/or submitted records.

Table F-12—Medical Record Review: Encounter Data Completeness

	Medical Record Omission		Encounter Data Omission	
Data Element	Denominator	Percent*	Denominator	Percent*
Date of Service	591	8.1%	556	2.3%
Diagnosis Code	1,602	10.0%	1,461	1.3%
Procedure Code	1,358	17.9%	1,130	1.3%

	Medical Record Omission		Encounter Data Omission	
Data Element	Denominator	Percent*	Denominator	Percent*
Procedure Code Modifier	523	26.6%	391	1.8%

* Lower rates indicate better performance.

Table F-13—Medical Record Review: Encounter Data Accuracy

Data Element	Denominator	Percent	Main Error Type
Diagnosis Code[1]	1,442	99.9%	Incorrect Code: (100%) Specificity Error: (0.0%)
Procedure Code[2]	1,115	96.4%	Incorrect Code: (97.5%) Higher Level of Service in Medical Record: (2.5%) Lower Level of Service in Medical Record: (0.0%)
Procedure Code Modifier	384	99.2%	—
All-Element Accuracy[3]	543	75.5%	—

"—" denotes that the error type analysis was not applicable to a given data element.
[1] Inaccurate coding and specificity errors in service records were collectively considered as the denominator for the error type rates.
[2] Inaccurate coding, codes with higher level of services, and codes with lower level of services in service records were collectively considered as the denominator for the error type rates.
[3] The denominator for the element accuracy rate for each data element was defined differently from the denominator for the all-element accuracy rate. Therefore, the all-element accuracy rate could not be derived from the accuracy rate from each data element.

Strengths, Weaknesses, and Recommendations

Based on the results from the comparative analysis and medical record review, HSAG identified the following areas of strength and opportunities for improvement. Along with each opportunity for improvement, HSAG has also provided a recommendation to help target improvement efforts.

Strengths

Comparative Analysis

Strength #1: UHC HPN's data exhibited high record-level data completeness, with minimal record omission (1.4 percent) and surplus (3.3 percent) rates for professional encounters.

Strength #2: UHC HPN's data exhibited strong data element completeness with all element omission and surplus rates less than 5.0 percent for all three encounter types.

Strength #3: UHC HPN's data exhibited strong professional and pharmacy data element accuracy, where all applicable evaluated data elements had data accuracy rates greater than 95.0 percent.

Medical Record Review

Strength #4: The *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier* identified in the medical records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 2.3 percent, 1.3 percent, 1.3 percent, and 1.8 percent, respectively.

Strength #5: When the three key data elements (*Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) were present in both the encounter data and the members' medical records and were evaluated independently, the data element values were found to be accurate with rates of at least 96.4 percent each.

Weaknesses and Recommendations

Comparative Analysis

Weakness #1: UHC HPN's institutional data had an elevated record surplus rate of 7.4 percent. Additionally, **UHC HPN**'s pharmacy data had an elevated record surplus rate of 8.6 percent.

Why the weakness exists: For the extra institutional records in Nevada Medicaid's data, **UHC HPN** noted that they were not the latest iteration of the encounters. This situation derived from where the original was a denied claim, and the latest iteration was a paid claim that was sent on a new day. Moreover, many of the pharmacy encounters in surplus were "voided" encounters.

Recommendation: UHC HPN should work with Nevada Medicaid to decide whether **UHC HPN** and/or Nevada Medicaid have the correct logic to identify final adjudicated records (e.g., denied first and paid later) and remove voids from final adjudicated records.

Weakness #2: Although matched records largely contained similar values between the **UHC HPN**-submitted data and Nevada Medicaid-submitted data, the following data elements had an accuracy rate lower than 95.0 percent:

- Institutional encounters: *Surgical Procedure Code(s)* and *TOB Code*.

Why the weakness exists: Additional analysis is needed to determine what caused the inaccuracies for the *Surgical Procedure Code(s)* and *TOB Code* data elements.

Recommendation: UHC HPN should work with Nevada Medicaid to further investigate the root causes for the *Surgical Procedure Code(s)* and *TOB Code* inaccuracies.

Medical Record Review

Weakness #3: UHC HPN was unable to procure all of the requested medical records from its contracted providers, resulting in a low medical record procurement rate (88.8 percent). The low medical record procurement rate consequently affected the results of the medical record reviews of key data elements that were evaluated.

Why the weakness exists: The most cited reason for non-submission was *Non-Responsive Provider or Provider Did Not Respond in a Timely Manner* (93.5 percent).

Recommendation: To ensure **UHC HPN**'s contracted provider accountability in addressing submission of medical records for auditing, inspection, and examination related to its members, **UHC HPN** should consider strengthening and/or enforcing its contract requirements with providers in providing the requested documentation.

Weakness #4: More than 8.0 percent of values for each of the data elements (*Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) identified in the encounter data were not supported by the members' medical records.

Why the weakness exists: While non-submission of the medical records was the primary cause, the findings where encounter data were not supported by the medical records can stem from several other potential reasons, which can involve provider documentation practices (e.g., incomplete or inaccurate documentation, coding errors, lack of detail), data submission (e.g., incorrect coding during data submission or data entry errors), or processing issues (e.g., data mapping or translation issues, errors in data transmission).

Recommendation: **UHC HPN** should investigate the root cause(s) of these omissions, with a focus on both provider documentation practices and data handling processes. Periodic medical record reviews of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers. Topics should include encounter data submissions, medical record documentation requirements, and coding practices to reduce future omissions and improve data accuracy.

Appendix G. Comparative Analysis and Dental Record Review Results for LIBERTY Dental Plan of Nevada, Inc.

This appendix contains detailed comparative analysis and dental record review results for **LIBERTY**.

Comparative Analysis Results

Table G-1—Record Omission and Surplus by Encounter Type

	Record Omission			Record Surplus		
Encounter Data Source	Denominator	Numerator	Rate*	Denominator	Numerator	Rate*
Dental	4,618	2,357,938	0.2%	43,751	2,397,071	1.8%

* Lower rates indicate better performance.

Table G-2—Element Omission, Surplus, and Missing, by Key Data Element—Dental Encounters

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in LIBERTY's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Number of Matched Records: 2,353,320						
Recipient ID	5,580	0.2%	0	0.0%	0	0.0%
Header Service From Date	0	0.0%	0	0.0%	0	0.0%
Header Service To Date	0	0.0%	0	0.0%	0	0.0%
Detail Service From Date	0	0.0%	0	0.0%	0	0.0%
Detail Service To Date	0	0.0%	0	0.0%	0	0.0%
Billing Provider NPI	0	0.0%	0	0.0%	0	0.0%
Rendering Provider NPI	6,124	0.3%	0	0.0%	0	0.0%
Referring Provider NPI^	0	0.0%	0	0.0%	2,353,320	100%
All Diagnosis Codes[1]	0	0.0%	64,117	2.7%	45,404	1.9%
Procedure Code	2	<0.1%	0	0.0%	0	0.0%
Units of Service	0	0.0%	0	0.0%	0	0.0%
POS Code	1	<0.1%	0	0.0%	0	0.0%

	Element Omission		Element Surplus		Element Missing+	
Key Data Element	Number of Records With Values Not in Nevada Medicaid's File	Rate*	Number of Records With Values Not in LIBERTY's Files	Rate*	Number of Records With Values Missing From Both Files	Rate
Tooth Number^	0	0.0%	0	0.0%	1,424,929	60.5%
Tooth Surface Codes[2,^]	92	<0.1%	0	0.0%	2,151,994	91.4%
Oral Cavity Codes[3,^]	35	<0.1%	0	0.0%	2,166,729	92.1%
Header Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail Paid Amount	0	0.0%	0	0.0%	0	0.0%
Paid Date	0	0.0%	0	0.0%	0	0.0%

* Lower rates indicate better performance.
+ Indicates that the element was not populated in either data source.
^ Indicates that the data field is situational (i.e., not required for every encounter line).
[1] All submitted diagnosis codes at the line level were aggregated to the header level, then ordered alphabetically and numerically, and then concatenated as a single data element.
[2] All submitted tooth surface codes were ordered alphabetically and numerically, then concatenated as a single data element.
[3] All submitted oral cavity codes were ordered alphabetically and numerically, then concatenated as a single data element.

Table G-3—Element Accuracy—Dental Encounters

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Recipient ID	2,347,740	2,347,532	>99.9%
Header Service From Date	2,353,320	2,353,314	>99.9%
Header Service To Date	2,353,320	2,353,314	>99.9%
Detail Service From Date	2,353,320	2,353,314	>99.9%
Detail Service To Date	2,353,320	2,353,143	>99.9%
Billing Provider NPI	2,353,320	2,239,404	95.2%
Rendering Provider NPI	2,347,196	2,346,032	>99.9%
Referring Provider NPI	0	0	—
All Diagnosis Codes[1]	2,243,799	2,219,435	98.9%
Procedure Code	2,353,318	2,353,253	>99.9%
Units of Service	2,353,320	2,353,320	100%
POS Code	2,353,319	2,352,740	>99.9%
Tooth Number	928,391	928,372	>99.9%

Key Data Element	Number of Records With Values Present in Both Files	Number of Records With Same Values in Both Files	Rate
Tooth Surface Codes[2]	201,234	201,224	>99.9%
Oral Cavity Codes[3]	186,556	186,266	99.8%
Header Paid Amount	2,353,320	2,351,444	99.9%
Detail Paid Amount	2,353,320	2,352,811	>99.9%
Paid Date	2,353,320	2,353,095	>99.9%

[1] All submitted diagnosis codes at the line level were aggregated to the header level, then ordered alphabetically and numerically, and then concatenated as a single data element.
[2] All submitted tooth surface codes were ordered alphabetically and numerically, then concatenated as a single data element.
[3] All submitted oral cavity codes were ordered alphabetically and numerically, then concatenated as a single data element.

Table G-4—All-Element Accuracy by Encounter Type

Encounter Type	Number of Records in Both Files	Number of Records With Same Values in Both Files	Rate
Dental	2,353,320	2,141,214	91.0%

Data Discrepancy Report

The last column in the image below displays the written responses from **LIBERTY** in the data discrepancy report noting **LIBERTY**'s investigative efforts, explanations of root causes, and action plans.

Table 3—Action Items from Comparative Analysis

Table	Discrepancy Item	LIBERTY's Investigation Efforts, Explanations of Root Cause(s), and Action Plan(s)
Table 2	LIBERY did not submit *Referring Provider NPI* values to HSAG or DHCFP.	**Audit Finding:** LIBERTY's current MIS system lacks the capability to capture the referring provider NPI, therefore, this data is not being transferred to the encounter file submitted to Nevada Health Authority and HSAG. This deficiency impacts the completeness and accuracy of data. **Investigation Efforts:** Following the identification of this HSAG audit finding, LIBERTY conducted an internal investigation to understand the scope and nature of the issue. LIBERTY efforts involved: • Review of System Architecture: LIBERTY examined the core MIS and associated systems involved in claim processing, prior authorization (PA), and encounter file generation. • Data Flow Analysis: LIBERTY traced the path of referring provider NPI data from initial submission (claim forms, EDI) through the system to the final encounter file sent to Nevada Health Authority or HSAG. • Current System Capabilities Assessment: LIBERTY confirmed that while the core MIS system possesses a field for referring provider NPI, it is not currently configured to automatically extract this information from submitted claims. • Stakeholder Interviews: LIBERTY engaged with various internal teams, including claims processing, IT, and compliance, to understand the current processes and identify potential points of failure or gaps in the NPI capture workflow. **Explanation of Root Cause(s):** LIBERTY's investigation identified the following root causes contributing to the inability to capture and transfer the referring provider NPI: • System Configuration Gap: The core MIS system, while equipped with an NPI field, lacks the necessary coding and logic to automatically extract the referring provider NPI from incoming claim submissions. This necessitates manual intervention in some cases, increasing the risk of errors or omissions. • Inadequate Business Rules: The absence of clearly defined business rules governing the matching of referrals to specific authorizations prevents the system from reliably pulling the correct NPI at the appropriate stage of the claims process. • Fragmented NPI Data Location: The referring provider NPI may reside in different modules or systems (e.g., UM module, Provider Portal), requiring more robust integration to ensure seamless data flow and capture during claim processing. • Provider Education & EDI Vendor Alignment: There is a need for enhanced communication with providers and EDI vendors to ensure they understand the importance of submitting the referring provider NPI and that their systems are configured to transmit this data effectively. **Action Plan(s):** LIBERTY is committed to addressing these root causes and has developed a comprehensive action plan, with specific timelines and responsibilities, to resolve this audit finding: **1. Internal System Enhancement & Upgrade (Estimated Completion: 9 Months)** • **System Analysis & Design:**

Table	Discrepancy Item	LIBERTY's Investigation Efforts, Explanations of Root Cause(s), and Action Plan(s)
		○ LIBERTY is developing a Business Requirements Document (BRD) to define the specific business rules and logic needed to enable the core MIS to automatically capture referring provider NPI from submitted claim forms. • **Claim Processing Enhancements:** ○ Paper Claims: LIBERTY will develop a temporary process to establish an action code, stopping paper claims, reviewing text remarks for the referring provider NPI, and manually adding the NPI to the appropriate field in the system. ○ Automated Claim Processing: Liberty will establish business rules to match referral claims with the exact authorization and configure the system to pull the referring provider NPI automatically. ○ Prior Authorization (PA) Integration: Liberty will analyze the Utilization Management (UM) module to identify where the referring provider NPI resides and implement the necessary logic for the claims system to pull this information and include it in the encounter file. • **Provider Portal Enhancement:** LIBERTY will test the Provider Portal's referral number functionality to understand data flow and develop the necessary coding and logic to correlate referral numbers with claims and extract the referring provider NPI. **2. External Stakeholder Engagement** • **Provider Education (Target Completion: 30 Days):** ○ LIBERTY will launch a targeted educational initiative to inform our provider network about the importance of submitting referring provider NPI numbers when appropriate. ○ Education materials will be tailored to different claim submission methods (paper, EDI, portal). • **EDI Vendor Outreach (Target Remediation: 2 Weeks):** Liberty will engage with our contracted EDI vendors to ensure that if providers enter the referring provider NPI, the data elements will flow seamlessly into our internal MIS systems. We are committed to the successful implementation of this corrective action plan to enhance the accuracy and completeness of our data submissions to the Nevada Health Authority and HSAG.

Dental Record Review Results

Table G-5—Dental Record Procurement Status: Requested Date of Service

Number of Dental Records Requested	Number of Dental Records Submitted[1]	Percentage of Dental Records Submitted
411	405	98.5%

[1] The number of dental records submitted was based on LIBERTY's responses within the submitted tracking sheets and/or submitted records.

Table G-6—Dental Record Non-Submission Reasons: Requested Date of Service

Non-Submission Reason	Number	Percent
Record was not located at this facility.	0	0.0%
Member was not a patient of this practice.	1	16.7%
Member was a patient of this practice; however, no documentation was available for date of service.	3	50.0%
Non-responsive provider or provider did not respond in a timely manner.	0	0.0%
Provider refused to release records.	0	0.0%
Facility was permanently closed.	2	33.3%
Other.	0	0.0%
Total	**6**	**100%**

Table G-7—Dental Record Submission Status: Second Date of Service

Number of Dental Records Submitted[1]	Number of Dental Records Submitted With a Second Date of Service	Percentage of Dental Records With a Second Date of Service
405	70	17.3%

[1] The number of dental records submitted was based on the **LIBERTY**'s responses within the submitted tracking sheets and/or submitted records.

Table G-8—Dental Record Review: Encounter Data Completeness

	Dental Record Omission		Encounter Data Omission	
Data Element	Denominator	Percent*	Denominator	Percent*
Date of Service	471	1.7%	473	2.1%
Diagnosis Code	760	13.8%	665	1.5%
Procedure Code	2,502	5.2%	2,382	0.4%

* Lower rates indicate better performance.

Table G-9—Dental Record Review: Encounter Data Accuracy

Data Element	Denominator	Percent	Main Error Type
Diagnosis Code[1]	655	71.6%	Incorrect Code: (100%) Specificity Error: (0.0%)
Procedure Code[2]	2,472	94.1%	—
All-Element Accuracy[3]	463	37.6%	—

"—" denotes that the error type analysis was not applicable to a given data element.
[1] Inaccurate coding and specificity errors in service records were collectively considered as the denominator for the error type rates.
[2] Inaccurate coding, codes with higher level of services, and codes with lower level of services in service records were collectively considered as the denominator for the error type rates.
[3] The denominator for the element accuracy rate for each data element was defined differently from the denominator for the all-element accuracy rate. Therefore, the all-element accuracy rate could not be derived from the accuracy rate from each data element.

Strengths, Weaknesses, and Recommendations

Based on the results from the comparative analysis and dental record review, HSAG identified the following areas of strength and opportunities for improvement. Along with each opportunity for improvement, HSAG has also provided a recommendation to help target improvement efforts.

Strengths

Comparative Analysis

Strength #1: LIBERTY's data exhibited high record-level data completeness, with minimal record omission (0.2 percent) and surplus (1.8 percent) rates for its dental encounters.

Strength #2: LIBERTY's data exhibited strong dental data element completeness with minimal element omission ranging from 0.0 to 0.3 percent and surplus rates ranging from 0.0 to 2.7 percent.

Strength #3: LIBERTY's data exhibited strong dental data element accuracy, where all of the evaluated data elements had data accuracy greater than 95.0 percent.

Dental Record Review

Strength #4: The *Date of Service*, *Diagnosis Code*, and *Procedure Code* identified in the dental records were generally present in the encounter data, as evidenced by the low encounter data omission rates of 2.1 percent, 1.5 percent, and 0.4 percent, respectively.

Weaknesses and Recommendations

Comparative Analysis

Weakness #1: LIBERTY's data element missing rate was 100 percent for the *Referring Provider NPI* data element.

Why the weakness exists: LIBERTY's current management information system lacks the capability to capture the *Referring Provider NPI* values; therefore, **LIBERTY** did not submit values for this data element to Nevada Medicaid or HSAG.

Recommendation: LIBERTY should follow through with the action plan described in the data discrepancy report to submit the *Referring Provider NPI* values to Nevada Medicaid.

Dental Record Review

Weakness #2: More than 13.0 percent of the *Diagnosis Code* values identified in the encounter data were not supported by the members' dental records.

Why the weakness exists: The findings where encounter data were not supported by the dental records can stem from several potential reasons, which can involve provider documentation practices (e.g., incomplete or inaccurate documentation, coding errors, lack of detail), data submission (e.g., incorrect coding during data submission or data entry errors), or processing issues (e.g., data mapping or translation issues, errors in data transmission).

Recommendation: LIBERTY should investigate the root cause(s) of these omissions, with a focus on both provider documentation practices and data handling processes. Periodic dental record reviews of submitted claims should be conducted to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should be used to develop and provide ongoing education and training for providers. Topics should include encounter data submissions, dental record documentation requirements, and coding practices to reduce future omissions and improve data accuracy.

Appendix H. Responses From the MCEs

Each MCE was given an opportunity to respond and provide feedback on a draft version of the EDV report. Responses from each MCO and the DBA are listed below.

EDV Responses—MCO

Anthem Blue Cross and Blue Shield Healthcare Solutions

Anthem has reviewed the EDV report and has no feedback/comments on the information reflected in this report.

Molina Healthcare of Nevada, Inc.

Molina has reviewed the EDV report and provided the following feedback/comments.

Information System Review: Weakness 1

Molina would like confirmation of Encounter data submissions based on the recommendations in from the HSAG ***NV FY_2025_EDV_Aggregate_Report, pg. D-11 section Weaknesses and Recommendations – IS Review.***

While submitting denied lines to Nevada Medicaid with $0 paid at the line level, ***Molina*** *did not submit fully denied claims (i.e., all lines were denied) to Nevada Medicaid.*

Why the weakness exists: *If fully denied claims (i.e., all lines were denied) represent services provided to the Medicaid members, Nevada Medicaid might be interested in collecting them.*

Recommendation: Molina *should work with Nevada Medicaid to decide whether the fully denied claims should be submitted to Nevada Medicaid.*

Molina Response: *Molina has received confirmation from Nevada that Fully Denied Encounters be submitted for reporting purposes on 10/29/2025. Molina will target to implement the submission of Fully Denied Encounters in Q1 2026.*

Information System Review: Weakness 2

While ***Molina*** *and/or its subcontractors evaluated claim volume by submission month, field-level completeness and accuracy, and submission timeliness, it did not note any reports regarding claim volume per member per month (PMPM), reconciliation with financial reports (e.g., clerk disperse journal), or medical record review. In addition, the example report from* ***Molina*** *appeared to include*

vision encounters in the "Professional" category, which may mask the data issues from vision encounters.

Why the weakness exists: *The implementation of comprehensive claims/encounter quality checks is required to ensure data accuracy, completeness, and timeliness.*

Recommendation: ***Molina*** *should explore the possibility of developing or enhancing monitoring reports to assess the accuracy, completeness, and/or timeliness of the encounters as noted below.*

- ***Molina*** *should develop reports regarding claim volume PMPM or reconciliation with financial reports (e.g., clerk disperse journal).*
- ***Molina*** *should monitor vision encounters separately from other professional encounters.*

Molina Response: *Molina is in the process of enhancing its internal reporting to account for sub-delegated vendor Encounter data submissions that will add PMPM reporting by 11/14/2025. We are implementing a CDJ reconciliation process with our sub-delegated vendors with the first phase of a CDJ template to be shared with its vendors by 11/24/2025, with the full process implemented by February 2025.*

Comparative Analysis Review: Weakness 3

Molina*'s professional data had elevated record omission (6.4 percent). Additionally, Molina's institutional data also had elevated record omission (7.3 percent).*

Why the weakness exists: ***Molina*** *included professional and institutional encounters rejected by Nevada Medicaid in the data submission to HSAG. In addition,* ***Molina*** *submitted some of the vision encounters in both the vision file and professional file to HSAG.*

Recommendation: ***Molina*** *should work with Nevada Medicaid to make sure that professional and institutional encounters denied by Nevada Medicaid are corrected and resubmitted to Nevada Medicaid. In addition,* ***Molina*** *should review and implement standard quality controls to ensure accurate data extracts from its respective systems.*

Molina Response: *As the state does not currently assign a Nevada Medicaid ICN to a rejected Encounter in the MMIS system, a path to remediate a rejection as a replacement or void is dependent upon referencing the ICN. Resolution of an Encounter rejection can include, but not limited to, recovery from the provider. A recovery as a void to a rejected paid claim cannot be remediated in this scenario.*

Molina will work with the Nevada Health Authority to address the dependency in remediating rejected Encounters.

Comparative Analysis Review: Weakness 4

Although the element omission and element surplus rates were low for most data elements between the ***Molina****-submitted data and Nevada Medicaid-submitted data, the following data elements had a rate higher than 5.0 percent:*

- *Institutional encounters: Element omission for Admission Date and Secondary Diagnosis Code(s)*

Why the weakness exists: *Because providers submitted the Admission Date values the same as the Header Service From Date values,* ***Molina*** *provided those dates to HSAG. For the Secondary Diagnosis Code(s) fields,* ***Molina*** *included secondary diagnosis codes with qualifiers other than "ABF" and "ABK" in the data to HSAG (e.g., qualifier "APR" for patient reason for visit codes).*

Recommendation: ***Molina*** *should follow the action plan noted in the data discrepancy report to ensure the data elements noted above are submitted to Nevada Medicaid and HSAG completely. In addition,* ***Molina*** *should review and implement standard quality controls to ensure accurate data extracts from its respective systems.*

Molina Response: *Molina has instituted a fix to its claims extracts for future audits. In addition, a QA process was implemented to adequately validate the extracts by the requested data elements.*

Comparative Analysis Review: Weakness 5

Although matched records largely contained similar values between the ***Molina****-submitted data and Nevada Medicaid-submitted data, the following data elements had an accuracy rate lower than 95.0 percent:*

- *Professional encounters: Detail Service From Date and Detail Service To Date.*
- *Institutional encounters: Detail Service From Date, Detail Service To Date, Secondary Diagnosis Code(s), Surgical Procedure Code(s), and TOB Code.*

Why the weakness exists: *While additional analysis is needed to determine what caused the inaccuracies for the Surgical Procedure Code(s) and TOB Code data elements,* ***Molina*** *prepared the remaining data fields incorrectly for the data submitted to HSAG.*

Recommendation: ***Molina*** *should follow the action plan noted in the data discrepancy report to ensure the data elements noted above have accurate values submitted to Nevada Medicaid and HSAG. Secondly,* ***Molina*** *should work with Nevada Medicaid to further investigate the root causes for the Surgical Procedure Code(s) and TOB Code inaccuracies. Lastly,* ***Molina*** *should review and implement standard quality controls to ensure accurate data extracts from its respective systems.*

Molina Response: *The action plan remediation has been implemented to our claims extracts.*

SilverSummit Healthplan, Inc.

SilverSummit has reviewed the EDV report and has no feedback/comments on the information reflected in this report.

UnitedHealthcare Health Plan of Nevada Medicaid

UHC HPN has reviewed the EDV report and has no feedback/comments on the information reflected in this report.

EDV Responses—DBA

LIBERTY Dental Plan of Nevada, Inc.

LIBERTY has reviewed the EDV report and has no feedback/comments on the information reflected in this report.